Women's Fertility History

Fertile Lifestyle Acupuncture and Integrative Medicine
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NAME: DATE:

Age at which menses began _____
Do you have pain with menses? Y or N
How many days does the pain last? _____
How many days do you usually bleed? _____
How heavy is the bleeding? Light, normal, or heavy?
What color is the blood? (circle which one below)
Light red/red/Dark red/Purple/brown/black
Is there clotting? Y or N
Do you have premenstrual Tension? Y or N
Do you have problems with acne before or during your menses? Y or N

Do you have breast tenderness before your period? Y or N
Do you experience spotting or bleeding between Your Menses? Y or N
Do you have irregularly spaced cycles? Y or N
How many days are there from Day 1 of your menses to the next? _____
What was the date of your last menstrual Period? _____

	Number	Years
How many pregnancies have you had?	____	_____
How many children do you have?	____	_____
How many abortions have you had?	____	_____
How many miscarriages?	____	_____
How many times has a D& C been performed?	____	_____

Have you ever had an abnormal pap smear? Y or N
Have you ever had a cervical biopsy, operation, curettage or conization, cerclage performed? Y or N
Have you ever had a venereal disease? Y or N
If yes, which one and what if any treatment was given? _____
Do you get yeast infections regularly? Y or N
Have you ever been diagnosed with Chlamydia? Y or N

Do you have any sore (s) on your genitalia? Y or N
Have you ever had Pelvic inflammatory disease? Y or N
Were you treated for it? Y or N
How? _____
Date of your last pap smear? _____
Have you ever been diagnosed with uterine fibroids or polyps? Y or N
Have you ever been diagnosed with endometriosis? Y or N
Have you ever been diagnosed with pelvic abnormalities? Y or N
Have you been diagnosed with P.C.O.S? Y or N

What medications, if any, have you taken for gynecological conditions other than contraception?

Medication	Reason	How long
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(if there is more, add it in the blank area below.)

Have your cycles changed since they began? Y or N (if yes, how?) _____
Do you ovulate on your own? Y or N
Which day of your cycle does this occur? _____
Do you notice good fertile cervical mucus around ovulation? Is it Scanty or a lasts a couple of days? _____
Do your breasts get tender at or during ovulation? Y or N
Do you get premenstrual low back pain? Y or N
Do your bowel movements become loose at the beginning of your period? Y or N
Do you have chronic vaginal discharge? Y or N
What color is it? _____

Women's fertility history (continued)

Have you ever had fertility treatments? Y or N If yes, where and when? _____ By whom? _____ What types? _____ Have you taken medication to help lose weight? Y or N Have you taken medication to help you ovulate? Y or N When? _____ How long? _____ Have you had your fallopian tubes evaluated? Y or N Medically? (an HSG performed? Y or N What were the results? _____ Have you had any tubule operations? Y or N Have you had your hormones tested? Y or N If yes, when? _____ What were the results? _____ Do you have a partner with whom you've been trying to conceive? Y or N How long have you been trying to conceive? _____ Has he had a fertility work up? Y or N What were the results? _____ Is your partner supportive of your wish to conceive? Y or N Have you taken oral contraceptives? Y or N If yes, when? _____For how long? _____ Have you ever had an IUD? Y or N If yes, when? _____ For how long? _____	How is your sexual energy (libido)? Low/ normal/ high? (circle one) Do you douche regularly? Y or N Do you use vaginal lubricants? Y or N If yes, which one? _____ Are you more than 20% below your ideal weight? Y or N Are you less than 20 % of your ideal weight? Y or N Do you have a stressful occupation? Y or N Do you feel like you are constantly stressed? Y or N Do you exercise regularly? Y or N Do you have excessive facial hair? Y or N Do you have excessively oily skin? Y or N Have you experienced excessive head hair loss? Y or N Have you noticed any discharge from your nipples? Y or N Was your mother ever exposed to diethylstilbestrol when she was pregnant with you? Y or N Have you been exposed to any known toxins, molds or hormones? Y or N Are you currently taking any steroids? Y or N Have you ever taken Depo Provera? Y or N When? _____ How long? _____ Have you had a diagnosis relating to infertility? Y or N What was it? _____
Comments/notes:	