Women's Fertility History

NAME: _____ DATE: _____

At what age did menses begun?	

				Yes		**No**
Are your periods painful?						
How many days does the last pain last?						
How many days do you normally bleed?						
How heavy is the bleeding?	Light:		Medium:		Heavy:	
What colour is the blood?	Light Red:	Red:	Dark Red:	Purple:	Brown:	Black:

	Yes	**No**
Is there clotting?		
Do you have premenstrual tension?		
Does your face break out before or during your period?		
Do your breasts become tender prematurely?		
Do you bleed or spot between periods?		
Are you menstrual cycles spaced irregularly?		

How many days are there from one period to the next?	
Date of last menstruation period?	

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

	Yes	**No**
Have you ever had an abnormal pap smear?		
Have you ever had a cervical biopsy, operation, cauterization or conization?		
Have you ever had a vaginal disease?		
Do you get yeast infections regularly?		
Have you ever been diagnosed with Chlamydia infection?		
Do you have chronic vaginal discharge?		
Do you have any sores on your genitalia?		
Have you ever had pelvic inflammatory disease?		
Have your cycles changed since they began?		
How?		
Do you ovulate on your own?		

		Yes	**No**
Have you ever been diagnosed with uterine fibroids or polyps?			
Have you ever been diagnosed with any pelvic abnormalities?			
Have you ever been diagnosed with any pelvic abnormalities?			
Have you ever taken any medications for gynaecological conditions other than contraceptives?			
Medication	**Reason**	**How Long**	

	Yes	No
Have your cycles changed since they began?		
How?		
Do you ovulate on your own?		
On what day of your cycle?		
Do your breasts get tender at/ during ovulation?		
Do you get premenstrual low back pain?		
Do your bowel movements become loose at the beginning of your period?		
Have you had fertility treatments?		
If yes, when and where?		
By whom?		
What Types?		

	Yes	No
Have you taken medication to help you ovulate?		
When?	How long?	
Have your fallopian tubes been evaluated medically?		
What were the results?		
Have you had any hormone laboratory tests performed?		
What were the results?		
Do you have a single partner with whom you have been trying to conceive with?		
How long have you been married or living together?		
Has he had a fertility workup?		
What were the results?		
Is your partner supportive of your wish to conceive?		
Have you taken oral contraceptives?		
When?	How long?	
Have you ever had an IUD coil?		
When?	How long?	
How long have you been trying to conceive?		
Have you had a diagnosis relating to infertility?		
What was it?		
How is you sexual energy?	Low:	Medium:	High:
Do you douche regularly?		
With what?		

	Yes	No
Do you use vaginal lubricants?		
Are you more than 20% over your ideal body weight?		
Are you more than 20% below you ideal body weight?		
Do you have a stressful occupation?		
Do you exercise regularly?		
Do you have excess facial hair?		
Do you have excessively oily skin?		
Have you experienced excessive loss of head hair?		
Have you noticed discharge from your nipples?		
Have you been exposed to any known environmental toxins or hormones?		
Are you presently taking steroids?		