**Women’s Fertility History**

**NAME: ­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| At what age did menses begun? |  |

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| --- | --- | --- |
|  | **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? |  |  |

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

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| --- | --- | --- |
|  | **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? |  |  |

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| --- | --- | --- |
|  | **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? |  |

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| --- | --- | --- |
|  | **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? |  |  |