**Women’s Fertility History**

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

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| 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: | |

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|  | **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? |  | |

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

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|  | | | | | | | | | **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? |  |  |