# Women's Fertility History

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Name:_____ Date:_____
Age at which menses began___
Are your periods painful? YES__ , NO___. How many days does the pain last?_____
How many days do you normally bleed? _____
How heavy is the bleeding? Light___, Normal___, Heavy____.
What color is the blood? Light red___, Red___, Dark red___,
Purple___, Brown ___, Black___.
Is there clotting? Yes___, No____.
Do you have premenstrual tension? Yes___, NO____.
Does your face break out before or during your period? Yes___, NO____.
Do you breasts become tender premenstrual ? Yes___, NO____. Yes___, NO____.
Do you bleed or spot between periods? Yes___, NO____.
Are you menstrual cycles spaced irregularly? Yes___, NO____.
How many days are there from one period to the next?
Date of 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 have you had? | _____ | _____ |

Have you ever had an abnormal pap smear? Yes___, NO____.
Have you ever had a cervical biopsy,
operation, cauterization or conization? Yes___, NO____.
Have you ever had a venereal disease? Yes___, NO____.
Do you get yeast infections regularly? Yes___, NO____.
Have you ever been diagnosed with a chlamydial infection? Yes___, NO____.
Do you have chronic vaginal discharge? Yes___, NO____.
Do you have any sores on your genitalia? Yes___, NO____.
Have you ever had pelvic inflammatory disease? YES__ , NO___.
Were you treated for it? Yes___, NO____.
How _____
_____
Date of last pap smear _____
Have you ever been diagnosed with uterine fibroids or polyps? Yes___, NO____.
Have you ever been diagnosed with endometriosis? Yes___, NO____.
Have you ever been diagnosed with pelvic adhesions? Yes___, NO____.
Have you ever been diagnosed with any pelvic abnormalities? Yes___, NO____.

Have you taken any medications for gynaecological conditions other than contraceptives?

| **Medication** | **Reason** | **How long** |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Have your cycles changed since they began? Yes___, NO____.

How? _____

Do you ovulate on your own? Yes___, NO____.

On what day of your cycle?

Do your breasts get tender at/ during ovulation? Yes___, NO____.

Do your bowel movements become loose at the beginning of your period? Yes___, NO____.

Have you had fertility treatments? Yes___, NO____.

If yes, when and where?_____

By whom?_____

What types? _____

Have you taken medication to help you ovulate? Yes___, NO____.

When _____ How long? _____

Have your fallopian tubes been evaluated medically? Yes___, NO____.

What were the results? _____

Have you had any tubal operations? Yes___, NO____.

Have you had any hormone laboratory tests performed? Yes___, NO____.

What were the results?_____

Do you have a single partner

with whom you have been trying to conceive? Yes___, NO____.

How long have you been married or living together?_____

Has he had a fertility workup? Yes___, NO____.

What were the results?_____

Is your partner supportive of your wish to conceive? Yes___, NO____.

Have you taken oral contraceptives? Yes___, NO____.

When _____ How long?_____

How long have you been trying to conceive? _____

Have you had a diagnosis relating to infertility? Yes___, NO____.

What was it? _____

How is your sexual energy? Low__ Normal__ High __

Are you more than 20% over your idea body weight? Yes___, NO____.

Are you more than 20% below your idea body weight? Yes___, NO____.

Do you have a stressful occupation? Yes___, NO____.

Do you exercise regularly? Yes___, NO____.

Do you have excessive facial hair? Yes___, NO____.

Have you experienced excessive loss of head hair? Yes___, NO____.

Are you presently taking steroids? Yes___, NO____.