Women's Fertility Questionnaire

All Information is Strictly Confidential.

Name____ Date of Birth___________________

MENSTRUAL HISTORY

Age at which menses began ________

Do you menstruate regularly? ❑ Yes ❑ No
Cycle is ______ days total
Cycle Varies from ____ to _____ days

When was your last menstrual Period? _______________

Have your cycles changed recently? ❑ Yes ❑ No
Do you know if you ovulate? ❑ Yes ❑ No
If yes, on what cycle day? _______

What methods do you use to track your cycle?

____

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Do you have any of the following PMS symptoms?
❑ Acne ❑ Cramps ❑ Bowel Changes ❑ Breast ❑ Backaches ❑ Food cravings
❑ Irritability ❑ Nausea ❑ Sad/Weeping
❑ Other symptoms:

____

How many days per cycle do you menstruate? _________

Do you spot between periods? ❑ Yes ❑ No

During your period, the flow is: *Please fill in cycle days*
❑ Spotting on days _________
❑ Light on days _________
❑ Medium on days _________
❑ Heavy on days _________
❑ Clots on days _________

What color is the blood? *Please fill in cycle days*
❑ Light red on days _________
❑ Bright red on days _________
❑ Dark red on days _________
❑ Purple on days _________
❑ Brown on days _________
❑ Black on days _________

Do you experience any symptoms just after menstruation?
❑ Dizziness ❑ Fatigue ❑ Insomnia ❑ Night Sweats
❑ Cramps ❑ Others: ___________________________

Do you experience any of the following?
❑ Day Sweats ❑ Oily Skin
❑ Hot Flashes ❑ Excessive Facial/Body Hair
❑ Insomnia ❑ Loss of Head Hair
❑ Night Sweats ❑ Sores on genitals
❑ UTIs ❑ Yeast Infections
❑ Chronic Discharge ❑ Vaginal Dryness

BREAST HEALTH

Do you have any of the following?
❑ Breast Lumps/Nodules ❑ Breast Cancer
❑ Breast Tenderness ❑ Inverted Nipples
❑ Nipple Discharge ❑ Mastitis

REPRODUCTIVE & GYNICOLOGICAL HISTORY

Previous methods of birth control, with approximate dates:
❑ Oral Contraceptives _________________________
❑ Hormonal Patch/Ring _________________________
❑ Birth Control Shot _________________________
❑ Intra Uterine Device _________________________
❑ Barrier-Method _________________________
❑ Fertility Awareness _________________________

Are you currently using a birth control? ❑ Yes ❑ No
Are you currently trying to conceive? ❑ Yes ❑ No
If yes, for how long? ______________________________

How is your libido? ❑ High ❑ Medium ❑ Low

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 experienced any of the following:
❑ Physical Trauma
❑ Sexual Abuse
❑ High-risk Pregnancies
❑ Difficult Labors
❑ Difficult Deliveries
❑ Post-Partum Concerns
❑ Lactation Concerns

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Have you ever been diagnosed with any of the following?
❑ Cysts ❑ Endometriosis
❑ Fibroids ❑ Pelvic abnormalities
❑ PID ❑ Adhesions
❑ STDs ❑ Cancer of reproductive organs
❑ PCOS ❑ Premature Ovarian Failure

Date of last pap smear? __________
Have you ever had an abnormal pap? ❑ Yes ❑ No

Please check the following that apply:
❑ Above your ideal body weight
❑ Below your ideal body weight
❑ Frequently Stressed
❑ Exercise Regularly
❑ Properly Hydrated
❑ Aware of Diet

FERTILITY HISTORY

Are you currently seeing an infertility specialist?
❑ Yes ❑ No *If yes, Practitioner name & Specialty:*

Have your fallopian tubes been evaluated? ❑ Yes ❑ No
Results:

Have you ever had a diagnosis relating to infertility?
❑ Yes ❑ No *If yes, please explain briefly:*

Do you have a partner with whom you are trying to conceive?
❑ Yes ❑ No
If yes, Name:

How long have you two been together? ________________
How is your partner's libido? ❑ High ❑ Medium ❑ Low
Has your partner had a fertility workup? ❑ Yes ❑ No

Has your partner had a diagnosis relating to infertility?
❑ Yes ❑ No *If yes, please explain briefly:*

Have you had any assisted reproductive treatments?
❑ Yes ❑ No *If yes, please explain briefly:*

Have you taken medications for gynecological conditions other than contraceptives? ❑ Yes ❑ No

Do you feel your partner is supportive of Assisted Reproductive Therapies? ❑ Yes ❑ No

Have you had any Holistic Fertility Enhancement Treatments? ❑ Yes ❑ No *If yes, please explain briefly:*

Do you feel your partner is supportive of Holistic Fertility Enhancement Therapies? ❑ Yes ❑ No

Do you feel you have enough emotional support?
❑ Yes ❑ No

Have you ever been exposed to any known environmental toxins or hormones? ❑ Yes ❑ No

Was your mother exposed to any hormones, procedures or traumas while she was pregnant with you? ❑ Yes ❑ No

ADDITIONAL INFORMATION: