



# Female Fertility History

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Birthdate: \_\_\_\_\_

## ○ FERTILITY

How long have you been trying to conceive: \_\_\_\_\_

Have you had any diagnosis relating to fertility:  No  Yes, Describe: \_\_\_\_\_

Have you had any fertility treatments:  No  Yes

When: \_\_\_\_\_

What types: \_\_\_\_\_

With whom: \_\_\_\_\_

Have you taken medications to aid in ovulation:  No  Yes

When, how long: \_\_\_\_\_

Have you had any hormonal lab tests:  No  Yes

The results: \_\_\_\_\_

Have your fallopian tubes been evaluated:  No  Yes

The results: \_\_\_\_\_

Have you had any tubal, or other operations:  No  Yes

Have you had any other diagnostic procedures:  No  Yes

Which ones: \_\_\_\_\_

## ○ MENSTRUAL HISTORY

At what age did you begin menstruating: \_\_\_\_\_

Have your cycles changed in any way over time:  No  Yes: \_\_\_\_\_

How many days do your periods usually last: \_\_\_\_\_

Are your periods hesitant to begin:  No  Yes

Do you have spotting or bleeding between cycles:  No  Yes, When: \_\_\_\_\_

How heavy is your menstrual bleeding:  Heavy  Medium  Light

Is there any clotting, and if so, when during your cycle:  No  Yes: \_\_\_\_\_

What color is your bleeding at start: \_\_\_\_\_ middle: \_\_\_\_\_ end: \_\_\_\_\_

What consistency is your blood at start: \_\_\_\_\_ middle: \_\_\_\_\_ end: \_\_\_\_\_

Does your blood contain any stringy tissue or mucus:  No  Yes

Is your menstrual cycle spaced regularly from one month to the next:  No  Yes

Have you ever charted your menstrual cycles:  No  Yes, When: \_\_\_\_\_

How many days are between your periods: \_\_\_\_\_

When was your last period: Start: \_\_\_\_\_ End: \_\_\_\_\_ Was it normal for you:  No  Yes

## ● MENSTRUAL SYMPTOMS

Are your periods painful or uncomfortable in any way:  No  Yes

What does the pain feel like: \_\_\_\_\_

During which phase of your cycle do you experience the discomfort: \_\_\_\_\_

How many days does the discomfort last: \_\_\_\_\_

Are your breasts tender before, during or after your period:  Before  During  After

Does your face break out before, during or after your period:  Before  During  After

Do you have bloating before, during or after your period:  Before  During  After

Do you have loose stools before, during or after your period:  Before  During  After

Do you have constipation before, during or after your period:  Before  During  After

Do you have low back pain before, during or after your period:  Before  During  After

Are you tired or fatigued during or after your period:  Before  During  After

What emotional symptoms do you experience before, during or after your period: \_\_\_\_\_

\_\_\_\_\_

Do you have any other symptoms related to your cycles:  No  Yes, Describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## ● OVULATION

Do you ovulate on your own:  No  Yes

On what day of your cycle do you ovulate: \_\_\_\_\_

Do you experience ovarian pain during ovulation:  No  Yes

Are your breasts tender during ovulation:  No  Yes

Is your mid-cycle cervical mucus scanty or missing:  No  Yes

Are you fatigued or tired during ovulation:  No  Yes

Are you bloated around ovulation:  No  Yes

Are you irritable around ovulation:  No  Yes

Do you feel as though your ovulation time lasts too long:  No  Yes

## ● GYNECOLOGICAL HISTORY

Have you ever had an abnormal pap smear:  No  Yes, When: \_\_\_\_\_

Date of last pap smear: \_\_\_\_\_

Have you ever had pelvic inflammatory disease:  No  Yes, When: \_\_\_\_\_

Have you ever had a venereal disease:  No  Yes, When: \_\_\_\_\_

Have you ever been diagnosed with a chlamydial infection:  No  Yes, When: \_\_\_\_\_

Do you have any genital sores:  No  Yes

Do you have regular yeast infections:  No  Yes

Do you have chronic vaginal discharge:  No  Yes, Color: \_\_\_\_\_ Consistency: \_\_\_\_\_

Do you have vaginal dryness:  No  Yes

Do you have vaginal itching or rashes:  No  Yes

Have you ever been diagnosed with uterine fibroids or polyps:  No  Yes, When: \_\_\_\_\_

Have you ever been diagnosed with endometriosis:  No  Yes, When: \_\_\_\_\_

Have you ever been diagnosed with pelvic adhesions:  No  Yes, When: \_\_\_\_\_

Have you ever been diagnosed with pelvic abnormalities:  No  Yes, When: \_\_\_\_\_

Have you ever had a cervical biopsy, operation, conization or cauterization:  No  Yes, When: \_\_\_\_\_

Do you have any breast lumps, masses or fibroids:  No  Yes

Do you have any discharge from your nipples:  No  Yes

Have you felt any lower abdominal hard or movable masses:  No  Yes

Have you had any other gynecological conditions:  No  Yes, Describe: \_\_\_\_\_

Have you taken any medications besides contraceptives or fertility drugs:  No  Yes, For what condition: \_\_\_\_\_

## ● PREGNANCY HISTORY

Have you had any pregnancies:  No  Yes

If so, what was your pregnancy health like: \_\_\_\_\_

How many children do you have: \_\_\_\_\_

How many abortions have you had: \_\_\_\_\_ When: \_\_\_\_\_

How many miscarriages have you had: \_\_\_\_\_ When: \_\_\_\_\_

How many times has a D&C been performed: \_\_\_\_\_ When: \_\_\_\_\_

## ● CONTRACEPTION

Are you currently using any form of contraception:  No  Yes, What type: \_\_\_\_\_

Have you taken oral contraceptives, and what type:  No  Yes, What type: \_\_\_\_\_

When: \_\_\_\_\_

Have you ever had an IUD:  No  Yes, When: \_\_\_\_\_

Have you ever taken DepoProvera:  No  Yes, When: \_\_\_\_\_

## ● YOUR PARTNER

Do you have a partner with which you are trying to conceive:  No  Yes

Is your partner supportive of your desire to conceive:  No  Yes

Has your partner's fertility been evaluated:  No  Yes

The results: \_\_\_\_\_

How is your partner's sexual energy:  Good  Fair  Low

Has your partner had any problems relating to his reproductive health:  No  Yes, Describe: \_\_\_\_\_

● L I F E S T Y L E

How is your sexual energy:  Good  Fair  Low

Do you have a very stressful job:  No  Yes

Do you have a stressful home environment:  No  Yes

Do you have an exercise routine:  No  Yes, Describe: \_\_\_\_\_

What do you do for relaxation: \_\_\_\_\_

Do you have difficulty sleeping:  No  Yes, Describe: \_\_\_\_\_

Are you overweight:  No  Yes, How many pounds: \_\_\_\_\_

Are you underweight:  No  Yes, How many pounds: \_\_\_\_\_

Do you regularly douche:  No  Yes

Do you use vaginal lubricants:  No  Yes

What do you typically eat during the day:

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

Beverages: \_\_\_\_\_

● Y O U R M O T H E R ' S H E A L T H

What was your mother's age when she was pregnant with you: \_\_\_\_\_

Did she have a difficult pregnancy:  No  Yes, Describe: \_\_\_\_\_

What was your mother's health like prior to and after your birth: \_\_\_\_\_

Was your mother exposed to DES while she was pregnant with you:  No  Yes

At what age did your mother begin menopause: \_\_\_\_\_

At what age did you mother begin menstruating: \_\_\_\_\_

● O T H E R M E D I C A L C O N D I T I O N S

Have you ever been diagnosed with hypothyroidism:  No  Yes

Have you ever been diagnosed with anemia:  No  Yes

Have you ever been diagnosed with any other blood or clotting disorder:  No  Yes, Describe: \_\_\_\_\_

Have you been exposed to any environmental toxins:  No  Yes

Are you currently taking any other medications:  No  Yes

Which ones: \_\_\_\_\_

What for: \_\_\_\_\_

● OTHER COMMENTS

Is there any thing else you would like to share, or any concerns you would like to express at this time: \_\_\_\_\_

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