



**Women seeking fertility treatments, please fill out this portion.**

**Women's Fertility History (page 1)**

Name (LAST, FIRST, MIDDLE) \_\_\_\_\_ DATE \_\_\_\_\_

At what age was your first menstrual period? \_\_\_\_\_

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

Does your face break out before or during your period?  Yes  No

Do your breasts become tender premenstrually?  Yes  No

Do you spot or bleed between periods?  Yes  No

How many days are there from one period to the next? \_\_\_\_\_

Date of last menstrual period \_\_\_\_\_

|                                    | #     | Year  |
|------------------------------------|-------|-------|
| How many pregnancies have you had? | _____ | _____ |

|                                |       |       |
|--------------------------------|-------|-------|
| How many children do you have? | _____ | _____ |
|--------------------------------|-------|-------|

|                                  |       |       |
|----------------------------------|-------|-------|
| How many abortions have you had? | _____ | _____ |
|----------------------------------|-------|-------|

|                                     |       |       |
|-------------------------------------|-------|-------|
| How many miscarriages have you had? | _____ | _____ |
|-------------------------------------|-------|-------|

|  |       |       |
|--|-------|-------|
| How many times has a D & C been performed? | _____ | _____ |
|--|-------|-------|



### Women's Fertility History (page 3)

Have your cycles changed since they began?  Yes  No

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, where and when \_\_\_\_\_

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 work up?  Yes  No

If so, 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? \_\_\_\_\_

Have you ever had an IUD?  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? \_\_\_\_\_

**Women's Fertility History (page 4)**

How is your sexual energy?  Low  Normal  High

Do you douche regularly?  Yes  No

With what? \_\_\_\_\_

Do you use vaginal lubricants?  Yes  No

Are you more than 20% over your ideal body weight?  Yes  No

Are you more than 20% below your ideal body weight?  Yes  No

Do you have a stressful occupation?  Yes  No

Do you have excessive facial hair?  Yes  No

Do you have excessively oily skin?  Yes  No

Have you experienced excessive loss of head hair?  Yes  No

Have you noticed any discharge from your nipples?  Yes  No

Was your mother exposed to diethylstilbestrol (DES) when she was pregnant with you?  
 Yes  No

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

Are you presently taking steroids?  Yes  No

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Comments / Notes: