

Women's Fertility History

**A. Menstruation History & Health**

Age at which menses began? \_\_\_\_\_

Taking birth control pill? Yes  No

How long? \_\_\_\_\_

Please answer the following based on the days of **FULL flow bleeding** (not the spotting/tapering before or after menstruation):

How many days is your menstrual cycle (ie: 28-30) \_\_\_\_\_ Regular? Yes  No

How many days of bleeding? \_\_\_\_\_

How many times in full flow days do you change your pad/tampon? \_\_\_\_\_

Blood volume light  normal  heavy

Blood Color light red/pink  bright red  dark red/purple  brown

Clotting? Yes  No

What size are the clots? \_\_\_\_\_

Breast tenderness? Yes  No

PMS? Yes  No  Fatigue? Yes  No

Low Back Pain? Yes  No  Facial skin break out? Yes  No

Cramps: none  light  medium  severe

Do you have loose bowel movements at onset/during menstruation? Yes  No

STD Yes  No  HPV? Yes  No

Herpes? Yes  No  PID Yes  No

Recurrent yeast infections? Yes  No

How often? \_\_\_\_\_

**B. Fertility History**

How long have you been trying to conceive? \_\_\_\_\_ What day of your cycle do you ovulate? \_\_\_\_\_

Have you had a diagnosis relating to infertility? Yes  No

Diagnosis? \_\_\_\_\_

List the number of:

Pregnancies? \_\_\_\_\_ Children? \_\_\_\_\_ Miscarriages? \_\_\_\_\_

Abortions? \_\_\_\_\_ Ectopics? \_\_\_\_\_ D&C? \_\_\_\_\_

Check all that apply:

- Abnormal Pap Smear  Endometriosis/Adhesions  Elevated FSH  Low Progesterone Level  
 Uterine Fibroids/Polyps  FSH Level Day  PCOS  HCG

**C. Male Fertility**

Has your husband/partner had a fertility work-up? Yes  No   
 Results? \_\_\_\_\_

Is your partner supportive of your wish to conceive? Yes  No

**D. Fertility Treatments(including cancelled cycles):**

Date	Natural, IUI, IVF, Other	Medication Used	# of Mature Eggs/Follicles	Pregnancy Yes/No	If miscarried, indicate at which week	Other comments & locations

**E. Fertility Plan for Next 6 Months**

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