



CONFIDENTIAL

WOMEN'S FERTILITY QUESTIONNAIRE

NAME: _____

DATE: _____

Date of last Pap _____

YOUR CYCLE:

- Age of onset of Menses _____ yrs old
Length of Cycles: _____ days
Days of bleeding: _____ days
Amount of bleeding: [] heavy [] med [] light
Color of the blood: [] Lt Red [] Red [] Dk Rd [] Purple [] Brn [] Blk
Fatigue around period [] Before [] During [] After
[] Pain ____ days of pain [] Clots [] Migraines
[] PMS [] Tender Breasts [] Irritability [] Emotional
[] Facial acne around period [] Spotting b/t periods
[] Low back pain b/f period [] Loose stools b/f period
[] Ovulate on your own around day _____
[] Ovulation Pain [] Do Not Ovulate

- [] Use Aluminum or Teflon cooking pans
How long have you tried to conceive naturally? _____
How long have you tried to conceive in total? _____
Married/Partner _____ years
[] Husband/partner is supportive of your intention to conceive.

FERTILITY TREATMENTS:

- [] Planning to [] In the middle of one [] Had one or more
When/where? _____
By Whom? _____
What Types _____

HAVE YOU HAD OR HAVE:

- [] pregnancies # _____
[] miscarriages # _____
[] D&Cs # _____
[] children # _____ ages _____
[] abortions # _____ when _____
[] Abnormal papsmear
[] Cervical biopsy
[] Venereal Disease
[] Chlamydia Infection
[] Yeast Infections How often _____
[] Chronic Vaginal Discharge
[] Sores on your Genitalia
[] Pelvic Inflammatory Disease
[] Uterine Fibroids or Polyps
[] Endometriosis
[] Pelvic Adhesions
[] Pelvic Abnormalities
[] Ovarian Cysts

HAVE YOU HAD/HAVE/USE:

- [] Fallopian Tubes Evaluated _____
[] Tubal Operations _____
[] Hormone Tests Taken Results _____
[] Husband Tested Results _____
[] Immune disorders Testing
[] Oral Contraceptives When and how long? _____
[] Ovulation Medications When? _____ How long? _____
[] IUD
[] DepoProvera
[] Diagnosis related to infertility _____
[] Low Sexual Energy
[] Douche regularly
[] Vaginal Lubricants
[] Excessive Facial Hair
[] Excessively Oily skin
[] Excessive hair loss
[] Discharge from your nipples
[] Steroids
[] Have been exposed to environmental toxins
[] Mom exposed to DES (diethylstilboestrol) when she was pregnant w/ you

If your cycles have changed, how have they changed?

- [] Over 20% over your ideal body weight
[] Over 20% below your ideal body weight
[] Stressful occupation
[] Exercise regularly _____
[] Coffee ____ cups/day [] Alcohol ____ servings/____
[] Cigarettes ____ /day [] Drugs or Marijuana