



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

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

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
- 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/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