



## WOMEN'S FERTILITY HISTORY

Patient Name \_\_\_\_\_ Today's  
Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Occupation \_\_\_\_\_ Height \_\_\_\_\_  
Weight \_\_\_\_\_

### Essentials

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

Have you had a diagnosis relating to infertility? \_\_\_Yes \_\_\_No  
What was it?  
\_\_\_\_\_

### Menstrual History

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

Are your periods painful? \_\_\_Yes \_\_\_No

How many days does the pain last? \_\_\_\_\_, which days \_\_\_\_\_

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 \_\_\_Brown \_\_\_Black

Is there clotting? \_\_\_Yes \_\_\_No

Does your face break out before or during your period? \_\_\_Yes \_\_\_No

Do you have premenstrual breast tenderness? \_\_\_Yes \_\_\_No

Do you bleed or spot between periods? \_\_\_Yes \_\_\_No

Are your menstrual cycles spaced irregularly? \_\_\_Yes \_\_\_No

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

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

Do you get premenstrual low back pain? \_\_\_Yes \_\_\_No

Do your bowel movements become loose at the beginning of your period?  
\_\_\_Yes \_\_\_No

### Ovulation

Do you ovulate on your own? \_\_\_Yes \_\_\_No

On what day of your cycle? \_\_\_\_\_ How did you find this out? \_\_\_\_\_

Do your breasts get tender at/during ovulation? \_\_\_Yes \_\_\_No

Do you get any other ovulatory symptoms? \_\_\_Yes \_\_\_No

\_\_\_\_\_

\_\_\_\_\_

### Pregnancy History

Number #

Dates

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 D & C's have been performed?

### Reproductive Health History

Have you ever had an abnormal Pap smear? \_\_\_Yes \_\_\_No

Date of last Pap smear \_\_\_\_\_

Have you ever had a cervical biopsy, operation, cauterization or conization? \_\_\_Yes \_\_\_No

Have you ever had a venereal disease? \_\_\_Yes \_\_\_No  
which \_\_\_\_\_

Do you get yeast infections regularly? \_\_\_Yes \_\_\_No

Have you ever been diagnosed with a chlamydial infection? \_\_\_Yes \_\_\_No

Do you have chronic vaginal discharge? \_\_\_Yes \_\_\_No

Do you have any sores on your genitalia? \_\_\_Yes \_\_\_No

Have you ever had pelvic inflammatory disease? \_\_\_Yes \_\_\_No

Were you treated for it? \_\_\_Yes \_\_\_No

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

Have you ever been diagnosed with uterine fibroids or polyps? \_\_\_Yes \_\_\_No

Have you ever been diagnosed with endometriosis? \_\_\_Yes \_\_\_No

Have you been diagnosed with pelvic adhesions? \_\_\_Yes \_\_\_No

Have you been diagnosed with any pelvic abnormalities? \_\_\_Yes \_\_\_No

Have you taken any medications for gynecological conditions other than contraceptives?

Medication

Reason

How Long?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have your cycles changed since they began? \_\_\_Yes \_\_\_No

Have you taken oral contraceptives? \_\_\_Yes \_\_\_No

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

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

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

Have you ever taken DepoProvera? \_\_\_Yes \_\_\_No

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

### Assisted Reproductive History

Have you had fertility treatments? \_\_\_Yes \_\_\_No

If yes, when and where?

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?

### Male Factor

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

What were the results?

Is your partner supportive of your wish to conceive? \_\_\_Yes \_\_\_No

### Additional Information

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 exercise regularly?  Yes  No

Do you have excessive facial hair?  Yes  No

Do you have excessive 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 ever been exposed to any known environmental toxins or hormones?

Yes  No

Are you presently taking steroids?  Yes  No

Comments/Notes:

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