Fertility History

Name_____Date_____

At what age did you begin menstruation?_____ Are your periods painful?_____

How many days of pain do you have?_____ Where is the pain?

_____

_____

_____

When does the pain start?_____ When does the pain stop?_____

What is the quality of pain?(ie. sharp, dull, hot cold) _____

Does anything give the pain relief? (ie. pressure, medication, hot packs, showers etc.)

_____

What is the color of you menstrual blood? (light red, red, dark red, purple, brown, black)_____ Is there clotting?_____

How long does your flow last?_____

Do you have premenstrual tension?_____Do you have premenstrual back pain?_____

Do your bowels become loose at the onset of your period?_____

Does your face break out during menstruation? _____

Do you have breast tenderness during menstruation?_____

Do you bleed or spot between periods?_____

Are you periods regular? _____How many days do you have between periods? _____

When was your last menstruation?_____ Have your periods changed since the began?_____ How? _____

Do you ovulate on your own?_____ On what day of your cycle do you ovulate?_____

Do you experience breast tenderness during ovulation?_____Have you ever had pelvic inflammatory disease?_____

If so how were you treated for it?_____

When was you last pap smear?_____ Have you ever had an abnormal pap smear? _____

Have you had a cervical biopsy, operation, cauterization, or conization.

Have you ever had any venereal disease?_____ Do you get yeast infections?_____

Have you ever been diagnosed with chlamydia?_____

Do you have any chronic vaginal discharge?_____ Do you have any genital sores?_____

Have you been diagnosed with any of the following?

Fibroids	When:
Endometriosis	When:
Pelvic adhesions	When
Pelvic abnormalities	When:
Ovarian cysts	When:

Have you taken any medication for gynecological conditions?_____

Explain?_____

_____

How many pregnancies have you had?_____ When?_____

How many children do you have?_____ When?_____

How many abortions have you had?_____ When?_____

How many miscarriages have you had?_____ When?_____

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

Have you had any fertility treatments?_____

When and where?_____

What type of treatment?_____

Have you taken medication to help you ovulate?_____

When and for how long?_____

Have your fallopian tubes been evaluated?_____ What was the evaluation?_____

Have you had any tubal operations?_____ Have you had any hormone tests?_____

What were the results?_____

Do you have a single partner with home you are trying to conceive?_____

How long have you been together?_____

Has he had a fertility workup?_____ Results:_____

Have you taken oral contraceptives?_____

When and for how long?_____

Have you ever had an IUD?_____

When and for how long?_____

Have you ever taken DepoProvera?_____

When and for how long?_____

How long have you been trying to conceive?_____

Have you had a diagnosis relating to infertility?_____

What was the diagnosis?_____

How is your sexual energy?(low, normal, high)_____ Do you douche regularly?_____

Do you use vaginal lubricants?_____ Do you experience a great deal of stress?_____

Do you exercise regularly?_____ What kind_____

Additional Comments:

_____

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