



The Center For Reproductive Healing

Women's Fertility History

CONFIDENTIAL

The Center for Reproductive Healing ■ 44 W. Market Street ■ Marietta, PA 17547
www.ReproductiveHealing.com

Phone: 1-877-619-2006

NAME (LAST, FIRST, MIDDLE)	DATE
----------------------------	------

Age at which menses began _____

Have your cycles changed since they began? Yes No

How? _____

Are your periods painful? Yes No

 How many days does the pain last? _____

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 Purple
 Brown Black

Is there clotting? Yes No

Do you have premenstrual tension? Yes No

Does your face break out before or during your period? Yes No

Do your breasts become tender premenstrually? Yes No

Do you bleed or spot between periods? Yes No

Are your menstrual cycles spaced irregularly? Yes No

How many days are there between periods? _____

Date of last menstrual period _____

	Number	Years
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 times has a D&C been performed?	_____	_____

Have you ever had an abnormal pap smear? Yes No

Have you ever had a cervical biopsy, operation, cauterization or conization? Yes No

Have you ever had a venereal disease? Yes No

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 _____

Date of last Pap smear _____

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 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? _____

How long have you been trying to conceive? _____

Have you had a diagnosis relating to infertility? Yes No

 What was it? _____



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? _____

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 workup? Yes No

What were the results? _____

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

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 excessively oily skin? Yes No

Have you experienced excessive loss of head hair? Yes No

Have you noticed discharge from your nipples? Yes No

Was your mother exposed to

diethylstilbestrol (DES) when she was pregnant with you? Yes No

Have you been exposed to any

known environmental toxins or hormones? Yes No

Are you presently taking steroids? Yes No

COMMENTS/NOTES