WOMEN'S FERTILITY HISTORY

 CONFIDENTIAL

8950 Villa La Jolla Dr, Ste C-117 ◆ La Jolla, CA 92037 ◆ Ph: (858) 546-1530
11515 El Camino Real, Suite 150 ◆ San Diego, CA 92130 ◆ Ph: (858) 546-1530

Name:	Date:

Age when menses began: ______

Have your cycles changed since they began? ☐ Yes ☐ No

If yes, how? ______

Are your periods painful? ☐ Yes ☐ No

If yes, how many days does the pain last? ______

How many days do you normally bleed? ______

How heavy is the bleeding?

Heavy										
Normal										
Light										
	1	2	3	4	5	6	7	8	9	10

Day

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 cycle spaced irregularly? ☐ Yes ☐ No

How many days are there between periods? ______

Date last mentrual cycle began ______

Have you ever had an abnormal pap smear? ☐ Yes ☐ No

	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 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 chlamydia? ☐ 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

If yes, how were you treated for it? ______

Date of last pap smear ______

Have you ever been diagnosed with uterine fibroids or polyps? ☐ Yes ☐ No

Have you been diagnosed with endometriosis? ☐ Yes ☐ No

Have you ever been diagnosed with adhesions? ☐ Yes ☐ No

Have you ever been diagnosed with any pelvic abnormalities? ☐ Yes ☐ No

Have you ever taken oral contracepives? ☐ Yes ☐ No
When? ______ How long? ______

Have you ever taken DepoProvera? ☐ Yes ☐ No
When? ______ How long? ______

Have you ever had an IUD? ☐ Yes ☐ No
When? ______ How long? ______

Have you ever taken medications for gynecological conditions other than contraceptives? ☐ Yes ☐ No

Medication	Reason	How Long

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Name:	Date:

How long have you been trying to conceive? ______

Have you had a diagnosis relating to fertility? ☐ Yes ☐ No

If yes, what was it? ______

Have you had fertility treatments? ☐ Yes ☐ No

If yes, when? ______
Where? ______
By whom? ______
What types? ______

Have you taken medication to help you ovulate? ☐ Yes ☐ No

If yes, what? ______
When? ______
How long? ______

Have your fallopian tubes been medically evaluated? ☐ Yes ☐ No

If yes, what were the results? ______

Have you had any tubal operations? ☐ Yes ☐ No

Have you had any hormone lab tests perfomed? ☐ Yes ☐ No

If yes, what were the results? ______

______

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 currently taking steroids? ☐ Yes ☐ No

How is your sexual energy? ☐ Low ☐ Normal ☐ High

Do you have a single partner with whom you have been trying to conceive? ☐ Yes ☐ No

If yes, how long have you been together? ______

Has he had a fertility workup? ☐ Yes ☐ No

If yes, what were the results? ______

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

Do you douce regularly? ☐ Yes ☐ No

If yes, 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% under your ideal body weight? ☐ Yes ☐ No

Do you have a stressful occupation? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No

Do you drink coffee, tea or sodas? ☐ Yes ☐ No

If yes, how much? ______

Do you smoke? ☐ 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

Notes: ______

______

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Name:	Date:

How long have you and your partner been trying to conceive? ______________

How is your sexual energy? ☐ Low ☐ Normal ☐ High

Do you have an undescended testes? ☐ Yes ☐ No

Have you ever been diagnosed with a varicocele? ☐ Yes ☐ No

Have you had any urologic surgeries? ☐ Yes ☐ No

Have you had a vasectomy reversed? ☐ Yes ☐ No

Have you experienced difficulty maintaining erection? ☐ Yes ☐ No

Have you experienced difficulty ejaculating? ☐ Yes ☐ No

Have you been exposed to any known environmental toxins or hormones? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

Have you experienced any penile discharge? ☐ Yes ☐ No

Do you regularly experience nocturnal emission? ☐ Yes ☐ No

Have you had a fertility workup? ☐ Yes ☐ No

If yes, what was your sperm count? ☐ Below normal ☐ Normal Number ______________

What was the sperm motility? ☐ Below normal ☐ Normal Notes ______________

What was the sperm morphology? ☐ Below normal ☐ Normal Notes ______________

Please list any prescription medications you are currently taking: ______________

____

Please list any non-prescription medications you are currently taking, including herbs, supplements, and over-the-counter medications:

____

____

Notes: ______________

____

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