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Female Fertility Patient Intake

Women's Fertility History

Age menses began: _____

Your last period:

Date: _____

days of flow: _____

Describe the color: Lt.Red Red Dk.Red Brown

Describe flow: Spotting Light Medium Heavy

Is there spotting between periods? Yes No

days of pain/cramping: _____

Any PMS symptoms: Yes No

If yes, describe: _____

_____

Any clots? Yes No

If yes, what size? <dime dime quarter >quarter

days of cycle: _____

Pregnancies:	#	Years
# of Pregnancies:	_____	_____
# of Children:	_____	_____
# of Abortions:	_____	_____
# of Miscarriages:	_____	_____
# of D&C's:	_____	_____

Medications: (list all gynecological medications taken in the last 2 years, other than contraceptives)

Medication	Reason	# mths
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

History:

Date of Last Pap Smear: _____

Have you ever had an abnormal pap smear? Yes No

If yes, list years:

_____

Have you ever had an STD (sexually transmitted disease)? Yes No

If yes, list the disease: _____

Have you ever had a cesarean birth? Yes No

Have you ever been diagnosed with a chlamydial infection? Yes No

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

Do you have any sores on your genitals? Yes No

Have you ever had Pelvic Inflammatory Disease? Yes No

If yes, describe treatment?

_____

_____

Have you ever been diagnosed with Luteal Phase Defect? Yes No

Have you ever been diagnosed with Hypothyroid/Hashimoto's? Yes No

Have you ever been diagnosed with pelvic adhesions? Yes No

Have you ever been diagnosed with any pelvic abnormalties? Yes No

Do you ovulate on your own? Yes No

If yes, on what day of your cycle? _____

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

Have you had a diagnosis relating to infertility? Yes No

If yes, what was it?

_____

_____

Are you currently taking steroids? Yes No

Have you ever been diagnosed with Polycystic ovarian syndrome? Yes No

Have you ever been diagnosed with High FSH levels? Yes No

Treatments:

Have you had fertility treatments? Yes No

If yes, where and when? _____

_____

_____

By whom? _____

What types? _____

_____

Have you taken drugs to help you ovulate? Yes No

If yes, what were the results? _____

_____

Have you had any hormone lab tests performed? Yes No

If yes, what were the results? _____

_____

Have you taken oral contraceptives? Yes No

If yes, when? _____ For how long? _____

What type: _____

Have you ever had an IUD? Yes No

If yes, when? _____ For how long? _____

Have you ever taken DepoProvera? Yes No

If yes, when? _____ For how long? _____

Have your fallopian tubes been evaluated medically? Yes No

Have you had any tubal operations? Yes No

Lifestyle:

How is your sexual energy? Low Normal High

Do you douche 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

What is your daily stress level? Low Normal High

If high, what is the cause? _____

_____

Do you exercise? Yes No

If yes, how many times a week? _____

Do you have excessive facial hair? Yes No

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

If yes, has he had a sperm analysis? Yes No

What were the results? _____

_____

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

How long have you been trying to conceive? _____

_____

Do you have lower back weakness, soreness, or pain, or knee problems?	Yes	No
Do you have ringing in your ears or dizziness?	Yes	No
Is your hair prematurely gray?	Yes	No
Do you have vaginal dryness?	Yes	No
Is your mid-cycle fertile cervical mucus scanty or missing?	Yes	No
Do you have dark circles around or under your eyes?	Yes	No
Do you have night sweats?	Yes	No
Are you prone to hot flashes?	Yes	No
Do you have back pain premenstrually?	Yes	No
Is your low back sore or weak?	Yes	No
Are your feet cold, especially at night?	Yes	No
Are you typically colder than those around you?	Yes	No
Is your libido low?	Yes	No
Are you often fearful?	Yes	No
Do you wake up at night or early in the morning because you have to urinate?	Yes	No
Do you urinate frequently, and is the urine diluted and/or profuse?	Yes	No
Do you have early morning loose, urgent stools?	Yes	No
Do you have profuse vaginal discharge?	Yes	No

Does your menstrual blood tend to be dull in color?	Yes	No
Do you feel cold cramps during your period that respond to a heating pad?	Yes	No
Are you often fatigued?	Yes	No
Do you have a poor appetite?	Yes	No
Is your energy lower after a meal?	Yes	No
Do you feel bloated after eating?	Yes	No
Do you crave sweets?	Yes	No
Do you have loose stools, abdominal pain, or digestive problems?	Yes	No
Are your hands and feet cold?	Yes	No
Is your nose cold?	Yes	No
Are you prone to feeling heavy or sluggish?	Yes	No
Are you prone to feeling heaviness or grogginess in the head?	Yes	No
Do you bruise easily?	Yes	No
Do you think you have poor circulation?	Yes	No
Do you have varicose veins?	Yes	No
Are you lacking strength in your arms and legs?	Yes	No
Are you lacking in exercise?	Yes	No
Are you prone to worry?	Yes	No
Have you been diagnosed with low blood pressure?	Yes	No
Do you sweat a lot without exerting yourself?	Yes	No
Do you feel dizzy or light-headed, or have visual changes when you stand up fast?	Yes	No
Is your menstruation thin, watery, profuse, or pinkish in color?	Yes	No
Are you more tired around ovulation or menstruation?	Yes	No
Do you ever spot a few days or more before your period comes?	Yes	No
Have you ever been diagnosed with uterine prolapse?	Yes	No
Are your menstrual cramps accompanied by a bearing down sensation in your uterus?	Yes	No
Are you often sick, or do you have allergies?	Yes	No
Have you been diagnosed with hypothyroid or anemia?	Yes	No
Do you have hemorrhoids or polyps?	Yes	No
Are your menses scanty and/or late?	Yes	No
Do you have dry, flaky skin?	Yes	No
Are you prone to getting chapped lips?	Yes	No
Are your fingernails or toenails brittle?	Yes	No
Are you losing hair on your head (not in patches, but all over)?	Yes	No
Is your hair brittle or dry?	Yes	No
Do you have diminished nighttime vision?	Yes	No
Do you get dizzy or light-headed around your period?	Yes	No
Is your menstrual flow ever brown or black in color?	Yes	No
Do you feel mid-cycle pain around your ovaries?	Yes	No
Do you have painful, unmovable breast lumps?	Yes	No
Do you experience periodic numbness of your hands and feet (especially at night)?	Yes	No
Do you have varicose or spider veins?	Yes	No
Do you have red hemangiomas (cherry-red spots) on you skin?	Yes	No
Do you have chronic hemorrhoids?	Yes	No
Does your menstrual blood contain clots?	Yes	No
Have you been diagnosed with endometriosis or uterine fibroids?	Yes	No
Is your lower abdomen tender to palpation (resisting touch)?	Yes	No
Can you feel any abnormal lumps in your lower abdomen?	Yes	No
Do you have piercing or stabbing menstrual cramps?	Yes	No
Have you been diagnosed with any vascular abnormality or blood clotting disorder?	Yes	No
Are you prone to emotional depression?	Yes	No
Are you prone to anger and/or rage?	Yes	No
Do you become irritable premenstrually?	Yes	No
Do you feel bloated or irritable around ovulation?	Yes	No

Does it feel as if your ovulation lasts longer than it should?	Yes	No
Are your breasts sensitive/sore at ovulation?	Yes	No
Do you experience nipple pain or discharge from your nipple?	Yes	No
Do you have a lot of premenstrual breast distention or pain?	Yes	No
Have you been diagnosed with elevated prolactin levels?	Yes	No
Do you become bloated premenstrually?	Yes	No
Do you have difficulty falling asleep at night?	Yes	No
Do you experience heartburn or wake up with a bitter taste in your mouth?	Yes	No
Are your menses painful?	Yes	No
Do you feel your menstrual cramps in the external genital area?	Yes	No
Is the menstrual blood thick and dark, or purplish in color?	Yes	No
Do you wake up early in the morning and have trouble getting back to sleep?	Yes	No
Do you have heart palpitations, especially when anxious?	Yes	No
Do you have nightmares?	Yes	No
Do you seem low in spirit or lacking in vitality?	Yes	No
Are you prone to agitation or extreme restlessness?	Yes	No
Do you fidget?	Yes	No
Do you sweat excessively, especially on your chest?	Yes	No
Are your mouth and throat usually dry?	Yes	No
Are you thirsty for cold drinks most of the time?	Yes	No
Do you often feel warmer than those around you?	Yes	No
Do you wake up sweating or have hot flashes?	Yes	No
Do you break out with red acne (especially premenstrually)?	Yes	No
Do you have a short menstrual cycle?	Yes	No
Do you have vaginal irritation or rashes?	Yes	No
Do you feel tired and sluggish after a meal?	Yes	No
Do you have fibrocystic breasts?	Yes	No
Do you have urgent or foul-smelling stools?	Yes	No
Does your menstrual blood contain stringy tissue or mucus?	Yes	No
Are you prone to yeast infections, frequent vaginal infections, or vaginal itching?	Yes	No
Do your joints ache, especially with movement?	Yes	No
Do you have foul-smelling, yellow or greenish vaginal discharge?	Yes	No
Are you prone to vaginal and/or rectal itching during your luteal or premenstrual phase?	Yes	No
Does your lower abdomen feel colder to the touch than the rest of your trunk?	Yes	No
Do your breasts get tender at other times besides ovulation?	Yes	No
Do your bowel movements become loose or soft at the beginning of your period?	Yes	No

I understand that the above information is complete and is correct to the best of my knowledge.

Signature: _____