Skyline Integrative Medicine

Women's Fertility Questionnaire

Name: _____
Date of Birth: _____
How long have you been trying to get pregnant? _____

Have you been pregnant before: _____
If so, when? _____
What was the outcome? (brought to term, miscarriage, abortion?)

_____
_____
_____
_____

Has your partner had a fertility workup? If so, what were the results?

_____
_____

Have you had a diagnosis relating to fertility? If so, what was it?

_____
_____

Have you had fertility treatments? If so, please fill in:

Type of Treatment	When	Where, By Whom
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you using currently or recently using Assisted Reproductive Technology (medical fertility treatment)? _____ If so, who is your physician? _____

Please list any drugs/medications and the date you will be using them.

Drug	Dates used or to be used
_____	_____
_____	_____
_____	_____
_____	_____

Have you ever had a hysterosalpinogram (HSG) or had your fallopian tubes medically evaluated?

_____

Have you had any hormone lab tests? (these would include thyroid, estrogen, progesterone, testosterone, FSH, LH prolactin, etc.) If so, what were results?

_____
_____
_____
_____

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Please describe your history of birth control.

Have you used	Approx, what dates?
Birth Control Pills	_____
IUD	_____
Depo-Provera	_____
Tubal ligation	_____

Do you keep track of your cycle by charting your BBT or testing for ovulation? _____
If so, what day of your cycle do you usually ovulate? _____

If you check your cervical fluid at ovulation, is it (circle)

Scanty or dry Tacky/sticky Stretchy like egg whites Creamy like lotion

Do you experience problems with vaginal dryness? _____

List any vaginal products you use, i.e. douches, lubricants, deodorants, creams:
_____
_____

Have you or your partner had significant exposure to toxic chemicals? List any you know of:
_____
_____

Do you weigh more than 20% above or below your ideal body weight? _____

How is your sexual energy? Circle one:

Non-existent Low Medium High VaVaVoom!

How often are you having sexual intercourse? _____

Is your partner equally invested in your attempt to get pregnant? _____
How are you feeling about your pursuit of pregnancy? _____
_____

Do you want information/education about your cycle or fertility in general? _____

Detailed Menstrual History

How long are your menstrual cycles (how many days from Day 1 of your period to Day 1 of the next period? _____
Has the length of your cycle changed over the past few years? _____

How many days do you bleed? (do not include light spotting) _____
Has the number of days changed over the past few years? _____

How heavy is your bleeding? _____
Has the heaviness changed over the past few years? _____

Do you spot, either at the beginning or the end of your period? _____
If so, for how long? _____

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What color is your menstrual blood? (circle)

Pink/light red bright red dark red purple brown black

Is menstruation (blood) thin or watery? _____
Do you notice clots? _____

Do you get mid-cycle cramping? _____

Circle any PMS symptoms you experience:

Abdominal cramping	Low back pain	Bearing down sensation
Headache	Loose stools	Constipation
Acne	Bloating	Breast tenderness
Coldness	Fatigue	Night sweats/hot flashes
Irritability	Nausea	Herpes outbreaks
Weepiness/Sadness		Yeast infections

Other: _____

Have you been diagnosed with endometriosis, fibroids, Pelvic Inflammatory Disease, ovarian cysts, polycystic ovaries, thyroid imbalance, uterus prolapse or tilt, etc?

_____
_____
_____

Please describe anything else about your period, cycle or menstrual history that you think is important or interesting:

_____
_____
_____
_____
_____
_____

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