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Health and Wellness Center
Acupuncture • Nutrition • Herbs

Woman's Fertility History

Confidential

Name	Date

Date of last mense?_____
Age of first mense _____
Number of bleeding days_____
Typical days per cycle_____

Are you periods painful? _____yes _____no
How heavy is your bleeding? ___ heavy ___normal ___ light
What color is your blood? ___light red ___red ___ dull-brick red ___wine red
___brown ___black

Is your menstrual blood ___thin & watery ___normal ___thick &clumpy
Are there clots? ___yes ___no
If yes, what size are your clots? ___ quarter size ___peas size ___stringy
Do you have cramps with your mense ___ yes ___no
Do they improve with heat ___yes ___no ___not sure
Do you take anything for your cramps ___ yes ___no if so what _____

Do you have PMS? ___yes ___no
Irritability/weepiness ___
Low back pain ___
Bloating ___
Headache ___
Loose stool/constipation ___
Breast tenderness ___
Acne ___

How is your sexual energy? ___normal ___high ___low
Do you use vaginal lubricant ___yes ___no

Do you have any ovulatory pain? ___yes ___no
Do you spot between periods? ___yes ___no
Do you have cervical mucous during ovulation? ___yes ___no

Do you frequently get yeast infections? ___yes ___no
Have you had a Chlamydia infection? ___yes ___no
Have you ever had an abnormal pap smear? ___yes ___no
If yes, what was the outcome?_____
Have you ever had a venereal disease? _____yes ___no
Have you had uterine fibroids or polyps? ___yes ___no
Have you been diagnosed with Polycystic Ovarian Syndrome ___yes ___no
Do you have excessive facial hair? ___yes ___no
Do you have excessive body hair? ___yes ___no

Name	Date

Do you have fibrotic breast disease? ___yes ___no
Have you 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 medication for gynecological conditions other than contraceptives?
___yes ___no

Medication	Reason	How long

Have you taken oral contraceptives? ___yes ___no
When_____ How long?_____
Have you been taking medication to help you ovulate? ___yes ___no
When_____ How long?_____

How long have you been trying to conceive? _____
Have you had a fertility work up? ___yes ___no
If so, when and what were the results? _____
Have you had your fallopian tubes evaluated?_____

For the following please include dates tested
FSH level_____
Estrodial level _____
Antral Follicle Count? _____

Have you been exposed to any environmental toxins? ___yes ___no
How many gold or amalgam fillings do you have? _____
How long have you had them? _____
Do you suffer from any environmental sensitivities? ___yes ___no
Do you have a stressful job? ___yes ___no
Do you exercise regularly? ___yes ___no
How many hours per week? _____