Kwan Yin Holistic Center

Holistic Assisted Reproductive Therapy

Fertility History

CONFIDENTIAL

NAME _____ **DATE** _____

Age at which menses began? _____

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

Number of days from one period to the next? _____

Date of last menstrual period _____

	NUMBER	YEAR
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 D&Cs have you had?		

Ever had an abnormal pap smear? ☐ YES ☐ NO

Ever had a cervical biopsy, operation, cauterization, or conization? ☐ YES ☐ NO

Ever had a venereal disease? ☐ YES ☐ NO

Do you get yeast infections regularly ☐ YES ☐ NO

Do you have chronic vaginal discharge? ☐ YES ☐ NO

Do you have any sores on your gentalia? ☐ YES ☐ NO

Ever had pelvic inflammatory disease? ☐ YES ☐ NO

Were you treated for it? ☐ YES ☐ NO
If so, how?

_____

Date of last pap smear: _____

Ever been diagnosed with uterine fibroids or polyps? ☐ YES ☐ NO

Ever been diagnosed with endometriosis? ☐ YES ☐ NO

Ever been diagnosed with pelvic adhesions? ☐ YES ☐ NO

Ever been diagnosed with any pelvic abnormalities? ☐ YES ☐ NO

Ever taken any medications for gynecological conditions? ☐ YES ☐ NO

Medication	Reason	How Long

Have your cycles changed since they began? ☐ YES ☐ NO
If so, how? _____

Do you ovulate on your own? ☐ YES ☐ NO

On what day of your cycle? _____

Do breasts get tender at/during ovulations? ☐ YES ☐ NO

Do you get premenstrual low back pain? ☐ YES ☐ NO

Do your bowel movements become loose at the beginning of your period? ☐ YES ☐ NO

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Have you had fertility treatments? ☐ YES ☐ NO

If so, when and where? _____

By whom? _____

What types? _____

Ever taken medication to aid ovulation? ☐ YES ☐ NO

When? _____ How long? _____

Have your fallopian tubes been evaluated? ☐ YES ☐ NO

What were the results? _____

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

Have you taken oral contraceptives? ☐ YES ☐ NO

When? _____ How long? _____

Have you ever had an IUD? ☐ YES ☐ NO

When? _____ How long? _____

Have you taken DepoProvera? ☐ YES ☐ NO

When? _____ How Long? _____

How long have you been trying to conceive? _____

Ever had a diagnosis relating to infertility? ☐ YES ☐ NO

Is so, what? _____

How is your sex drive? ☐ 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 weight? ☐ YES ☐ NO

Are you more than 20% under your ideal weight? ☐ YES ☐ NO

Do you have a stressful occupation? ☐ YES ☐ NO

Do you have excessive facial hair? ☐ YES ☐ NO

Do you have excessively oily skin? ☐ YES ☐ NO

Have you experienced excessive hair loss on the head? ☐ 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 been exposed to any known environmental toxins or hormones? ☐ YES ☐ NO

Are you presently taking steroids? ☐ YES ☐ NO

COMMENTS/NOTES