

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 Dark Red Purple
Red

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 _____

How many pregnancies have you had? NUMBER YEAR

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 genitalia? 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? _____

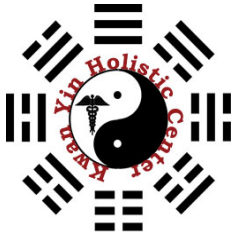
Do you ovulate on your own? YES NO

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