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# FEMALE FERTILITY QUESTIONNAIRE

Name _____ Age_____ Date _____

## GENERAL

| | | | |
|---|---|---|---|
| Date of last menses | | Date of last PAP | |
| # of pregnancies | | # of miscarriages | |
| Date (year) of pregnancies | | # of abortions | |
| # of children | | # of D&Cs | |

| | | | |
|---|---|---|---|
| Is your libido low \| average \| high? (Circle) if low, please explain: | | Are you more than 20% **above** your ideal body weight? | **Y / N** |
| Do you douche regularly? | **Y / N** | Are you more than 20% **below** your ideal body weight? | **Y / N** |
| Do you exercise regularly? | **Y / N** | Do you have high stress levels? | **Y / N** |
| Have you had any hormone replacement therapy? If yes, what kind and when? | | | **Y / N** |

## GYNECOLOGICAL HISTORY

Check if you've had any of the following. If checked, add year(s) applicable.

| | | | |
|---|---|---|---|
| Abnormal PAP | | Endometriosis | |
| Cervical biopsy, cauterization or conization | | Pelvic adhesions | |
| Venereal disease | | Pelvic abnormalities | |
| Recurrent yeast infections | | Excessive facial hair | |
| Chronic vaginal discharge | | Excessively oily skin | |
| Uterine fibroids or polyps | | Nipple discharge | |
| Vaginal pain at rest or with intercourse | | Hair loss | |

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## MENSES

| | | | |
|---|---|---|---|
| How long is your cycle? (Count from 1st day of bleeding to next cycle's 1st day of bleeding, average is 28 days) | | | |
| Do you experience spotting before your period? | **Y / N** | How many days before? | |
| Cramping and pain with your period?<br>Before / during / after (Circle) | **Y / N** | How many days does the pain last? | |
| Is the bleeding light / medium / heavy? (Circle) | | Clotting or clumps? | **Y / N** |
| What color is the blood? Light red / red / dark red / purple / brown / black (circle all that apply) | | | |
| Do you get PMS? | **Y / N** | Breast tenderness? | **Y / N** |
| Low back pain on/before your period? | **Y / N** | Looser bowel movements? | **Y / N** |

## OVULATION

| | | | |
|---|---|---|---|
| Has your cycle changed since it began? | **Y / N** | If so, how? | |
| Do you ovulate on your own? | **Y / N** | If so, what day of your cycle? | |
| Do you track your temperature? | **Y / N** | Do you note your cervical position? | **Y / N** |
| Do you notice fertile cervical mucus (slippery and profuse) at ovulation? | | | **Y / N** |
| Do you have an increased libido at ovulation? | | | **Y / N** |

## CONTRACEPTION

| | | | |
|---|---|---|---|
| Have you taken oral contraceptives? | **Y / N** | If so, how long? | |
| Have you taken Depo-Provera? | **Y / N** | If so, how long? | |
| Have you had an IUD? | **Y / N** | If so, how long? | |

## ENVIRONMENT

Have you been exposed to any environmental toxins or strong chemicals at home or in the workplace? **Y / N** If so, what kind? _____

Was your mother exposed to diethylstilbestrol (DES) while she was pregnant with you? **Y / N**

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## FERTILITY

| | | |
|---|---|---|
| How long have you been trying to conceive? | | |
| Have you had fertility treatments? | **Y / N** | If yes, when and where? |
| Have you received a diagnosis related to fertility? | **Y / N** | If yes, what was the diagnosis? |
| Have you ever taken medication to help you ovulate? | **Y / N** | If so, what/when/how long/results? |
| Have your fallopian tubes been medically evaluated? | **Y / N** | If yes, what were the results? |
| Have you had any hormone lab tests performed? | **Y / N** | If yes, what were the results? |
| Have you had any tubal operations? | **Y / N** | If yes, which? |

## PARTNER

| | |
|---|---|
| Do you have a single partner with whom you are trying to conceive? | **Y / N** |
| Is your partner supportive of your wish to conceive? | **Y / N** |
| Have they had a fertility workup?<br>If so, results: _____ | **Y / N** |
| Have they had children previously? | **Y / N** |

Anything else you want us to know?_____

_____

_____

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