New Life Acupuncture Clinic
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WOMEN'S FERTILITY QUESTIONNAIRE

NAME ____ AGE______ DATE___________________

Date of last menstrual period _________

Number of pregnancies ___________

Dates (year)________________

Number of children?________

Number of abortions? _______

Number of miscarriages? _________

Number of D and C's? _________

Date of last PAP? _________

GYNECOLOGICAL HISTORY

Check if you have had any of the following.

______ Abnormal PAP?

______ Cervical biopsy, cauterization or conization?

______ Venereal disease?

______ Recurrent yeast infections?

______ Chronic vaginal discharge?

______ Uterine fibroids or polyps?

______ Vaginal pain at rest / with intercourse?

______ Endometriosis

______ Pelvis adhesions?

______ Pelvic abnormalities?

______ Excessive facial hair?

______ Excessively oily skin?

______ Discharge from your nipples?

______ Hair loss?

GENERAL

Is your sex drive low / normal / high?

Do you douche regularly? Y N

Do you use vaginal lubricants?_________

Do you exercise regularly? ________

Are you more than 20% above your ideal body weight? Y N

Are you more than 20% below your ideal body weight? Y N

Do you have high stress levels?_______

MENSES

How long is your cycle from first day of bleeding to the next cycle's first day of bleeding? ___________

Do you spot or stain before your period?____ How many days before?________

Cramping and pain with your period? Y N Before / during / after

How many days does the pain last?____

Is the bleeding light / medium / heavy? Is there clotting or clumps? ____

What color is the blood? Light red / red / dark red / purple / brown / black

PMS

Do you get PMS? Y N Breast tenderness before period/ at ovulation? Y N

Low back pain before your period? Y N Looser bowel movements before your period? Y N

OVULATION

Has your cycle changed since it began? ______ How? ___________________________________

Do you ovulate on your own? Y N What day of your cycle?_________

Do you track your temperature? Y N

Do you notice fertile cervical mucus (slippery and profuse) at ovulation? ______________

Do you have an increased libido at ovulation?________

Do you note your cervical position? Y N

FERTILITY

Have you had fertility treatments? Y N If yes, where and when______________________________

What types?____

Have you been given a diagnosis relating to fertility? Y N What was it?_______________________

How long have you been trying to conceive? ___________

Have you ever taken medication to help you ovulate? Y N

What?____ When?____________ How long?____________

Results?____

Have your fallopian tubes been medically evaluated?_____ Results?______________________________

Have you had any tubal operations? Y N Which? ______________________

Have you had any hormone lab test performed? Y N What were the results?__________________________

CONTRACEPTION

Have you taken oral contraceptives? Y N How long?__________

Have you taken Depro Provera? Y N How long? __________

Have you had an IUD? _______ How long? __________

ENVIRONMENT

Have you been exposed to any environmental toxins or strong chemicals at home or in the workplace?

Y N What? ______________________

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

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 __________________________

Has he had a fertility workup? Y N What were the results?___________

Has your partner had children previously? Y N