Questionnaire for Women Seeking Treatment for Fertility Support

Name: _____ Date: _____

Do you do the following: □Basal Body Temperature (BBT) charting □Cervical Mucus (CM) charting
□douche regularly: _____ □use vaginal lubricants: _____ □use steroids: _____
Pre-menstrual Symptoms: □acne □trouble falling asleep □trouble staying asleep □wake too early
□headache □tension □irritability □depression □tendency to cry □breast swelling □painful breasts
□cravings: _____ □abdominal bloating □nausea/vomiting □constipation □diarrhea □low back pain
Menstrual Periods: Age of first period: ____ **Have your periods changed since you started**? □yes □no
Please explain: _____
Frequency of Menstrual Periods: every _____ - _____ days **First day of last period**: _____
Average number of tampons used per day ____ Amount of bleeding: □scanty □normal □heavy
Color of menstrual blood:
Day 1: _____ Day 2: _____ Day 3: _____
Day 4: _____ Day 5: _____ Day 6: _____
Consistency of menstrual blood: □watery □thin □thick without clots □dime size clots □penny size clots
□nickel size clots □quarter size clots □red clots □dark red clots □purple clots □brown clots □black clots
Menstrual Pain (please check all that apply): □before periods □during periods □after periods
□dull ache □mild pain □severe stabbing pain □ severe cramping pain □"sinking feeling" in abdomen
□feeling of "heaviness" in abdomen □pain worse with pressure □pain better with pressure
□pain worse with heat □pain better with heat □pain worse with cold □pain better with cold
□lower back ache □belly button pain □pain radiates down into thighs □pain rushes up abdomen to chest
□abdomen hard & bloated □other pain: _____
Other Symptoms during menstrual period: _____
Between Menstrual Periods: □pain with ovulation □spotting □bleeding: _____
Vaginal Discharge: □color: _____ □consistency:_____ □smell: _____ □itching
□excessive discharge □irritation
Reproductive History:
How long have you been trying to get pregnant: _____
Is your partner supportive of your desire to conceive? _____
Approximately how many times a week do you have intercourse: _____
How is your sexual energy / interest in intercourse? _____
Do you have any pain or bleeding with / after intercourse? _____
How many pregnancies have you had? ____ Describe any birth trauma: _____
children: ____ # miscarriages: ____ # abortions: ____ # ectopic pregnancies: ____ # stillbirths: ____
Have you ever had: □abnormal PAP smear □cervical biopsy □cervical cauterization □cervical conization
□pelvic inflammatory disease □uterine fibroids □uterine polyps □endometriosis □pelvic adhesions
□pelvic abnormalities □D&C □tubal operations □hormone lab tests: _____
□yeast infections □sores on genitals □burning on urination □urine leaking with coughing / sneezing
□excessive facial hair □excessively oily skin □excessive loss of head hair □discharge from nipples
□HPV □HIV □Chlamydia □other sexually transmitted disease: _____
Previous Birth Control Methods: _____
Do you have a diagnosis of infertility from a physician? _____
_____
Are you currently receiving Western Medical treatment for your fertility? _____
_____
Has your partner had fertility testing? _____