Age when menses began:

Have your cycles changed since they began?

◯ Yes ◯ No

If yes, how?

Are your periods painful?

◯ Yes ◯ No

If yes, how many days does the pain last?

How many days do you normally bleed?

How heavy is the bleeding?

Heavy

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Normal

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Light

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

1 2 3 4 5 6 7 8 9 10 11 12

Day

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 cycle spaced irregularly?

◯ Yes ◯ No

Date last mentrual cycle began

DD/MM/YYYY

Have you ever had an abnormal pap smear?

◯ Yes ◯ No

Have you ever had a cervical biopsy, operation, cauterization or conization?

◯ Yes ◯ No

Have you ever had a venereal disease?

◯ Yes ◯ No

Do you get yeast infections regularly?

◯ Yes ◯ No

Have you ever been diagnosed with chlamydia?

◯ Yes ◯ No

Do you have chronic vaginal discharge?

◯ Yes ◯ No

Do you have any sores on your genitalia?

◯ Yes ◯ No

Have you ever had pelvic inflammatory disease?

◯ Yes ◯ No

If yes, how were you treated for it?

Date of last pap smear

DD/MM/YYYY

Have you ever been diagnosed with uterine fibroids or polyps?

◯ Yes ◯ No

Have you been diagnosed with endometriosis?

◯ Yes ◯ No

Have you ever been diagnosed with adhesions?

◯ Yes ◯ No

Have you ever been diagnosed with any pelvic abnormalities?

◯ Yes ◯ No

Have you ever taken oral contraceptives?

◯ Yes ◯ No

When?

How long?

Have you ever taken DepoProvera?

◯ Yes ◯ No

When?

How long?

Other than contraceptives?

◯ Yes ◯ No

How many pregnancies have you had?

Number

Years

Medication

Reason

How Long

How many children do you have?

Number

Years

Medication

Reason

How Long

How many abortions have you had?

Number

Years

Medication

Reason

How Long

How many miscarriages have you had?

Number

Years

Medication

Reason

How Long

How many times has a D&C been performed?

Number

Years

Medication

Reason

How Long

How long have you been trying to conceive?

Have you had a diagnosis relating to fertility?

◯ Yes ◯ No

If yes, what was it?

Have you had fertility treatments?

◯ Yes ◯ No

If yes, when?

Where?

By whom?

What types?

Have you taken medication to help you ovulate?

◯ Yes ◯ No

If yes, what?

When?

How long?

Have your fallopian tubes been medically evaluated?

◯ Yes ◯ No

If yes, what were the results?

Have you had any tubal operations?

◯ Yes ◯ No

Have you had any hormone lab tests performed?

◯ Yes ◯ No

If yes, what were the results?

Have you been exposed to any known environmental toxins or hormones?

◯ Yes ◯ No

Are you currently taking steroids?

◯ Yes ◯ No

How is your sexual energy?

◯ Low ◯ Normal ◯ High

Do you have a single partner with whom you have been trying to conceive?

◯ Yes ◯ No

If yes, how long have you been together?

Has he had a fertility workup?

◯ Yes ◯ No

If yes, what were the results?

Is your partner supportive of your wish to conceive?

◯ Low ◯ Normal ◯ High

Do you douche regularly?

◯ Yes ◯ No

If yes, with what?

Do you use vaginal lubricants?

◯ Yes ◯ No

Are you more than 20% over your ideal body weight?

◯ Yes ◯ No

Are you more than 20% under your ideal body weight?

◯ Yes ◯ No

Do you have a stressful occupation?

◯ Yes ◯ No

Do you exercise regularly?

◯ Yes ◯ No

Do you drink coffee, tea or sodas?

◯ Yes ◯ No

If yes, how much?

Do you smoke?

◯ Yes ◯ No

Do you have excessive facial hair?

◯ Yes ◯ No

Do you have excessively oily skin?

◯ Yes ◯ No

Have you experienced excessive loss of head hair?

◯ Yes ◯ No

Have you noticed discharge from your nipples?

◯ Yes ◯ No

Notes:

Record