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Women's Fertility History

CONFIDENTIAL

Please provide the following information:

1. Age at which menses began ___________________
2. Date of the first day of your last period _________________________________
3. Number days bleeding lasts ____
4. Number of days in your cycle ____
5. Have your cycles changed since they first began? □ Yes □ No
   How? ____

7. Are you currently pregnant? □ Yes □ No
8. Menstrual Flow:
   □ Heavy □ Moderate □ Light □ None
9. Color of Menstrual Flow:
   □ Light Red □ Red/Purple □ Dark Red □ Brown
10. Cramping:
    □ Severe □ Moderate □ Mild □ None
    □ Before period □ During □ After period
11. Clotting:
    □ Large □ Medium □ Small □ None
    □ Bright in color □ Dark in color
12. Birth Control:
    □ None □ IUD
    □ Barriers □ Spermicides
    □ Rhythm method □ Condoms
    □ Birth control pills
13. How many pregnancies have you had? Number____________ Year _____________
14. How many children do you have?
15. How many abortions have you had?
16. How many miscarriages have you had?
17. Have you ever had an abnormal pap smear? □ Yes □ No Date _____________
18. Have you ever had a cervical biopsy, operation, cauterization, or conization? □ Yes □ No Date _______________
19. Have you ever been diagnosed with Chlamydia? □ Yes □ No
20. Do you have chronic vaginal discharge? □ Yes □ No If yes, what color? ____
21. Have you gone, or are you currently going through menopause? □ Yes □ No Age of menopause _______________
    If yes, are you currently taking any medications or hormone replacement therapy? □ Yes □ No Type __________

Please check any of the premenstrual syndrome symptoms that apply:

□ Fluid retention/Bloating
□ Cravings
□ Acne/Break outs
□ Other ______________
□ Mood swings
□ Irritability
□ Back pain
□ Breast tenderness
□ Depression
□ Fatigue

Please check any that apply:

□ Hysterectomy
□ Infertility
□ Ovaries removed
□ Mastitis
□ Breast cysts
□ Brain fog
□ Pelvic inflam. disease
□ Frequent UTI
□ Vaginal discharge
□ PCOS
□ Fibroids/cysts
□ Irregular periods
□ Abnormal pap smear
□ Endometriosis
□ Post-menopausal bleeding
□ Abnormal mammogram
□ Pain/itching of the genitalia
□ Bleeding between periods
□ Recurrent yeast infection
□ Nipple discharge
□ Hot flashes
□ Vaginal dryness
□ Moodiness
□ Other ____________