PENNRIDGE
WELLNESS CENTER

Female Fertility Questionnaire

Please help us provide with a complete evaluation by taking the time to fill out this questionnaire carefully. *All of your answers will be help absolutely confidential.* If you have questions, please ask. If there is anything you wish to bring to our attention which is not asked on this form, please note it in the "Comments" section. ***Whenever possible, please provide a copy of lab reports.*** Thank you.

Name: _____ Age: _____ Date: _____

Name of fertility doctor/specialist: _____

Fertility History:

How long have you been trying to conceive with your partner? _____

Have you had any diagnosis relating to fertility? □ No □ Yes If yes, please explain _____

Please check if the following:

□ Pregnancies Dates: _____ □ Births Dates: _____

□ Miscarriages Dates: _____ □ Terminations Dates: _____

□ Ectopics Dates: _____ □ D&Cs Dates: _____

□ Abnormal Pap Smears Dates: _____

Have you had any of the following diagnostic procedures?

□ HSG Date: _____ □ Laparoscopy Date: _____

□ Other Date: _____

Have you had any hormonal blood-work evaluation? □ No □ Yes *(If yes, please provide a copy of lab report)*

Results: _____

Do you have a history of any of the following: *Please check all that apply*

□ Amenorrhea (lack of menstrual periods) □ Uterine fibroids □ Ovarian cysts

□ Irregular Periods □ Endometriosis □ PCOS

□ Chronic vaginal or yeast infections □ Vaginal discharge □ Bleeding between periods

□ Pelvic Inflammatory Disease □ STDS

Have you used any of the following contraception methods in the past? If so, how long and latest date used?

□ Birth control pill _____ □ Condoms _____

□ Patch _____ □ Diaphragm _____

□ Shot _____ □ Vaginal Ring _____

□ IUD: non hormonal _____ □ Fertility Awareness Month _____

□ IUD: hormonal _____ □ Other: _____

Menstrual History:

At what age was your first menstrual period? _____

When was your last menstrual period? _____

What day of your cycle are you currently on? _____

How long is your cycle (days between & including periods)? _____

How long is your period? _____

Please fill in the following menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color: medium red, bright red, pale, brown, rust, dark purple, other							
Amount of flow: Medium, heavy, light							
Clots: Size – large, medium, small, stringy Color – black, purple, red, other							

Please check if you experience any of the following menstrual/premenstrual symptoms:

□ Pain/Cramps Describe (dull, sharp, achy): _____ When: _____

Location: _____

□ Migraines Describe (dull, sharp, achy): _____ When: _____

Location: (temple, vertex, forehead, etc.) _____

□ Headaches Describe (dull, sharp, achy): _____ When: _____

Location: (temple, vertex, forehead, etc. _____

□ Vomiting/nausea When: _____

□ Change in mood/emotions Describe (irritable, sad, weepy, etc): _____

When: _____

□ Breast distension/tenderness When: _____

□ Bloating When: _____

□ Constipation When: _____

□ Diarrhea When: _____

□ Changes in sleep Describe: _____ When: _____

□ Cravings Describe (sweet, salty, etc.): _____ When: _____

□ Acne Where: _____ When: _____

Fertility Treatments (including cancelled cycles):

□ IUI Date: _____ Medications: _____ Outcome:_____

□ IVF Date: _____ Medications: _____ Outcome:_____

Date: _____ Medications: _____ Outcome:_____

Date: _____ Medications: _____ Outcome:_____

Date: _____ Medications: _____ Outcome:_____

Date: _____ Medications: _____ Outcome:_____

Future ART plans

□ IUD w/ oral meds Date: _____ □ IUI w/ injectables Date: _____

□ Clomid Date: _____ □ IVF Date: _____

□ Other Date: _____

Lifestyle:

Do you smoke? □ Yes □ No

If yes: # of cigarettes/packs per day: _____

Do you drink alcohol? □ Yes □ No

If yes: # of drinks per week: _____

Have you had any exposure to known environmental toxins? □ Yes □ No

Please describe: _____

Do you use recreational drugs? □ Yes □ No

If yes: # of times per week: _____

Have you had any exposure to steroidal hormones? □ Yes □ No

Please describe: _____