

ATHENS NATURAL MEDICINE

Naturopathic Medicine and Acupuncture

Women's Fertility History

Confidential

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Name (Last, First, Middle)	Date
Age _____ Date of Birth _____	How many abortions have you had?
What was your age at the start of menstruation? _____	number ____ years ____
When was your last period? _____	How many miscarriages have you had?
How many days are there <i>between</i> your periods? ____	number ____ years ____
Are your periods painful? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had a cervical biopsy, conization, or cauterization? <input type="checkbox"/> Yes <input type="checkbox"/> No
How many days does the pain typically last? ____	Have you ever had an abnormal pap?
How many days do you normally bleed? ____	<input type="checkbox"/> Yes <input type="checkbox"/> No
How heavy is the bleeding? <input type="checkbox"/> Light <input type="checkbox"/> Normal <input type="checkbox"/> Heavy	Have you ever had a sexually transmitted infection? <input type="checkbox"/> Yes <input type="checkbox"/> No
How many pads or tampons do you use on the heaviest days? _____	Have you had vaginal infections? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what type? _____
What color is the blood? <input type="checkbox"/> Light red <input type="checkbox"/> Red	Do you have chronic vaginal discharge?
<input type="checkbox"/> Dark red <input type="checkbox"/> Brown <input type="checkbox"/> Black	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there any clots? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had pelvic inflammatory disease?
If so, what size are they? <input type="checkbox"/> Tiny <input type="checkbox"/> Dime	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Quarter	How were you treated for it? _____
Do you bleed or spot between periods? _____	Have you ever been diagnosed with uterine fibroids or polyps? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have PMS? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you been diagnosed with polycystic ovarian syndrome? <input type="checkbox"/> Yes <input type="checkbox"/> No
If so, which of the following do you experience before or during your period?	If so have you been treated for it and how? _____
____Breast tenderness ____Headaches	_____
____Low back pain ____Bloating ____Cramping	Have you ever been diagnosed with endometriosis?
____Constipation ____Diarrhea ____Irritability	<input type="checkbox"/> Yes <input type="checkbox"/> No
____Weepiness ____Acne ____Spotting	Have you been diagnosed with pelvic adhesions? <input type="checkbox"/> Yes <input type="checkbox"/> No
Other _____	Have you been diagnosed with any pelvic abnormalities? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had an absence of menses for more than 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	Describe _____
Have your cycles changed since they began?	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
How? _____	
How many pregnancies have you had?	
number ____ years ____	
How many children do you have?	
number ____ years ____	

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Have you taken any medications for gynecological conditions? Include birth control pills and number of years on them.

How long have you been trying to conceive?

Do you ovulate on your own? Yes No

On what day(s) of your cycle? _____

Have you done basal body temperature charting?

Yes No

Do you have symptoms during ovulation?

Yes No

If so, what are they? _____

Have you had any fertility treatments?

Yes No

If so, when, where and what type?

Have you taken medicine to help you ovulate?

Yes No

What? _____ How long? _____

Have your fallopian tubes been evaluated medically? Yes No

What were the results? _____

Do you have a single partner with whom you are trying to conceive? Yes No

If your partner is male, has he had a fertility workup? Yes No

What were the results? _____

Is your partner supportive of your wish to conceive? _____

Have you ever had a D & C? Yes No

Have you ever had an IUD? Yes No

Have you ever taken Depo Provera

Yes No

When? _____ How long? _____

Have you had a diagnosis related to infertility?

Yes No

What was it? _____

How is your sexual energy? Low Normal

High

Do you douche? Yes No

Do you use vaginal lubricants? Yes No

What kind? _____

What is your current weight? _____

Maximum weight? _____ Minimum weight? _____

Are you more than 20% **over** or **under** your ideal body weight? If so, check one above.

Have you ever had an eating disorder?

Yes No

Do you have a stressful occupation?

Yes No

Do you exercise regularly? Yes No

How often and what form? _____

Do you have excessive hair growth or facial hair? Yes No

Have you been exposed to any environmental toxins, heavy metals or pesticides? Yes No

Was your mother exposed to DES when she was pregnant with you? Yes No

I certify that the above information is accurate to the best of my knowledge.

Name _____ Date _____