

# Women's Health, Naturally

## Fertility Questionnaire

**Name :** \_\_\_\_\_ **Age:** \_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Tel. #-Day:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **Evening:** \_\_\_\_--\_\_\_\_\_-\_\_\_\_\_

**Partner's Name:** \_\_\_\_\_ **Partner's date of birth:** \_\_\_\_\_

### GYNECOLOGICAL HISTORY

How old were you when you had your first period \_\_\_\_\_

How frequently do your periods come? Every \_\_\_\_days

How long do your periods last? \_\_\_\_\_days. When did your last period start? \_\_\_\_\_

Do you experience cramping with your periods? ☐ Yes ☐ No

If yes, when during your cycles do you have pain (check all that apply) :

☐ Before ☐ During ☐ After

How would you describe the cramps? ☐ Mild ☐ Moderate ☐ Severe

Do you take pain medication for the cramps? ☐ Yes ☐ No If yes, specify  
medication \_\_\_\_\_

Do you bleed or spot between periods? ☐ Yes ☐ No

If yes, please describe: \_\_\_\_\_

Have you ever had an abnormal Pap smear result? \_\_\_\_\_

If yes, what therapy was required : ☐ Cryotherapy(freezing of cervix) ☐ Laser  
therapy

☐ Cone biopsy ☐ LEEP ☐ Other: \_\_\_\_\_

Have you ever had any of the following infections involving any part of the reproductive tract

(vagina,cervix,uterus,ovaries)? Check all that apply

☐ Chlamydia ☐ Trichomonas ☐ Gonorrhea ☐ Herpes ☐ Genital warts

What treatment did you receive? \_\_\_\_\_Year:\_\_\_\_\_

Do you have pain with intercourse? ☐ never ☐ sometimes ☐ frequently ☐ always

If yes, does the pain remain in your lower abdomen after intercourse if over ?

☐ Yes ☐ No if yes, for how many minutes? : \_\_\_\_\_

How frequently do you and your partner have intercourse? \_\_\_\_\_per week/Month  
(circle)

How frequently do you and your partner have intercourse around ovulation?

\_\_\_\_\_times per month

Do you usually use lubrication during intercourse? ☐ Yes ☐ No

If yes, please specify: \_\_\_\_\_

Have you experienced any difficulties with intercourse that may be contributing to infertility?

☐ Yes ☐ No If yes, please explain:  
\_\_\_\_\_

Have you ever used contraception in the past? ☐ Yes ☐ No

if yes, please check all that apply:

☐ Contraceptive pills ☐ Condoms ☐ IUD ☐ Foam/Sponge ☐ Rhythm

☐ Withdrawal ☐ Other \_\_\_\_\_

### **FERTILITY EVALUATION**

How long have you and your partner been attempting to achieve pregnancy? \_\_\_\_\_

Have you been using temperature charts? ☐ Yes ☐ No

If yes, for how long?\_\_\_\_\_ months

Have you been using urine ovulation predictors

☐ Yes ☐ No if yes, what kind and for how long?

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Have you ever tried to achieve a pregnancy with a different partner? ☐ Yes ☐ No

Have you ever conceived with a different partner? ☐ Yes ☐ No

Has your male partner ever gotten someone else pregnant? ☐ Yes ☐ No

Have you been treated for infertility previously

☐ Yes ☐ No If Yes, where/when:

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What was the cause of infertility?

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Which of the following tests have already been performed?

☐ Infection test (Mycoplasma, Chlamydia) ☐ Postcoital test ☐ Endometrial biopsy

☐ Hysteroscope

☐ Hormonal tests ☐ Antichlamydia Antibody ☐ Ultrasound ☐ Sonohysterogram

☐ Hysterosalpingogram (HSG) ☐ Antisperm antibody ☐ Laparoscopy

Have you ever taken any of the medications listed below?

☐ Clomiphene (Clomid, Serophene) ☐ Injectable gonadotropins

(Pergonal, Repronex, Humagon, Fertinex, Gonal-F, Follistim)

☐ HCG (Profasi, Pregnyl) ☐ GnRH agonist (Lupron, Synarel, Zoladex) ☐ Estrogens

☐ steroids (prednisone, dexamethasone) ☐ GnRH Antagonist (Antagon)

☐ Bromocriptine (Parlodel, Dostinex)

☐ Glucophage (Metformin) ☐ Progesterone ☐ Heparin

☐ Baby aspirin ☐ Danazol

Have you ever had Intrauterine inseminations (IUI)? ☐ Yes ☐ No

if so, for how many cycles? \_\_\_\_\_cycles

If yes, specimen was provided by : Check all that apply) ☐ Partner ☐ Donor

Have you ever attempted in vitro fertilization? ☐ Yes ☐ No if yes, please specify below :

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### **OBSTETRICAL HISTORY**

Have you ever been pregnant (including elective terminations, miscarriages, births?)

☐ Yes ☐ No

### **PAST MEDICAL HISTORY**

Do you have or have you ever had any of the following (check all that apply):

☐ Ovarian cysts ☐ Anaemia ☐ Endometriosis ☐ Gallbladder disease ☐ Arthritis

☐ Heat/cold intolerance ☐ hair loss ☐ Seizures ☐ high blood pressure ☐ mumps

☐ Hirsutism (excess hair growth) ☐ hot flashes ☐ vision problems

☐ Cystic Fibrosis ☐ Diabetes ☐ Breast (Nipple discharge)

☐ Colitis ☐ Acne ☐ chronic headaches ☐ Kidney /Liver problems ☐ German Measles

☐ Regular Measles ☐ Neurological problems ☐ Autoimmune disease (e.g. Lupus)

Immunizations: ☐ Tetanus ☐ Hepatitis B ☐ German Measles ☐ Polio

☐ Mumps ☐ Chicken Pox ☐ Hepatitis B or C

### **PAST SURGICAL HISTORY**

Have you ever had any surgeries in the past ?

☐ Yes ☐ No If yes, please indicate date, type, findings of surgery:

\_\_\_\_\_

## **FAMILY HISTORY**

Have any of these problems occurred in your family? Check all that apply and indicate relationship to you:

☐ High blood pressure \_\_\_\_\_ ☐ Ovarian cancer \_\_\_\_\_

☐ Infertility \_\_\_\_\_ ☐ DES exposure in utero/early menopause \_\_\_\_\_

☐ Heart disease \_\_\_\_\_ ☐ colon/breast CA \_\_\_\_\_

☐ diabetes \_\_\_\_\_ ☐ Thyroid disease \_\_\_\_\_

## **REVIEW OF SYSTEMS**

Have you noted any significant:

Heat/Cold intolerance recently? ☐ Yes ☐ No if yes, please explain:

\_\_\_\_\_

Unusual hair distribution changes or breast nipple discharge ? ☐ Yes ☐ No

if yes, please explain: \_\_\_\_\_

Significant weight change in the last year? If so, please describe how many lbs and over what time: \_\_\_\_\_

## **HABITS**

Do you smoke? ☐ Yes ☐ No if yes, how many packs per day? \_\_\_\_\_

☐ Do you take hot baths? \_\_\_\_

Do you drink alcohol ☐ Yes ☐ No if yes, how many alcoholic beverages per week: \_\_\_\_\_

Do you smoke marijuana ☐ Yes ☐ No if yes, how much per week: \_\_\_\_\_

Do you exercise regularly? ☐ Yes ☐ No if yes, please indicate type of exercise  
and estimate hrs per week spent

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### **ALLERGIES to medication**

Are you allergic to any medication? ☐ Yes ☐ No

if yes, please indicate name of medication and type of reaction

Medication Reaction

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### **MEDICATIONS:**

Are you currently taking any prescription medications ☐ Yes ☐ No

Medications Reason

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Do any of you use herbal medications? ☐ Yes ☐ No

if yes, types of medications used: \_\_\_\_\_

## **SECTION FOR MALE PARTNER**

### **FERTILITY EVALUATION**

Which of the following test have already been performed?

- ☐ Semen analysis ☐ Chromosome test ☐ ☐ test (FSH,LH,Prolactin,Testosterone)
- ☐ Ultrasound of testis ☐ Antisperm antibody test ☐ myco/Ureaplasma culture ☐ Testicular biopsy

Have you ever had any of the following procedures done? (check all that apply)\_

- ☐ Varicocele repair ☐ hernia repair ☐ prostate surgery ☐ testicular torsion repair  
☐ testicular biopsy ☐ vasectomy reversal ☐ other (please specify):  
\_\_\_\_\_

Have you ever had any significant testicular injury? ☐ Yes ☐ No If yes, please describe:  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever taken any of the medications listed below?:

- ☐ Clomiphene (Clomid,Serophene) ☐ Proxecto ☐ Testosterone ☐ Viagra  
☐ GnRH agonist (Lupron,Synarel,Zoladex) ☐ Bromocriptine (Parlodel, Dostinex)  
☐ Other (please list): \_\_\_\_\_

Do you have or have you ever had any of the following (check all that apply):

- ☐ Cystic Fibrosis ☐ Delay of puberty ☐ Anemia ☐ Arthritis ☐ Cancer  
☐ Autoimmune disease ☐ Heat/cold intolerance ☐ Seizures ☐ Neurological problems  
☐ high blood pressure ☐ vision problems ☐ Testicular tumor  
☐ chronic headaches ☐ Kidney /Liver problems ☐ Colitis ☐ Cystic Fibrosis Diabetes  
☐ Regular Measles ☐ German Measles ☐ mumps ☐ Mumps with testes involved

Immunizations:

- ☐ Tetanus ☐ Hepatitis B ☐ German Measles ☐ Polio ☐ Mumps ☐ Chicken Pox  
☐ Hepatitis B or C

## **PAST SURGICAL HISTORY**

Have you ever had any surgeries in the past ☐ Yes ☐ No

If yes, please indicate date, type, findings of surgery:

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## **FAMILY HISTORY**

Have any of these problems occurred in your family? Check all that apply and indicate relationship to you:

- ☐ High blood pressure \_\_\_\_\_ ☐ Ovarian cancer \_\_\_\_\_
- ☐ Infertility \_\_\_\_\_ ☐ Prostate CA \_\_\_\_\_
- ☐ Heart disease \_\_\_\_\_ ☐ colon/breast CA \_\_\_\_\_
- ☐ diabetes \_\_\_\_\_ ☐ Other \_\_\_\_\_

## **REVIEW OF SYSTEMS**

Have you noted any significant:

Heat/Cold intolerance recently? ☐ Yes ☐ No if yes, please explain:

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Unusual hair distribution changes? ☐ Yes ☐ No if yes, please explain:

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Significant weight change in the last year? If so, please describe how many lbs and over what time: \_\_\_\_\_

## **HABITS**

Do you smoke? ☐ Yes ☐ No if yes, how many packs per day? \_\_\_\_\_

Do you drink alcohol ☐ Yes ☐ No No if yes, how many alcoholic beverages per week: \_\_\_\_\_



Do you smoke marijuana ☐ Yes ☐ No if yes, how much per week: \_\_\_\_\_

Do you take hot baths ☐ Yes ☐ No if yes, how much per week: \_\_\_\_\_

Do you exercise regularly? ☐ Yes ☐ No if yes, please indicate type of exercise and  
estimate hrs per week spent

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### **ALLERGIES TO MEDICATIONS**

Are you allergic to any medication? ☐ Yes ☐ No

if yes, please indicate name of medication and type of reaction

Medication Reaction

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### **MEDICATIONS:**

Are you currently taking any prescription medications

☐ Yes ☐ No Medications: \_\_\_\_\_ Reason: \_\_\_\_\_

Do any of you use herbal medications? ☐ Yes ☐ No if yes, types of medications used:  
\_\_\_\_\_