HEALTH OFFERINGS, INC.
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Women's Fertility History

Date completed: ____________ Referred by: ____

Identification Information

Name: ____ DOB:___________ Age:___________

Partner's Name: _____________________________________ DOB:___________ Age:___________

Primary Care Physician: ____________________________ OBGYN: __________________________

Reproductive Endocrinologist: __________________________________

How long have you been attempting to conceive?___________________

General frequency of intercourse?______________________________

Do you or your partner travel for work? □ Yes □ No

Do you and your partner live together? □ Yes □ No

Who sleeps in the bed with you? (please include animals / children) ____________________________

Family History

Mother: Living? □ Yes; □ No Age? _________ Health? ________________________________

Father: Living? □ Yes; □ No Age? _________ Health? ________________________________

Do any blood relatives have any of the following (check all that apply):

□ Cancer □ Blood Clotting □ Diabetes □Hypertension □ High Cholesterol □ Heart Disease

□ Stroke □ Premature Menopause □ Endometriosis □ Uterine Fibroids

How many biological siblings do you have? Brothers ________ Sisters ________

Half brother(s) ________ Half-sister(s) ________

Where are you in your family's birth order? ____________________

How old was your mother when she had you? ___________________

Do you know anything about your mother's pregnancy with you?

____

____

Do you know anything about your mother's delivery with you?

____

____

Do you know if your mother smoked while pregnant with you? □ Yes; □ No; □ Don't know

Do you know if your mother drank alcohol while she was pregnant with you? □ Yes; □ No; □ unknown

Are you aware of any stresses or illnesses or accidents during your mother's pregnancy with you?

____

____

Do you know if you were breastfeed as a baby? □ Yes; □ No; □ Don't know

*If you have been diagnosed with a hormone imbalance/disorder, please specify it here:

____

Present weight: ________________ Present Height: _____________________

Have you had a history of weight changes? □ Yes; □ No

If yes, please explain: ____

____

Menstrual History

Bleeding

At what age was your first menstrual period? (ok to approximate) ______________________________

Did you cycle regularly after first period? □ Yes; □ No

If no, please describe: ____

____

Please list dates of your last 3 periods (if possible):

____

Over the last year, about how many days does your period last? ________________________________

Over the last year, how many days from onset (of bleeding) to onset (of next period)

____

How heavy is your bleeding? □ Light; □ Normal; □ Heavy

What day(s) do you bleed the heaviest? ____

Will you also have loose stool on the heaviest day of flow? □ Yes; □ No

Are you afraid to wear light colored clothes during your period due to heavy flow? □ Yes; □ No

Will you bleed heavy at night or though to the sheets? □ Yes; □ No

Do you wonder about the lightness of your flow? □ Yes; □ No

If yes, please explain: ____

Do you spot or bleed between periods? □ Yes; □ No

If yes, please explain: ____

Do you you skip periods? ☐ Yes; ☐ No

What Color is the menstrual blood? ☐ Light red; ☐ Red; ☐ Dark Red; ☐ Purple; ☐ Black; ☐ Brown

Are you slow to start bleeding? ☐ Yes; ☐ No

Are you slow to end bleeding? ☐ Yes; ☐ No

Does your menstrual blood change color during? ☐ Yes; ☐ No

If yes, please explain: ____________________

Is there clotting with your menstrual flow? ☐ Yes; ☐ No; If yes, please describe: ____________________

Are menstrual blood clots: ☐ small? (pea size); ☐ Large? (quarter size); ☐ Like sand? (dry)

Are the clots darker than the menstrual flow blood? ☐ Yes; ☐ No

Do you have fresh red blood after passing clots? ☐ Yes; ☐ No

Is there pain or distress passing clots? ☐ Yes; ☐ No

Overall, when menstruating do you feel: ☐ good; ☐ bad; ☐ I have not noticed?

Please explain: ____________________

Cramping

During your period, do you get menstrual cramps: ☐ before; ☐ during; ☐ after; ☐ I don't get cramps

Are your cramps: ☐ mild; ☐ moderate; ☐ bad; ☐ very bad; ☐ I don't get cramps

Do you generally have to take something or do something for menstrual cramping? ☐ Yes; ☐ No

If yes, please list what and/or explain pain relief methods: ____________________

Do you get cramps during ovulation? ☐ Yes; ☐ No

Do you get emotional during ovulation? ☐ Yes; ☐ No

If yes, please explain: ____________________

Do you get more tired during ovulations? ☐ Yes; ☐ No; ☐ I haven't noticed

Premenstrual History

Do you get sore breasts? ☐ Yes; ☐ No

Do you have skin break outs? ☐ Yes; ☐ No; If yes, where?____________________

Do you get food cravings? ☐ Yes; ☐ No; If yes, what do you crave?____________________

Do you get emotional before your menstrual period? ☐ Yes; ☐ No

If yes, can you identify with: ☐ Tearful; ☐ Frustrated; ☐ Aggressive; ☐ Sudden Outbursts

Do you get stomach bloating before your period? ☐ Yes; ☐ No

Do you retain water before your period? ☐ Yes; ☐ No

If yes, in ☐ fingers; ☐ face; ☐ feet; ☐ other ____

Overall do you associate your periods to be painful? ☐ Yes; ☐ No

Overall do you associate your periods to be too long? ☐ Yes; ☐ No

Overall, do you think your periods are too light? ☐ Yes; ☐ No

Overall do you avoid any activities while on your period? ☐ Yes; ☐ No

If yes, what? Please explain:____

Pregnancy History

Have you ever had a positive pregnancy test? ☐ Yes; ☐ No

How many pregnancies have you had?______________________________

How many children do you have?__________________________________

Have you had any premature births? ☐ Yes; ☐ No

Have you had any miscarriages? ☐ Yes; ☐ No If so, which trimester? _____________________________

Have you had a D&C performed ever? ☐ Yes; ☐ No

Do you have adopted children? ☐ Yes; ☐ No; Are you in the adoption process? ☐ Yes; ☐ No

If you have had a child(ren) before, please list their present sex & age(s)___________________________

____

Fertility Therapy History

Have you ever been treated for infertility before? ☐ Yes; ☐ No

If yes, where and when?____

Dr/Practice?____

If yes, were you given a diagnosis? ☐ No; ☐ Yes

If yes, diagnosis?____

Have you taken medication to help you ovulate (outside of IUI/IVF)? ☐ Yes; ☐ No

When? ________________________________ How long? __________________________________

Have your fallopian tubes been evaluated medically? ☐ Yes; ☐ No

What were the results? ____

Have you had any tubal operations? ☐ Yes; ☐ No

Have you had any hormone laboratory tests performed? ☐ Yes; ☐ No

What were the results? ______________________________

Do you have a single partner with whom you have been trying to conceive? ☐ Yes; ☐ No

How long have you been married or living together? ______________________________

Has he had a fertility work up? ☐ Yes; ☐ No

If so, what were the results? ______________________________

Is your partner supportive of your wish to conceive? ☐ Yes; ☐ No

Have you taken oral contraceptives? ☐ Yes; ☐ No

When? ______________________________ How long? ______________________________

Have you ever had an IUD? ☐ Yes; ☐ No

When? ______________________________ How long? ______________________________

How long have you been trying to conceive? ______________________________

How is your sexual energy? ☐ Low ☐ Normal ☐ High

Do you douche regularly? ☐ Yes; ☐ No

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% below your ideal body weight? ☐ Yes; ☐ No

Do you have a stressful occupation? ☐ Yes; ☐ No

Do you have excessive facial hair? ☐ Yes; ☐ No

Have you ever undergone Artificial Insemination (IUI) or Invitro Fertilization (IVF)? ☐ Yes; ☐ No

If yes, the sperm was from: ☐ your partner; ☐ donor

Number of IUI's______________ dates (approximate ok)______________________________

Number of IVF cycles___________ dates (approximate ok)______________________________

Have you ever used Clomid? ☐ Yes; ☐ No Fertility Shots? ☐ Yes; ☐ No

What other medications, if any, have you taken with IUI/IVF? ______________________________

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