

# Skyline Integrative Medicine

## Women's Fertility Questionnaire

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

How long have you been trying to get pregnant? \_\_\_\_\_

Have you been pregnant before: \_\_\_\_\_

If so, when? \_\_\_\_\_

What was the outcome? (brought to term, miscarriage, abortion?)

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Has your partner had a fertility workup? If so, what were the results?

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Have you had a diagnosis relating to fertility? If so, what was it?

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Have you had fertility treatments? If so, please fill in:

Type of Treatment

When

Where, By Whom

Type of Treatment	When	Where, By Whom
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you using currently or recently using Assisted Reproductive Technology (medical fertility treatment)? \_\_\_\_\_ If so, who is your physician? \_\_\_\_\_

Please list any drugs/medications and the date you will be using them.

Drug

Dates used or to be used

Drug	Dates used or to be used
_____	_____
_____	_____
_____	_____

Have you ever had a hysterosalpinogram (HSG) or had your fallopian tubes medically evaluated?

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Have you had any hormone lab tests? (these would include thyroid, estrogen, progesterone, testosterone, FSH, LH prolactin, etc.) If so, what were results?

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Please describe your history of birth control.

Have you used \_\_\_\_\_ Approx, what dates?  
Birth Control Pills \_\_\_\_\_  
IUD \_\_\_\_\_  
Depo-Provera \_\_\_\_\_  
Tubal ligation \_\_\_\_\_

Do you keep track of your cycle by charting your BBT or testing for ovulation? \_\_\_\_\_

If so, what day of your cycle do you usually ovulate? \_\_\_\_\_

If you check your cervical fluid at ovulation, is it (circle)

Scanty or dry                      Tacky/sticky                      Stretchy like egg whites                      Creamy like lotion

Do you experience problems with vaginal dryness? \_\_\_\_\_

List any vaginal products you use, i.e. douches, lubricants, deodorants, creams:

\_\_\_\_\_  
\_\_\_\_\_

Have you or your partner had significant exposure to toxic chemicals? List any you know of:

\_\_\_\_\_  
\_\_\_\_\_

Do you weigh more than 20% above or below your ideal body weight? \_\_\_\_\_

How is your sexual energy? Circle one:

Non-existent                      Low                      Medium                      High                      VaVaVoom!

How often are you having sexual intercourse? \_\_\_\_\_

Is your partner equally invested in your attempt to get pregnant? \_\_\_\_\_

How are you feeling about your pursuit of pregnancy? \_\_\_\_\_  
\_\_\_\_\_

Do you want information/education about your cycle or fertility in general? \_\_\_\_\_

### **Detailed Menstrual History**

How long are your menstrual cycles (how many days from Day 1 of your period to Day 1 of the next period)? \_\_\_\_\_

Has the length of your cycle changed over the past few years? \_\_\_\_\_

How many days do you bleed? (do not include light spotting) \_\_\_\_\_

Has the number of days changed over the past few years? \_\_\_\_\_

How heavy is your bleeding? \_\_\_\_\_

Has the heaviness changed over the past few years? \_\_\_\_\_

Do you spot, either at the beginning or the end of your period? \_\_\_\_\_

If so, for how long? \_\_\_\_\_

What color is your menstrual blood? (circle)

Pink/light red      bright red      dark red      purple brown      black

Is menstruation (blood) thin or watery? \_\_\_\_\_

Do you notice clots? \_\_\_\_\_

Do you get mid-cycle cramping? \_\_\_\_\_

Circle any PMS symptoms you experience:

Abdominal cramping

Low back pain

Bearing down sensation

Headache

Loose stools

Constipation

Acne

Bloating

Breast tenderness

Coldness

Fatigue

Night sweats/hot flashes

Irritability

Nausea

Herpes outbreaks

Weepiness/Sadness

Yeast infections

Other: \_\_\_\_\_

Have you been diagnosed with endometriosis, fibroids, Pelvic Inflammatory Disease, ovarian cysts, polycystic ovaries, thyroid imbalance, uterus prolapse or tilt, etc?

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Please describe anything else about your period, cycle or menstrual history that you think is important or interesting:

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