WOMEN'S REPRODUCTIVE HISTORY

CONFIDENTIAL

NAME (LAST, FIRST, MIDDLE) _____ **DATE** _____

Age at which menses began _____

Are your periods painful? Yes No

How many days does the pain last? _____

How many days do you normally bleed? _____

How heavy is the bleeding? light normal heavy

What color is the blood? light red / red / dark red / purple / brown / black

Is there clotting? Yes No

Does your face break out before or during your period? Yes No

Do your breasts become tender premenstrually? Yes No

Do you bleed or spot between periods? Yes No

Are your menstrual cycles spaced irregularly? Yes No

How many days are there from one period to the next? _____

Date of last menstrual period _____

How many pregnancies have you had? _____

How many children do you have? _____ age(s) _____

How many abortions have you had? _____

How many miscarriages have you had? _____

How many times has a D&C been performed? _____

Have you ever had an abnormal pap smear? Yes No

Have you ever had a cervical biopsy, operation, cauterization, or conization? Yes No

Have you ever had a venereal disease? Yes No

Do you get yeast infections regularly? Yes No

Have you ever been diagnosed with a chlamydia infection? Yes No

Do you have chronic vaginal discharge? Yes No

Do you have any sores on your genitalia? Yes No

Have you ever had pelvic inflammatory disease? Yes No

Were you treated for it? Yes No

How? _____

Date of last pap smear _____

Have you ever been diagnosed with uterine fibroids or polyps? Yes No

Have you ever been diagnosed with endometriosis? Yes No

Have you been diagnosed with pelvic adhesions? Yes No

Have you been diagnosed with any pelvic abnormalities? Yes No

Have you taken any medication for gynecological conditions other than contraceptives? Yes No

Medication	**Reason**	**How long**

Have your cycles changed since they began? Yes No

How? _____

Do you ovulate on your own? Yes No

On what day of your cycle? _____

Do your breasts get tender at/during ovulation? Yes No

Do you get premenstrual low back pain? Yes No

Do your bowel movements become loose at the beginning of your period? Yes No

Have you had fertility treatments? Yes No

If yes, when and where? _____

By whom? _____

What type(s)? _____

PLEASE SEE REVERSE

~Heal in Harmony™
Isthmus Wellness™

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WOMEN'S REPRODUCTIVE HISTORY

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Have you taken medication to help you ovulate? 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 workup? Yes No

What were the results? _____

_____

_____

Is your partner supportive in your wish to conceive? Yes No

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 exercise regularly? Yes No

Do you have excessive facial hair? Yes No

Do you have excessively oily skin? Yes No

Have you experienced excessive loss of head hair? Yes No

Have you noticed discharge from your nipples? Yes No

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

Have you been exposed to any known environmental toxins or hormones? Yes No

Are you presently taking steroids? Yes No

Have you taken oral contraceptives? Yes No

When? _____

How long? _____

_____

Have you ever had an IUD? Yes No

When _____

How long? _____

Have you ever taken DepoProvera? Yes No

When? _____

How long? _____

How long have you been trying to conceive? _____

Have you had a diagnosis relating to infertility? Yes No

What was it? _____

_____

_____

_____

_____

ADDITIONAL COMMENTS/NOTES:

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