Fertility Questionnaire

How long have you been trying to conceive?_____

Dates and results of past pregnancies _____

Do you have a diagnosis regarding infertility?_____

Have you attempted IUI? Dates and Results_____

Have you attempted IVF? Dates and Results_____

Please list any current medications/supplements_____

Describe current treatment for infertility_____

Please circle all that apply:

Uterine fibroids

Endometriosis

Endometrial polyps

Tubal reversal

Low progesterone

Polycystic Ovarian Syndrome (PCOS)

Uterine anomaly (structural abnormality)

Ovarian cysts

History of ectopic pregnancy

History of uterine infection or PID

Hirsutism (excessive hair growth)

weight change loss gain

history of gynecological cancer

Please list any testing, surgeries, and procedures and the results you have undergone for infertility

_____

_____

Have you charted your basal body temperature? _____ Results? _____

Have you tested OPKs (urine ovulation predictors)?_____Results?_____

Have you ever achieved pregnancy with a different partner?_____

Has your partner had infertility testing? Results?_____

Contraceptive history_____

Please list any Western Medical Diagnoses and surgeries (high blood pressure, hypothyroid, etc)

_____

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Age of first menstrual period_____

Length of menstrual cycle (day 1 of period to day 1 of next period)_____

How long does your period last (days of bleeding) _____

Has your period changed in the last year? How? _____

Menstrual Cramps (please circle all that apply)

Before period	start of period	during period	end of period
front/low abdomen	low back	hips	feel burning
sharp pain	dull pain	achy	full feeling
stabbing pain	mild pain	moderate pain	severe pain
heat helps pain	pressure helps pain	activity helps pain	rest helps pain
heat worsens pain	pressure worsens pain	activity worsens pain	

Do you experience pain or spotting mid-cycle? Please describe_____

_____

Menstrual Blood (Circle all that apply)

Bright red	dark red/purple	pale red/pink	Brown
large clots	small clots	thick	thin/watery
normal consistency	heavy flow	light flow	medium flow

Vaginal Discharge (Circle all that apply)

Thin	thick	watery	clumpy
Egg white	creamy	burning	itchy
Cold	hot	white	yellow
Red/pink	tan/brown	dry	scanty
Copious	irritated	frequent yeast infections	

Fertility Questionnaire

Other Menstrual Related Symptoms (Circle all that apply)

Headache/migraine	breast tenderness	irritability	anger
Sadness	dizziness	lightheadedness	fatigue
feeling “spacey”	inability to concentrate	memory issues	acne
vivid dreaming	poor sleep	ear ringing	heartburn
abdominal bloating	constipation	loose stool	diarrhea
blurry vision	eye floaters	sore/weak low back	
water retention	UTI/urinary difficulty	hot flashes	

Other Systems Symptoms (circle all that apply)

Dry eyes	blurry vision/floaters	dry skin	ear ringing
Hearing loss	sore/weak low back	tight low back	brittle nails
Hair loss	sadness	anger	fear
difficulty falling asleep	difficulty staying asleep	vivid dreaming	irritability
Nightmares	stabbing headache	pressure headache	dull headache
Dry skin	hot hands or feet	cold intolerance	heat intolerance
Cold extremities	cold abdomen	core/internal heat	facial flushing
Sweat without exercise	sore joints worse with heat	sore joints worse with cold	
Sore joints worse with damp	abdominal bloating	poor appetite	heavy limbs
Abdominal pain	chest pain	rib/flank pain	weak/sore knees
Numb/tingling limbs	heart palpitations	shortness of breath	dizziness
Lightheadedness	empty/spacey head	poor memory	difficulty concentrating
Hot flashes	crave sweet	crave salty	crave spicy
Crave sour	loose stool	diarrhea	nausea
Drink hot liquid	drink cold liquid	poor immunity	skin itching

Please describe any other mind/body therapies, dietary techniques, etc, you are incorporating into your fertility plan