Women's Fertility Questionnaire
Wichita Holistic, Inc.

All Information is Strictly Confidential.

Name_____ Date of Birth_____

MENSTRUAL HISTORY

Age at which menses began _____

Do you menstruate regularly? ❑ Yes ❑ No
Cycle is _____ days total
Cycle Varies from ____ to _____ days

When was your last menstrual Period? _____

Have your cycles changed recently? ❑ Yes ❑ No
Do you know if you ovulate? ❑ Yes ❑ No
If yes, on what cycle day? _____

What methods do you use to track your cycle?
_____
_____

Do you have any of the following PMS symptoms?

❑ Acne	❑ Cramps	❑ Bowel Changes
❑ Breast	❑ Backaches	❑ Food cravings
❑ Irritability	❑ Nausea	❑ Sad/Weeping

❑ Other symptoms:
_____

How many days per cycle do you menstruate? _____

Do you spot between periods? ❑ Yes ❑ No

During your period, the flow is: *Please fill in cycle days*

❑ Spotting on days	_____
❑ Light on days	_____
❑ Medium on days	_____
❑ Heavy on days	_____
❑ Clots on days	_____

What color is the blood? *Please fill in cycle days*

❑ Light red on days	_____
❑ Bright red on days	_____
❑ Dark red on days	_____
❑ Purple on days	_____
❑ Brown on days	_____
❑ Black on days	_____

Do you experience any symptoms just after menstruation?
❑ Dizziness ❑ Fatigue ❑ Insomnia ❑ Night Sweats
❑ Cramps ❑ Others: _____

Do you experience any of the following?

❑ Day Sweats	❑ Oily Skin
❑ Hot Flashes	❑ Excessive Facial/Body Hair
❑ Insomnia	❑ Loss of Head Hair
❑ Night Sweats	❑ Sores on genitals
❑ UTIs	❑ Yeast Infections
❑ Chronic Discharge	❑ Vaginal Dryness

BREAST HEALTH

Do you have any of the following?

❑ Breast Lumps/Nodules	❑ Breast Cancer
❑ Breast Tenderness	❑ Inverted Nipples
❑ Nipple Discharge	❑ Mastitis

REPRODUCTIVE & GYNICOLOGICAL HISTORY

Previous methods of birth control, with approximate dates:

❑ Oral Contraceptives	_____
❑ Hormonal Patch/Ring	_____
❑ Birth Control Shot	_____
❑ Intra Uterine Device	_____
❑ Barrier-Method	_____
❑ Fertility Awareness	_____

Are you currently using a birth control? ❑ Yes ❑ No
Are you currently trying to conceive? ❑ Yes ❑ No
If yes, for how long? _____

How is your libido? ❑ High ❑ Medium ❑ Low

How many pregnancies have you had? _____
How many children do you have? _____
How many abortions have you had? _____
How many miscarriages have you had? _____

Have you experienced any of the following:
❑ Physical Trauma
❑ Sexual Abuse
❑ High-risk Pregnancies
❑ Difficult Labors
❑ Difficult Deliveries
❑ Post-Partum Concerns
❑ Lactation Concerns

Have you ever been diagnosed with any of the following?

❑ Cysts ❑ Endometriosis
❑ Fibroids ❑ Pelvic abnormalities
❑ PID ❑ Adhesions
❑ STDs ❑ Cancer of reproductive organs
❑ PCOS ❑ Premature Ovarian Failure

Date of last pap smear? _____
Have you ever had an abnormal pap? ❑ Yes ❑ No

Please check the following that apply:
❑ Above your ideal body weight
❑ Below your ideal body weight
❑ Frequently Stressed
❑ Exercise Regularly
❑ Properly Hydrated
❑ Aware of Diet

FERTILITY HISTORY

Are you currently seeing an infertility specialist?
❑ Yes ❑ No *If yes, Practitioner name & Specialty:*
_____
_____

Have your fallopian tubes been evaluated? ❑ Yes ❑ No
Results: _____

Have you ever had a diagnosis relating to infertility?
❑ Yes ❑ No *If yes, please explain briefly:*
_____
_____
_____
_____

Do you have a partner with whom you are trying to conceive?
❑ Yes ❑ No
If yes, Name:
_____

How long have you two been together? _____
How is your partner's libido? ❑ High ❑ Medium ❑ Low
Has your partner had a fertility workup? ❑ Yes ❑ No

Has your partner had a diagnosis relating to infertility?
❑ Yes ❑ No *If yes, please explain briefly:*
_____
_____
_____
_____

Have you had any assisted reproductive treatments?
❑ Yes ❑ No *If yes, please explain briefly:*
_____
_____
_____
_____

Have you taken medications for gynecological conditions other than contraceptives? ❑ Yes ❑ No
_____
_____
_____
_____

Do you feel your partner is supportive of Assisted Reproductive Therapies? ❑ Yes ❑ No

Have you had any Holistic Fertility Enhancement Treatments? ❑ Yes ❑ No *If yes, please explain briefly:*
_____
_____
_____
_____

Do you feel your partner is supportive of Holistic Fertility Enhancement Therapies? ❑ Yes ❑ No

Do you feel you have enough emotional support?
❑ Yes ❑ No

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

Was your mother exposed to any hormones, procedures or traumas while she was pregnant with you? ❑ Yes ❑ No
_____
_____

ADDITIONAL INFORMATION: