# 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:**