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: