ADVANCED HEALTHCARE SOLUTIONS

Female Fertility Health History Questionnaire

Please complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, however, they may play a major role in diagnosis. All information is strictly confidential.

General Patient Information

Date: _____ / _____ / _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Date Of Birth: _____ Age: _____

Email: _____ Height: _____ Weight: _____

Appointment Reminders? ☐ Text ☐ Email

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partnership

Name of Spouse/Partner: _____

Is your spouse/partner under the care of our clinic? ☐ YES ☐ NO

Primary Healthcare Provider: _____

OB/GYN:
_____

Reproductive Endocrinologist: _____

Midwife:
_____

How long have you and your partner been trying to conceive? _____

Do you have any biological children with your spouse/partner? ☐ YES ☐ NO

If yes, how many and their ages? _____

Do you have any biological children with a previous spouse/partner? ☐ YES ☐ NO

If yes, how many and their ages? _____

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Are you currently undergoing assisted reproductive treatments (IUI, IVF, ICSI, Superovulation, etc.)? _____

If yes, at what clinic are you receiving treatments? _____

List all medications you are currently taking: _____

_____

List Supplements/Vitamins/Herbs you are currently taking: _____

_____

Number of:

Pregnancies	
Cesarean Births	
Vaginal Births	
Abortions	
Miscarriages	
Ectopic Pregnancy(ies)	
Failed IUI's	
Failed IVF's	

Do you regularly experience PMS? ☐ Yes ☐ No

If yes, which symptoms do you experience?

☐ Breast tenderness ☐ Constipation ☐ Diarrhea ☐ Back Pain
☐ Acne ☐ Food Cravings ☐ Bloating ☐ Dizziness
☐ Fatigue ☐ Mood Swings ☐ Headache/Migraine

Age menstruation began: _____

Your periods are: ☐ Like clockwork ☐ Some-what regular ☐ Erratic

Number of days in your typical cycle: _____

If your cycle is erratic: Shortest number of days in cycle: _____
Longest number of days in cycle: _____

Menstrual bleeding tends to be: ☐ Light ☐ Normal ☐ Heavy

On what cycle day do you typically ovulate? _____

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During ovulation, is your cervical mucus clear, stretchy and abundant? □ Yes □ No

If not all three, please describe _____

_____

Is there clotting with your period? □ Yes □ No

Do you have spotting before or between periods? □ Yes □ NO

Check any diagnosis received by you OB/GYN or Fertility Specialist:

□ Advanced Maternal Age
□ Amenorrhea
□ Anovulation
□ Anti-sperm Antibodies
□ Autoimmune Oopharitis
□ Cervical Stenosis
□ Clotting with Period
□ Delayed Cycles
□ Menstrual Pain (mild)
□ Menstrual Pain (moderate)
□ Menstrual Pain (severe)
□ Resistant Ovarian Syndrome
□ Spotting between periods
□ Erratic Cycles
□ Fallopian Tube Blockage
□ Habitual Miscarriage
□ Hostile Cervical Mucus
□ Luteal Phase Defect
□ Menorrhagia
□ Ovarian Cyst (single)
□ Ovarian Cyst (multiple)
□ Ovarian Hyperstimulation Syndrome
□ Pelvic Inflammatory Disease
□ Phospholipid Antibodies
□ Polycystic Ovarian Syndrome
□ Premature Menopause
□ Premature Ovarian Failure
□ Short Cycles
□ Elevated FSH
□ Endometriosis (mild/moderate/severe)
□ Unexplained Infertility
□ Uterine Fibroids
□ Uterine Septum
□ Hyperproactinemia

Other(s):_____

Check any surgical procedures that you have had:

□ Dilations & Curettages (D&C)
□ Mymectomy
□ Laparoscopy (uterine fibroids)
□ Hysteroscopy
□ Tuboplasty
□ Falloposcopy
□ Laparoscopy (ovarian cysts)
□ (HSG) Hysterosalpingogram
□ Neosalpingostomy
□ Laparoscopy (endometriosis)

Other(s): _____

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Have you been diagnosed with a sexually transmitted disease (STD)? ☐ YES ☐ NO

Have you been diagnosed with chromosomal abnormalities/translocations? ☐ YES ☐ NO

Check any conditions you currently have or have had in the past:

☐ Diabetes	☐ Allergies	☐ Glaucoma
☐ Heart Disease	☐ Stroke	☐ Tuberculosis
☐ Asthma	☐ Pneumonia	☐ Mumps
☐ Mental Illness	☐ Measles	☐ Chicken Pox
☐ Kidney Disease	☐ HIV	☐ Polio
☐ Meningitis	☐ High Fever	☐ Hepatitis
☐ Epilepsy	☐ Cancer	☐ Migraines
☐ Paralysis	☐ Chlamydia	☐ Emphysema
☐ Lung Disease	☐ Liver Disease	☐ Bleeding/Hemorrhage
☐ Gonorrhea	☐ High Cholesterol	☐ Auto Immune Disease
☐ Thyroid Disorder	☐ Hypertension	☐ Rheumatic Fever

Tell me about your sleep: _____

_____

Have you been exposed to any chemicals? If yes, when and which chemical?

_____

_____

Tell me about your vaccine history: _____

_____