Female Fertility Questionnaire

SYNERGY
acupuncture & wellness
working together toward better health

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. *All of your answers will be held absolutely confidential*. If you have questions, please ask. If there is anything you wish to bring to our attention which is not asked on this form, please note it in the "Comments" section. ***Whenever possible, please provide a copy of lab reports.*** Thank you.

Name	Age:	Date
Name of fertility doctor/specialist:		Contact Number:

Fertility History:

How long have you been trying to conceive with your partner?

Have you had any diagnosis relating to fertility? ☐ No ☐ Yes If yes, please explain.

Please check if the following:

☐ Pregnancies Dates: _____ ☐ Births Dates: _____

☐ Miscarriages Dates: _____ ☐ Terminations Dates: _____

☐ Ectopics Dates: _____ ☐ D&Cs Dates: _____

☐ Abnormal Pap Smear Dates: _____

Have you had any of the following diagnostic procedures?

☐ HSG Date: _____ ☐ Laparoscopy Date: _____

☐ Other Date: _____

Have you had any hormonal blood-work evaluations? ☐ No ☐ Yes *(If yes, please provide a copy of lab report)*

Results:

Do you have a history of any of the following: *Please check all that apply*

☐ Amenorrhea (lack of menstrual periods)	☐ Uterine fibroids	☐ Chronic vaginal or yeast infections
☐ Irregular periods	☐ Ovarian cysts	☐ Pelvic Inflammatory Disease
☐ Bleeding between periods	☐ Endometriosis	☐ Sexually Transmitted Disease (STDs)
☐ Vaginal discharge	☐ PCOS	

Have you used any of the following contraception methods in the past? If so, how long and latest date used?

☐ Birth control pill	_____	☐ IUD: non-hormonal	_____
☐ Patch	_____	☐ Condoms	_____
☐ Shot	_____	☐ Diaphragm	_____
☐ Vaginal ring	_____	☐ Fertility Awareness Method	_____
☐ IUD: hormonal	_____	☐ Other: _____	_____

Female Fertility Questionnaire (continued)

Menstrual History:

At what age was your first menstrual period?

When was your last menstrual period?

What day of your cycle are you currently on?

How long is your cycle (days between & including periods)?

How long is your period?

Please fill in the following menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color : Medium red, bright red, pale, brown, rust, dark purple, other							
Amount of flow: Medium, heavy, light							
Clots: Size – large, medium, small, stringy Color – black, purple, red, other							

Please check if you experience any of the following menstrual/premenstrual symptoms:

- ☐ Pain/Cramps Describe (dull, sharp, achy):_____ When:_____ Location:_____
- ☐ Migraines Describe (dull, sharp, achy):_____ When:_____ Location (temple, vertex, forehead, etc):_____
- ☐ Headaches Describe (dull, sharp, achy):_____ When:_____ Location (temple, vertex, forehead, etc):_____
- ☐ Vomiting/nausea When:_____
- ☐ Change in mood/emotions Describe (irritable, sad, weepy, etc):_____ When:_____
- ☐ Breast distension/tenderness When:_____
- ☐ Bloating When:_____
- ☐ Constipation When:_____
- ☐ Diarrhea When:_____
- ☐ Fatigue When:_____
- ☐ Changes in sleep Describe:_____ When:_____
- ☐ Cravings Describe (sweet, salty, etc):_____ When:_____
- ☐ Acne Where:_____ When:_____

Fertility Treatments (including cancelled cycles):

- ☐ IUI Dates: _____ Medications: _____ Outcome:_____
- ☐ IVF Date: _____ Medications: _____ Outcome:_____
  - Date: _____ Medications: _____ Outcome:_____
  - Date: _____ Medications: _____ Outcome:_____
  - Date: _____ Medications: _____ Outcome:_____
  - Date: _____ Medications: _____ Outcome:_____

Female Fertility Questionnaire (continued)

Fertility Treatments (including cancelled cycles) (continued):

☐ Other Date: _____ Medications: _____ Outcome:_____

Future ART plans

☐ IUI w/oral meds Date: _____ ☐ IUI w/injectables Date: _____

☐ Clomid Date: _____ ☐ IVF Date: _____

☐ Other Date: _____

Lifestyle:

Do you smoke? ☐ No ☐ Yes
If yes: # of cigarettes/ packs per day:

Do you drink alcohol? ☐ No ☐ Yes
If yes: # of drinks per week:

Have you had any exposure to known environmental toxins? ☐ No ☐ Yes
Please describe:

Do you use recreational drugs? ☐ No ☐ Yes
If yes: # of times per week:

Have you had any exposure to steroidal hormones? ☐ No ☐ Yes

Please describe: