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Gynecological and Fertility History

This information is essential for the diagnosis procedure and helps us to provide you with a better treatment. Please fill out the following questions as accurately as you can. All information given is kept in your personal file and will not be released without your written instructions to do so.

Name: _____ Age: _____ Date of Birth: _____

Primary Care Physician: _____ Tel: _____

OB/GYN Physician: _____ Tel: _____

Date of last GYN exam: _____

Principle complaint: _____

Previous GYN diagnosis: _____

Previous fertility diagnosis: _____

What age did your menses begin/end? _____ Date of last period: _____

Do you have premenstrual tension? ☐ Yes ☐ No

Do you have acne or other skin disorders? ☐ Yes ☐ No

Do you experience breast tenderness premenstrually or during ovulation? ☐ Yes ☐ No

How many days between periods? (count from first day of cycle) _____

How many days does your period last? _____

Do you bleed or spot between periods? ☐ Yes ☐ No

Are your menstrual cycles spaced irregularly? ☐ Yes ☐ No

How heavy is the bleeding? ☐ Light ☐ Normal ☐ Heavy

What color is the blood? ☐ Light red ☐ Red ☐ Dark red ☐ Purple ☐ Brown ☐ Black

Is there clotting? ☐ Yes ☐ No

Are your periods painful? ☐ Yes ☐ No

How many days does the pain last? _____

How many pregnancies have you had? _____

How many children do you have? _____

How many abortions have you had? _____

How many miscarriages have you had? _____

How many times has a D&C been performed? _____

Have you ever had an abnormal pap smear? ☐ Yes ☐ No

Have you ever had a cervical biopsy, operation, cauterization or conization? ☐ Yes ☐ No

Have you ever had a sexually transmitted disease? ☐ Yes ☐ No

Do you have abnormal vaginal discharge? ☐ Yes ☐ No

Have you been diagnosed with a gyn disorder? ☐ Yes ☐ No

Date of last pap smear? _____

Do you have endometriosis, fibroids, polyps, pelvic adhesions, pelvic abnormalities? ☐ Yes ☐ No

Have you taken oral contraceptives? ☐ Yes ☐ No

Have your cycles changed since they began? ☐ Yes ☐ No

Do you ovulate on your own? ☐ Yes ☐ No

On what day of your cycle? _____

Do you get low back pain? ☐ Yes ☐ No

Do you notice any change in bowel movements before or during your cycle? ☐ Yes ☐ No

Have you had fertility treatments? ☐ Yes ☐ No

If so, please list: _____

Have you taken any medication to help you ovulate? ☐ Yes ☐ No

Have your fallopian tubes ever been evaluated medically? ☐ Yes ☐ No

If so, what were the results? _____

Have you had any tubal operations? ☐ Yes ☐ No

Have you had any hormonal laboratory tests preformed? ☐ Yes ☐ No

Do you have a partner with whom you have been trying to conceive? ☐ Yes ☐ No

Has your partner received a fertility work up? ☐ Yes ☐ No

Is your partner supportive of your wish to conceive? ☐ Yes ☐ No

Have you ever had an IUD? ☐ Yes ☐ No

Have you ever taken Depo Provera? ☐ Yes ☐ No

How long have you been trying to conceive? _____

How is your sexual energy? ☐ Low ☐ Normal ☐ High

Do your have excessive facial or body hair? ☐ Yes ☐ No

Do you have excessively oily skin? ☐ Yes ☐ No

Have you experienced hair loss? ☐ Yes ☐ No

Have you noticed any discharge from your nipples? ☐ Yes ☐ No

Have you been exposed to any known environmental toxins or hormones? ☐ Yes ☐ No

Are you presently taking steroids? ☐ Yes ☐ No

List history of all medications, herbs, and supplements, and whether you are taking them presently.

Medications/supplements/herbs:	Indication/for treatment of:	duration:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Cancellation Policy

Because our practice is by appointment only, your appointment time is reserved exclusively for you. If you need to reschedule or cancel an appointment, we require a minimum of 24 hours notice. Full visit fees will be charged for missed visits and late cancellations.

Signature _____ Date _____