Fertility and menstrual History Questionnaire

Name: _____ **Date:** _____

Menstrual History

What age did menstruation begin? _____

Are your periods:

- ☐ Somewhat regular
- ☐ Erratic
  - ☐ Like clockwork
- ☐ **Total Boxes Checked:**

What is the interval between your menstrual cycle in days? _____

If your period is erratic, please complete the following statement: "My period comes sometime betwee' ____ days and _____ days after completion c' my previous cycle."

During a typica' menstrual period, how many days of bleeding do you have? _____

Is your bleeding:

- ☐ Heavy
- ☐ Light
  - ☐ Normal
- ☐ **Total Boxes Checked:**

Which of the following describes the predominant color of your menstrual blood?

- ☐ Light Red
- ☐ Purple
- ☐ Brown
- ☐ Dark Red
- ☐ Black
  - ☐ Bright Red
- ☐ **Total Boxes Checked:**

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Fertility and menstrual History Questionnaire

Menstrual History -- Continued

Is there clotting with your period?

☐ Yes ☐ No

☐ **Total Boxes Checked:**

Do you regularly experience PMS:

☐ Yes ☐ No

☐ **Total Boxes Checked:**

Check which symptoms best describe your PMS:

- ☐ Breast tenderness or swelling
- ☐ Irritability
- ☐ Abdominal Bloating
- ☐ Diarrhea
- ☐ Constipation
- ☐ Pain / Cramping
- ☐ Headaches or Migraines
- ☐ Mood Swings
- ☐ Low Back Pain
- ☐ Dizziness
- ☐ Extreme Fatigue
- ☐ Acne
- ☐ Food Cravings

☐ **Total Boxes Checked:**

During your menstrual flow, how many times would you soak a tampon or pad in a 4 hour time? _____

On what day of your cycle do you ovulate? _____

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Fertility and menstrual History Questionnaire

Menstrual History -- Continued

During ovulation, is your cervical mucus:

☐ Clear
☐ Abundant and Stretchy
If not, please describe: _____
☐ **Total Boxes Checked**

What is the most important thing that you think your acupuncturist should know about your menstrual cycle?

_____

Have you had a veneral disease?
☐ Yes ☐ No
If yes, please describe: _____
☐ **Total Boxes Checked**

Do you have a history with any of the following:

☐ Yes	☐ No	Regularly occurring yeast infectons
☐ Yes	☐ No	An abnormal pap smear
☐ Yes	☐ No	Any kind of uterine surgery
☐ Yes	☐ No	Endometriosis
☐ Yes	☐ No	Chronic vaginal discharge
☐ Yes	☐ No	Uterine fibroids or polyps
☐ Yes	☐ No	Pelvis Inflammatory Disease
☐ Yes	☐ No	Polycystic ovarian syndrome
☐ Yes	☐ No	Spotting or bleeding between periods

☐ **Total Boxes Checked**

Have you used oral contraceptives?
If yes, please list the dates of use and disuse below:
☐ Yes ☐ No _____

☐ **Total Boxes Checked**

Date of your last pap smear or ob/gyn exam: _____

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Fertility and menstrual History Questionnaire

Fertility History

Have you ever been pregnant before?

☐ No ☐ Yes

Total number of pregnancies: _____
Number of vaginal deliveries: _____
Number of Cesarian (C-Section) deilveries: _____
Number of Abortions: _____
Number of Miscarriages: _____
Number of still births: _____

If you have ever had a miscarriage, please list the week of pregnancy when the miscarriage occurred and the reason (if known): _____

_____

During ovulation do you experience the following:

☐ Yes ☐ No Pain or cramping
☐ Yes ☐ No Bleeding or spotting
☐ Yes ☐ No Copious or excessive discharge
☐ Yes ☐ No Breast pain or tenderness

During ovulation is your cervical mucous

☐ Dense/cloudy
☐ Unknown
☐ Clear/stretchy

How long have you been trying to get pregnant? _____

☐ No ☐ Yes Do you have a committed partner with whom you are trying to conceive?
If yes, how long have you been married/living together? _____

☐ No ☐ Yes Has he had a male fertility work-up?
If yes, what were the results? _____

☐ No ☐ Yes If no, do you intend to get one?

Fertility and menstrual History Questionnaire

Fertility History -- Continued

☐ Yes ☐ No Have you ever undergone fertility treatments or used Assisted Repro.Technology?
If yes, please describe methods that you have used and the dates of each procedure:

_____

_____

☐ Yes ☐ No Have you ever taken medication to help you ovulate?
If yes, when? _____ And how long? _____

_____

☐ No ☐ Yes Have your fallopian tubes been evaluated medically?
☐ Yes If yes, were the results "obstructed"
☐ No or clear/patent

☐ No ☐ Yes Have you had any hormonal lab tests done?
If yes, when and what were the results? _____ _____

_____ _____ _____

_____ _____ _____

☐ Yes ☐ No
Have you been given any biomedical diagnosis that might explain why you are having trouble getting pregnant?
If yes, what was it? _____

_____

☐ No ☐ Yes Have you ever charted your Basal Body Temperature (BBT)?
If yes, please bring your charts to your next appointment.

Disregarding anything that anyone has told you previously, why do YOU think that you are having difficulty getting pregnant?

_____

_____

On a 1 to 10 scale (10 being very commited), rate your commitment level to do whatever it takes to get pregnant? (including making dietary and lifestyle changes / quitting smoking and drinking alcohol / taking herbs regularly).

My level of commitment is: ☐ **out of 10.**

Fertility and menstrual History Questionnaire

Health History

Kidney

☐	Yes	☐	No	Do you have vaginal dryness?
☐	Yes	☐	No	Is your midcycle cervical mucus scanty or missing?
☐	Yes	☐	No	Does your menstrual blood tend to be dull in color?
☐	Yes	☐	No	Do you feel cold cramps during your period that respnds to heat?

☐ **Total Boxes Checked**

Spleen

☐	Yes	☐	No	Is your menstruaton thin, watery, profuse or pink in color?
☐	Yes	☐	No	Are you more tired around ovulation or menstruaton?
☐	Yes	☐	No	Have you ever been diagnosed with uterine prolapse?
☐	Yes	☐	No	Are your menstrual cramps accompanied by a bearing-down sensation in your uterus?

☐ **Total Boxes Checked**

Blood

☐	Yes	☐	No	Are your menses scanty and/or late?
☐	Yes	☐	No	Is your menstrual flow ever brown or black in color?
☐	Yes	☐	No	Do you have painful, unmovable breast lumps?
☐	Yes	☐	No	Can you feel any abnormal lumps in your lower abdomen?
☐	Yes	☐	No	Do you have piercing or stabbling menstrual cramps?

☐ **Total Boxes Checked**

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Fertility and menstrual History Questionnaire

Health History -- Continued

Liver

☐	Yes	☐	No	Do you feel bloated or irritable around ovulation?
☐	Yes	☐	No	Does it feel as if your ovulation lasts longer than it should?
☐	Yes	☐	No	Do you experience nipple pain or discharge from your nipples?
☐	Yes	☐	No	Have you been diagnosed with elevated prolactin levels?
☐	Yes	☐	No	Are your menses painful?
☐	Yes	☐	No	Do you feel your menstrual cramps in the external genital area?
☐	Yes	☐	No	Is the menstrual blood thick and dark, or purplish in color?

☐ **Total Boxes Checked**

Damp

☐	Yes	☐	No	Do you break out with red acne (especially premenstrually)?
☐	Yes	☐	No	Do you have a short menstrual cycle?
☐	Yes	☐	No	Do you have vaginal irritation or rashes?
☐	Yes	☐	No	Do you have fibrocystic breasts?
☐	Yes	☐	No	Do you have cystic or pustular acne?
☐	Yes	☐	No	Do you have foul smelling, yellow or greenish vaginal discharge?
☐	Yes	☐	No	Are you prone to vaginal and/or rectal itching during your luteal or premenstrual phase?

☐ **Total Boxes Checked**

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