FEMALE QUESTIONNAIRE

Patient Name _____ Date _____

Age of 1st period (menarche) _____ Can you be pregnant? _____ Age of last period (if in menopause) _____

Number of days from one period to the next? (cycle length) _____ Number of days of the flow _____

Do you bleed or spot between periods? _____ yes _____ no Date of the first day of your last period _____

Form and name of birth control (if applicable) _____ If yes – for how long? _____

Date of last: GYN exam _____ Pap Smear _____ Mammogram _____ Bone Density Scan _____ Results _____

List any PMS symptoms you experience before your period	10-14 days before	1 week before	2-3 days before
Breast tenderness			
Depression			
Mood swings/irritability			
Fatigue			
Low Back Pain			
Abdominal Pain			
Headaches			
Face Break Out			
Loose stools/constipation			
Bloating			
Fluid Retention			
Food Cravings			
Appetite increase/decrease			

Describe your period below, please:

Symptoms (please check everything that applies)	Day 1	Day 2	Day 3	Day 4	Day 5	Days 6-7
Back Pain						
Cramps (light, medium, severe)						
Nature of abdominal pain (dull, aching, stabbing)						
Blood flow color (light red, red, dark red, purple, brown)						
Average # of tampons/pads you use each day						
Is there clotting?						
Is there spotting?						

FEMALE QUESTIONNAIRE

Patient Name _____ Date _____

FERTILITY INTAKE:

How long have you been trying to get pregnant? _____ Current month treatment plan _____ (IVF, IUI, Natural, Tests, etc)

Name of fertility center/group you're working with _____

Name of your GYN doctor/fertility specialist _____

1. **Please list all that applies and if yes - how many:**

	Pregnancies	Children	Ectopic	Miscarriages	D & C
Date & Number					

2. **Please list below all pregnancies and fertility treatments that you've had (including cancelled cycles):**

Date	**Natural, IVF, IUI, other**	**Medications used**	**# of retrieved/ mature eggs/follicles**	**# of eggs fertilized**	**# of embryos transferred/ frozen**	**Pregnancy (yes/no)**	**If miscarried – indicate which week**	**Comments**

3. **Mark everything that applies (including past diagnoses):**

Have you ever had an abnormal pap smear? _____

Have you ever had a cervical biopsy, operation, cauterization or conization? _____

Do you get yeast infections often? _____

Have you ever had a chlamydial infection? _____

Do you have vaginal discharge? _____

Have you been diagnosed with fibrocystic breasts? _____

Have you had hysterectomy/ovaries removed? _____

4. **Have you been diagnosed with any of these?**

	High FSH/ low AMH	Uterine Fibroids/Polyps	Endometriosis/ Adhesions	PCOS	Hyper-prolactinemia	POF	Low Progesterone
Date							