

Women Only:

Are you pregnant now? Yes No

How many pregnancies have you had? _____ Number of living children & age? _____

Terminations: _____ When _____ Complications? _____

Miscarriages or losses: _____ When _____

No. of IUI cycles: _____ When? _____ Known or Donor Sperm? Outcome? _____

No. of IVF cycles: _____ When? _____ Known or Donor Sperm? Outcome? _____

Donor Egg cycles? _____ When? _____ Outcome? _____

Maternal Family History (please circle): Infertility Fibroids Endometriosis

Cancer (type) _____ Menstrual Problems: PMS Menopause

Number of days from the start of one period to the start of the next: _____

Are your menstrual cycles spaced regularly? Yes No

Average number of days of flow: _____ Flow is: Light Normal Heavy

Color at the beginning of your period: Pale Normal Dark Bright Red Brown

Color during is: Pale Normal Dark Bright Red Brown

Are blood clots present? Yes No Quarter? or Dime sized?

Does your period cause you pain or cramping? Yes No

When? Before During After

Do you experience nausea or vomiting with your period? Yes No

When? Before During After

Does your period deplete your energy? Yes No

Do you experience any of the following before your period each month?

Bloating Breast tenderness or swelling Mental depression

Irritability Food cravings Headaches/Migraines Other _____

Do you experience a sensation of cold in the abdomen or low back during or prior to your menstruation?

Do you ever bleed or spot between periods? Yes No

Do your bowel movements become loose at the beginning of your period? Yes No

Do you have any vaginal discharge between periods (other than normal discharge during time of ovulation)? Yes No Color _____ Is there a foul odor associated with this discharge? Yes/No

Do you have/have you ever had:

Abnormal pap smear? Yes No When/Why? _____

Yeast infections? Yes No

Uterine fibroids or polyps? Yes No Endometriosis? Yes No

Varicose veins? Yes No

Painful intercourse? Yes No

Numb legs/feet when standing still? Yes No

Pelvic inflammatory disease? Yes No Difficulty experiencing orgasm? Yes No

Have you been diagnosed with any pelvic "abnormalities"? Yes No Type_____

Do you have a history of anemia? Are you currently taking iron supplements for this condition?