



Denise Wiesner, L.Ac.
 Alex Berks, L.Ac.

Women's Fertility History

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Name (Last, First, middle)	Date
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1. Menstrual cycle

How long does your period last? _____
 Date of last menstrual period? _____
 How many days between cycles? _____
 Are your periods irregular? Please explain _____

How many days are there from one period to next _____
 How heavy is the bleeding? light normal heavy
 What color is the blood? Normal red Light red dark red purple brown black
 Is there clotting? Yes No
 Age at which menses began _____
 Have cycles changed since they began _____

If you ovulate, what day of the cycle? _____

2. Pre-menstrual issues

Check if you have any of the following:

- PMS symptoms
- Sore/tender breasts?
- acne breakouts?
- Irritable, depressed?
- Low back pain? (circle one) before during after cycle
- Loose stools? (circle one) before during after cycle
- Headaches? (circle one) before during after cycle
- Other _____

3. Gynecology History

Have you ever had any of the following procedures: (please check box)
 Abnormal Pap smear, cervical biopsy, cervical operation, cauterization, conization?
 When? _____

Date of last Pap smear? _____
 Other gynecological procedures? _____
 Gynecology surgeries? _____

Have you ever had any of the following?

- Yeast infections regularly
- Chronic vaginal discharge
- Painful Intercourse



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Have you ever been diagnosed with any of the following:

- Endometriosis
- HPV (human papiloma virus)
- Venereal disease
- Chlamydia
- Genital herpes
- Uterine fibroids or polyps
- Pelvic adhesions
- Pelvic inflammatory disease

If yes to any of the above, when were you treated? _____

How were you treated? _____

	How many	Year
Pregnancy	_____	_____
Children	_____	_____
Abortions	_____	_____
Miscarriages	_____	_____
D&C's	_____	_____

Have you taken oral contraceptives? When? _____ How long? _____

Do you use an IUD?

4. Fertility Treatment History

How long have you been trying to conceive? _____

Do you have a diagnosis related to infertility? _____

Have you had fertility treatments? Please explain when and by whom? (use another sheet if necessary)

Have you had a fallopian tube evaluation? Yes

Have you had other functional tests? _____

What were the results? _____

What hormonal laboratory tests were performed? _____

What were the results? _____



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Please list any and all medications you are currently taking?

Medication	Reason	How long
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. Lifestyle

How is your sexual energy? (check a box) Low normal high

- Do you douche?
 - Do you use vaginal lubricants?
 - Do you have a stressful occupation?
 - Do you exercise regularly?
 - What do you do and how often? _____
 - Do you have excessive facial hair ?
 - Excessive loss of head hair?
 - Discharge from nipples?
 - What is your height? _____ and weight _____
 - Was your mother exposed to DES (diethylstilbestrol) when she was pregnant?
 - Have you been exposed to any known environmental toxins or hormones?
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