glow
NATURAL HEALTH CENTER, PLLC

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NAME _____ AGE_____ DATE _____

Date of last menstrual period _____
Number of pregnancies _____
Dates (year)_____
Number of children?_____

Number of abortions? _____
Number of miscarriages? _____
Number of D and C's? _____
Date of last PAP? _____

GYNECOLOGICAL HISTORY

Check if you have had any of the following.

_____ Abnormal PAP?
_____ Cervical biopsy, cauterization or conization?
_____ Venereal disease?
_____ Recurrent yeast infections?
_____ Chronic vaginal discharge?
_____ Uterine fibroids or polyps?
_____ Endometriosis

_____ Pelvis adhesions?
_____ Pelvic abnormalities?
_____ Excessive facial hair?
_____ Excessively oily skin?
_____ Discharge from your nipples?
_____ Hair loss?

GENERAL

Is your sex drive low / normal / high?
Do you douche regularly? Y N
Do you use vaginal lubricants?_____
Do you exercise regularly? _____

Are you more than 20% <u>above</u> your ideal body weight? Y N
Are you more than 20% <u>below</u> your ideal body weight? Y N
Do you have high stress levels?_____

MENSES

How long is your cycle from first day of bleeding to the next cycle's first day of bleeding? _____

Do you spot or stain before your period?____ How many days before?_____

Cramping and pain with your period? Y N Before / during / after How many days does the pain last?____

Is the bleeding light / medium / heavy? Is there clotting or clumps? ____

What color is the blood? Light red / red / dark red / purple / brown / black

PMS

Do you get PMS? Y N Breast tenderness before period/ at ovulation? Y N

Low back pain before your period? Y N Looser bowel movements before your period? Y N

OVULATION

Has your cycle changed since it began? _____ How? _____
Do you ovulate on your own? Y N What day of your cycle?_____
Do you track your temperature? Y N
Do you notice fertile cervical mucus (slippery and profuse) at ovulation? Y N _____
Do you have an increased libido at ovulation?_____
Do you note your cervical position? Y N _____

FERTILITY

Have you had fertility treatments? Y N If yes, where and when_____
What types?_____

Have you been given a diagnosis relating to fertility? Y N What was it?_____

How long have you been trying to conceive? _____

Have you ever taken medication to help you ovulate? Y N What?_____
When?_____ How long?_____ Results?_____

Have you fallopian tubes been medically evaluated?_____ Results?_____

Have you had any tubal operations? Y N Which? _____

Have you had any hormone lab test performed? Y N What were the results?_____

CONTRACEPTION

Have you taken oral contraceptives? Y N How long?_____
Have you taken Depro Provera? Y N How long? _____
Have you had an IUD? _____ How long? _____

ENVIRONMENT

Have you been exposed to an environmental toxins? Y N What? _____
Was your mother exposed to diethylstilbestrol (DES) when she was pregnant with you? Y N

PARTNER

Do you have a single partner with whom you are trying to conceive? Y N
Is your partner supportive of your wish to conceive? Y N _____
Has he had a fertility workup? Y N What were the results?_____
Has your partner had children previously? Y N