

Shelly A. Krahn, L.Ac
910 East Ohio Avenue, Suite 101B, Escondido, CA 92025
(760) 419-6863

FERTILITY HISTORY

NAME: _____	DATE: _____
-------------	-------------

Age at which menses began _____

Have you ever had Pelvic Inflammatory Disease? Yes or No
Were you treated for it? Yes or No
How _____

Do you have pain with your periods? Yes or No
How many days does the pain last? _____
How many days do you usually bleed? _____
How heavy is the bleeding? Light, Normal or Heavy
What color is the blood? (Circle one)
Light red / Red / Dark Red/ Purple/ Brown/ Black
Is there clotting? Yes or No
Do you have premenstrual tension? Yes or No
Do you have problems with facial breakouts before or during your period? Yes or No

Date of last Pap smear? _____
Have you ever been diagnosed with uterine fibroids or polyps? Yes or No
Have you ever been diagnosed with endometriosis? Yes or No
Have you ever been diagnosed with pelvic adhesions? Yes or No
Have you ever been diagnosed with any pelvic abnormalities? Yes or No
What medications, if any, have you taken for gynecological conditions other than contraceptives?

Do you have breast tenderness before your period? Yes or No
Do you experience spotting or bleed between periods? Yes or No
Do you have irregularly spaced cycles? Yes or No
How many days are there from one period to the Next?

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

What was the date of your last menstrual period? _____
Number Years
How many pregnancies have you had? _____
How many children do you have? _____
How many abortions have you had? _____
How many miscarriages? _____
How many times has a D &C Been performed? _____

Have your cycles changed since they've begun? Yes or No
How? _____

Have you ever had an abnormal pap smear? Yes or No
Have you ever had a cervical biopsy, operation, curettage or conization? Yes or No
Have your ever had a venereal disease? Yes or No
If yes which one and what if any treatment was given?

Do you get yeast infections regularly? Yes or No
Have you ever been diagnosed with Chlamydia? Y or N
Do you have any sore on your genitalia? Yes or No

Do you ovulate on your own? Yes or No
On which day of your cycle does this occur? _____
Do your breasts get tender at or during ovulation? Yes or No
Do you get premenstrual low back pain? Yes or No
Do your bowel movements become loose at the at the beginning of your period? Yes or No
Do you have chronic vaginal discharge? Yes or No