



### **Female Fertility Questionnaire**

Name (Last, First) \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

#### **Menses**

Age at which menses began \_\_\_\_\_

Are your periods painful? Yes No

How many days do you normally bleed? \_\_\_\_\_

How heavy is the bleeding? Light Normal Heavy

What color is the blood? Light red Red Dark red Purple Brown Black

Is there clotting? Yes No

Does your face break out before or during your period? Yes No

Do your breasts become tender when you are premenstrual? Yes No

Do you get premenstrual low back pain? Yes No

Do you bleed or spot between periods? Yes No

Are your menstrual cycles spaced irregularly? Yes No

How many days are there from one period to the next? \_\_\_\_\_

Date of last menstrual period \_\_\_\_\_

Have your cycles changed since they began? Yes No

Do you ovulate on your own? Yes No On what day of your cycle? \_\_\_\_\_

Do your breasts become tender at ovulation? Yes No

Do you experience pain at ovulation? Yes No

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

#### **Western Diagnosis**

Have you ever been diagnosed with uterine fibroids or polyps? Yes No

Have you ever had pelvic inflammatory disease? Yes No Were you treated for it? Yes No

Have you ever been diagnosed with endometriosis? Yes No

Have you been diagnosed with pelvic adhesions? Yes No

Have you been diagnosed with any pelvic abnormalities? Yes No

Have you had surgeries besides a D&C? Yes No When? \_\_\_\_\_ What kind? \_\_\_\_\_

#### **Medication History**

Have you taken oral contraceptives? Yes No When? \_\_\_\_\_ How long? \_\_\_\_\_

Have you ever had an IUD? Yes No When? \_\_\_\_\_ How long? \_\_\_\_\_

Have you ever taken DepoProvera? Yes No When? \_\_\_\_\_ How long? \_\_\_\_\_

Have you taken medication to help you ovulate? Yes No When? \_\_\_\_\_ How long? \_\_\_\_\_

Are you presently taking steroids? Yes No

List all medications you are currently taking \_\_\_\_\_

**Pregnancy History**

How many pregnancies have you had? \_\_\_\_\_

How many children do you have? \_\_\_\_\_

Were there complications during your pregnancies? Yes No If yes, what? \_\_\_\_\_

How many abortions have you had? \_\_\_\_\_

How many miscarriages have you had? \_\_\_\_\_

How many times has a D & C been performed? \_\_\_\_\_

**Well-Woman History**

Have you ever had an abnormal pap smear? Yes No

Have you ever had a cervical biopsy, operation, cauterization or conization? Yes No

Have you ever had a venereal disease? Yes No What kind? \_\_\_\_\_

Do you get yeast infections regularly? Yes No

Do you have chronic vaginal discharge? Yes No

Do you douche regularly? Yes No With what? \_\_\_\_\_

Do you use vaginal lubricants? Yes No Which Ones? \_\_\_\_\_

Do you use tampons? Yes No Do you sleep with one in? Yes No

Do you ever experience pain with sex? Yes No

**Fertility Treatments**

Have you had fertility treatments? Yes No

If yes, when and where? \_\_\_\_\_

By whom? \_\_\_\_\_

What types? \_\_\_\_\_

Have you had a diagnosis relating to infertility? Yes No What was it? \_\_\_\_\_

Have your fallopian tubes been evaluated medically? Yes No What were the results? \_\_\_\_\_

Have you had any tubal operations? Yes No

Have you had any hormone laboratory tests performed? Yes No What were the results? \_\_\_\_\_

Do you have a single partner with whom you have been trying to conceive? Yes No

Has he had a fertility workup? Yes No What were the results? \_\_\_\_\_

Is your partner supportive of your wish to conceive? Yes No

How long have you been trying to conceive? \_\_\_\_\_

How is your sexual energy? Low Normal High

**General Health**

Are you more than 20% over your ideal body weight? Yes No

Are you more than 20% below your ideal body weight? Yes No

Do you have a stressful occupation? Yes No

Do you exercise regularly? Yes No

Do you have excessive facial hair? Yes No

Do you have excessively oily skin? Yes No

Have you experienced excessive loss of head hair? Yes No

Have you been exposed to any known environmental toxins or hormones? Yes No

Was your mother exposed to DES when she was pregnant with you? Yes No

### **Eastern Diagnosis**

Answer YES or NO to each of the following questions. Don't worry about what the symptoms mean; just note whether you experience them. If you have more than one-fourth to one-third YES responses in any diagnostic category, then you may have an element of this imbalance in your system. It is common to have this occur in more than one category. This **DOES NOT** mean that you have problems with the organs themselves.

### **Kidney Yin Deficiency**

Do you have lower back weakness, soreness, or pain, or knee problems? Yes No

Do you have ringing in your ears or dizziness? Yes No

Does your hair prematurely gray? Yes No

Do you have vaginal dryness? Yes No

Is your midcycle fertile cervical mucus scanty or missing? Yes No

Do you have dark circles around or under your eyes? Yes No

Do you have night sweats? Yes No

Are you prone to hot flashes? Yes No

Would you describe yourself as afraid a lot? Yes No

Does your tongue lack coating? Does it appear shiny or peeled? Yes No

### **Kidney Yang Deficiency**

Do you have premenstrual low back pain? Yes No

Is your low back sore or weak? Yes No

Are your feet cold, especially at night? Yes No

Are you typically colder than those around you? Yes No

Is your libido low? Yes No

Are you often fearful? Yes No

Do you wake up at night or early in the morning because you have to urinate? Yes No

Do you urinate frequently, and is the urine diluted and/or profuse? Yes No

Do you have early morning loose, urgent stools? Yes No

Do you have profuse vaginal discharge? Yes No

Does your menstrual blood tend to be dull in color? Yes No

Do you feel cold cramps during your period that respond to a heating pad? Yes No

Is your tongue pale, moist, and swollen? Yes No

### **Spleen Qi Deficiency**

- Are you often fatigued? Yes No
- Do you have poor appetite? Yes No
- Is your energy lower after a meal? Yes No
- Do you feel bloated after eating? Yes No
- Do you crave sweets? Yes No
- Do you have loose stools, abdominal pain, or digestive problems? Yes No
- Are your hands and feet cold? Yes No
- Is your nose cold? Yes No
- Are you prone to feeling heavy or sluggish? Yes No
- Are you prone to feeling heaviness or grogginess in the head? Yes No
- Do you bruise easily? Yes No
- Do you think you have poor circulation? Yes No
- Do you have varicose veins? Yes No
- Are you lacking strength in your arms and legs? Yes No
- Are you lacking in exercise? Yes No
- Are you prone to worry? Yes No
- Have you been diagnosed with low blood pressure? Yes No
- Do you sweat a lot without exerting yourself? Yes No
- Do you feel dizzy or light-headed, or have visual changes when you stand up fast? Yes No
- Is your menstruation thin, watery, profuse or pinkish in color? Yes No
- Are you more tired around ovulation or menstruation? Yes No
- Do you ever spot a few days or more before your period comes? Yes No
- Have you ever been diagnosed with uterine prolapse? Yes No
- Are your menstrual cramps accompanied by a bearing-down sensation in your uterus? Yes No
- Are you often sick, or do you have allergies? Yes No
- Have you been diagnosed with hypothyroid or anemia? Yes No
- Do you have hemorrhoids or polyps? Yes No
- Does your tongue look swollen, with teeth marks on the sides? Yes No
- Do you have a pale, yellowish complexion? Yes No

### **Blood Deficiency (not necessarily equated with anemia)**

- Are your menses scanty and/or late? Yes No
- Do you have dry, flaky skin? Yes No
- Are you prone to getting chapped lips? Yes No
- Are your fingernails or toenails brittle? Yes No
- Are you losing hair on your head (not in patches, but all over)? Yes No
- Is your hair brittle or dry? Yes No
- Do you have diminished nighttime vision? Yes No
- Do you get dizzy or light-headed around your period? Yes No
- Are your lips, the inner side of your lower eyelids, or tongue pale in color? Yes No

## **Blood Stasis**

- Is your menstrual flow ever brown or black in color? Yes No
- Do you feel midcycle pain around your ovaries? Yes No
- Do you have painful, unmovable breast lumps? Yes No
- Do you experience periodic numbness of your hands and feet (especially at night)? Yes No
- Do you have varicose or spider veins? Yes No
- Do you have red hemangiomas (cherry red spots) on your skin? Yes No
- Does your complexion appear dark and "sooty"? Yes No
- Do you have chronic hemorrhoids? Yes No
- Does your menstrual blood contain clots? Yes No
- Have you been diagnosed with endometriosis or uterine fibroids? Yes No
- Is your lower abdomen tender to palpation (resisting touch)? Yes No
- Can you feel any abnormal lumps in your lower abdomen? Yes No
- Do you have piercing or stabbing menstrual cramps? Yes No
- Does your tongue look dark? Yes No
- Do you have dark spots on your tongue? Yes No
- Are the veins beneath your tongue twisty and tortuous? Yes No
- Do you have dark spots in your eyes? Yes No
- Have you been diagnosed with any vascular abnormality or blood clotting disorder? Yes No

## **Liver Qi Stagnation**

- Are you prone to emotional depression? Yes No
- Are you prone to anger and/or rage? Yes No
- Do you become irritable premenstrually? Yes No
- Do you feel bloated or irritable around ovulation? Yes No
- Does it feel as if your ovulation lasts longer than it should? Yes No
- Are your breasts sensitive/sore at ovulation? Yes No
- Do you experience nipple pain or discharge from your nipples? Yes No
- Do you have a lot of premenstrual breast distension or pain? Yes No
- Have you been diagnosed with elevated prolactin levels? Yes No
- Do you become bloated premenstrually? Yes No
- Are your pupils usually dilated and large? Yes No
- Do you have difficulty falling asleep at night? Yes No
- Do you experience heartburn or wake up with a bitter taste in your mouth? Yes No
- Are your menses painful? Yes No
- Do you feel your menstrual cramps in the external genital area? Yes No
- Is your menstrual blood thick and dark, or purplish in color? Yes No
- Is your tongue dark or purplish in color? Yes No

### **Heart Deficiency**

Do you wake up early in the morning and have trouble getting back to sleep? Yes No

Do you have heart palpitations, especially when anxious? Yes No

Do you have nightmares? Yes No

Do you seem low in spirit or lacking in vitality? Yes No

Are you prone to agitation or extreme restlessness? Yes No

Do you fidget? Yes No

Is the tip of your tongue red? Yes No

Is there a crack in the center of your tongue that extends to the tip? Yes No

Do you sweat excessively, especially on your chest? Yes No

### **Excess Heat**

Is your pulse rate rapid? Yes No

Is your mouth and throat usually dry? Yes No

Are you thirsty for cold drinks most of the time? Yes No

Do you often feel warmer than those around you? Yes No

Do you wake up sweating or have hot flashes? Yes No

Do you break out with red acne (especially premenstrually)? Yes No

Do you have a short menstrual cycle? Yes No

Do you have vaginal irritation or rashes? Yes No

### **Dampness**

Do you feel tired and sluggish after a meal? Yes No

Do you have fibrocystic breasts? Yes No

Do you have cystic or pustular acne? Yes No

Do you have urgent, bright, or foul-smelling stools? Yes No

Does your menstrual blood contain stringy tissue or mucus? Yes No

Are you prone to yeast infections and vaginal itching? Yes No

Do your joints ache, especially with movement? Yes No

Are you overweight? Yes No

Do you have a wet, slimy tongue? Yes No

### **Damp Heat**

Do you have signs of heat and/or dampness as indicated above? Yes No

Do you have foul-smelling, yellow, or greenish vaginal discharge? Yes No

Are you prone to vaginal and/or rectal itching during your luteal or premenstrual phase? Yes No

### **Cold Uterus**

Do you fit the Kidney Yang deficiency category (50% or more answered Yes)? Yes No

Do you fall into the Blood stasis pattern (50% or more answered Yes)? Yes No

Does your lower abdomen feel cooler to the touch than the rest of your trunk? Yes No