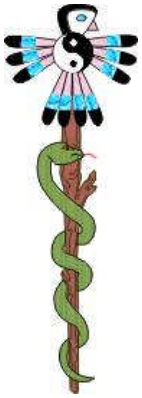


Female Fertility Questionnaire

Orville R Weyrich, Jr PhD NMD

Comprehensive Health Services
3543 N 7th Street, Phoenix, AZ 85014
Office (602) 263-8484 Fax (602) 263-3697
www.DrWeyrich.com, Orville2@DrWeyrich.com

Name _____ Date _____

Age at which menses began _____

Are your periods painful? **Yes** **No**

How many days does the pain last?

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**

Do you have premenstrual tension? **Yes** **No**

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

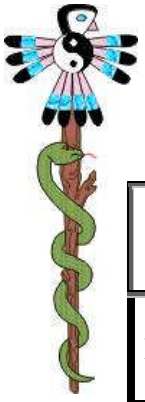
Do your breasts become tender premenstrually? **Yes** **No**

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 _____



Female Fertility Questionnaire

Orville R Weyrich, Jr PhD NMD

	Number	Years
How many pregnancies have you had?		
How many children do you have?		
How many abortions have you had?		
How many miscarriages have you had?		
How many times has a D&C been performed?		

Have you ever had pelvic inflammatory disease? **Yes** **No**

Were you treated for it? **Yes** **No**

How?

Date of last Pap smear _____

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

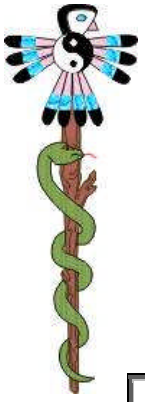
Have you ever been diagnosed with endometriosis? **Yes** **No**

Have you been diagnosed with pelvic adhesions? **Yes** **No**

Have you been diagnosed with any pelvic abnormalities? **Yes** **No**

Have you ever had an abnormal pap smear? **Yes** **No**

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



Female Fertility Questionnaire

Orville R Weyrich, Jr PhD NMD

Have you taken any medications for gynecological conditions other than contraceptives?

Medication	Reason	How long

Have you ever had a venereal disease? **Yes** **No**

Do you get yeast infections regularly? **Yes** **No**

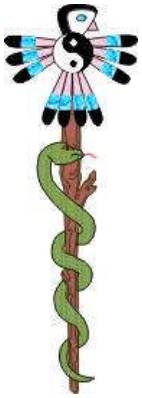
Have you ever been diagnosed with a chlamydial infection? **Yes** **No**

Do you have chronic vaginal discharge? **Yes** **No**

Do you have any sores on your genitalia? **Yes** **No**

Have your cycles changed since they began? **Yes** **No**

How?



Female Fertility Questionnaire

Orville R Weyrich, Jr PhD NMD

Do you ovulate on your own? **Yes** **No**

On what day of your cycle? _____

Do your breasts get tender at/during ovulation? **Yes** **No**

Do you get premenstral low back pain? **Yes** **No**

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

Have you had fertility treatments? **Yes** **No**

If yes, when and where? _____

By whom? _____

What types? _____

Have you taken medication to help you ovulate? **Yes** **No**

When? _____

How long? _____

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? _____

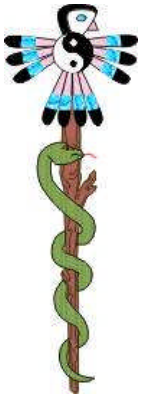
Do you have a single partner with whom you have been trying to conceive? **Yes** **No**

How long have you been married or living together? _____

Has he had a fertility workup? **Yes** **No**

What were the results? _____

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



Female Fertility Questionnaire

Orville R Weyrich, Jr PhD NMD

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? _____

How long have you been trying to conceive?

Have you had a diagnosis relating to infertility? **Yes** **No**

What was it? _____

How is your sexual energy? **Low** **Normal** **High**

Do you douche regularly? **Yes** **No**

With what? _____

Do you use vaginal lubricants? **Yes** **No**

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

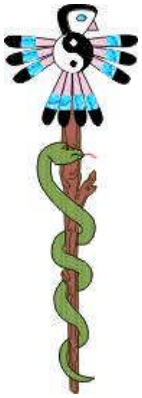
Are you more than 20% below your ideal body weight? **Yes** **No**

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**



Female Fertility Questionnaire

Orville R Weyrich, Jr PhD NMD

Have you experienced excessive loss of head hair? **Yes** **No**

Have you noticed discharge from your nipples? **Yes** **No**

Was your mother exposed to diethylstilbestrol (DES) when she was pregnant with you? **Yes** **No**

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

Are you presently taking steroids? **Yes** **No**

COMMENTS/NOTES