Page 4. Case Study Intake Form

Female Reproductive History

Method of contraception (circle one): pills patch diaphragm injection condoms IUD abstinence rhythm method fertility awareness other: _____

Length of time using method _____ Last Pap smear ____Results _____

Are you now experiencing fertility challenges? Yes ___ No ___ Describe your treatment :_____

(IUI, IVF, etc.) _____

Have you in the past experienced fertility challenges? Yes ____ No ____

Describe your treatment: _____

(IUI, IVF, etc.) _____

Menstrual History

Review and check as indicated:

Age at first menses_____ What was this like for you? _____

Last menstrual period:_____ Length of menses _____

Are you trying to conceive? Yes _____ No _____ Are you pregnant? Yes ____ No ____ Unsure ____

SYMPTOM/CONDITION	PAST	PRESENT	SYMPTOM/CONDITION	PAST	PRESENT
Painful Periods			Irregular cycles (early? late?)		
Heaviness in pelvis prior to menses			Dark, thick blood at Beginning End Both		
Excessive bleeding Pads per hour			Headache or migraine with menses		
Dizziness			Bloating		
Water retention			Ovulation Painful Failure to		
Endometriosis Location (if known)			Fibroids Location (if known)		
Uterine or cervical polyps			Uterine infection(s)		
Vaginal infection(s)			Cysts Location		
Bladder infection(s)			Urinary Incontinence		
Painful intercourse			Vaginal dryness		
Episodes of amenorrhea How long?					

Rate your interest in sex: high _____ moderate _____ low _____ none _____

Do you have or have you ever had difficulty experiencing orgasms?_____

Have you experienced trauma? Yes ___ No ____ Describe _____

Did you undergo counseling for this? _____

What was this like for you? _____