

Female Infertility Questionnaire

Name _____ Age _____
LAST FIRST MI

SS# _____ - _____ - _____ Date of Birth ____/____/____

Name of partner _____ Partner's Date of Birth ____/____/____

Current Obstetrician/Gynecologist _____ Phone _____

Address _____

Current Primary Care Physician _____ Phone _____

Address _____

How did you hear about our program? _____

Pharmacy for prescriptions to be called in _____ phone _____

How long have you been in your current relationship?.... _____

Are you married currently?

How long have you been trying to get pregnant?..... _____ months/years?

How many times a month do you have intercourse?..... _____

Date of last menstrual period..... ____/____/____

Age of first menstrual period..... _____ years old

Number of days between menstrual periods..... _____ days (typically 25-35 days)

How many days do you bleed during your period?..... _____ days (typically 3-6 days)

			comments
Have your periods gotten shorter or longer recently?.....	Yes	No	_____
Do you have any PMS symptoms prior to your menses? (bloating, breast tenderness, mood changes).....	Yes	No	_____
Do you have painful menses (dysmenorrhea)?.....	Yes	No	_____
Is intercourse often painful (dyspareunia)?.....	Yes	No	_____
Have you ever been diagnosed with endometriosis?.....	Yes	No	_____
Have you ever used an intrauterine device (IUD)?.....	Yes	No	_____
Have you ever had a pelvic infection (PID) caused by gonorrhea (GC) or chlamydia?	Yes	No	_____
Did your mother take DES while pregnant with you?	Yes	No	_____
Do you have discharge from your breasts?.....	Yes	No	_____
Do you feel you have excessive hair growth)?.	Yes	No	_____
Have experienced an eating disorder (anorexia / bulimia) ?	Yes	No	_____

Female Infertility Questionnaire

Please list your previous pregnancies:

#	Date	Pregnancy outcome: <i>Normal or Cesarean delivery? Termination or miscarriage? Tubal or ectopic pregnancy?</i>	Infertility treatment if any?	# of months required to conceive?	Conceived with current partner?	Comments or complications?

Previous Testing – list any previous fertility testing

Results (if known).

Urine LH kit (LH surge testing)	Yes	No	_____ what day did you ovulate?
Hysterosalpingogram (HSG)	Yes	No	_____
Semen analysis (current partner)	Yes	No	_____
Blood test	Yes	No	_____
Endometrial Biopsy	Yes	No	_____
Laparoscopy/hysteroscopy	Yes	No	_____

Please list any previous fertility treatments, including date and # of cycles.

Clomiphene citrate (Clomid / Serophene) _____

Gonadotropins (Pergonal / Humegon/ Fertinex /Metrodin) _____

Intrauterine insemination (IUI) _____

In vitro fertilization (IVF) of Gamete intrafallopian transfer (GIFT) _____

Please list previous surgeries (GYN and non-GYN):

Date	Location	Procedure	Findings	Surgeon

Additional Information (if known)

Rubella immunity..... Date tested ___/___/___ immune / non-immune

Pap smear..... Date tested ___/___/___ normal / abnormal Physician: _____

Mammogram..... Date tested ___/___/___

Have you ever had chicken pox (varicella?)_____ What is your blood type?_____



Female Infertility Questionnaire

Medical problems:

Problem	Yes or No?	Currently active?	In the past?	Comments
Have you ever had a problem with headaches or migraines?	Y / N			
Have you ever had a problem with your heart or heart valves (heart murmur)?	Y / N			
Have you ever had any lung problems (such as asthma)?	Y / N			
Have you ever had any stomach or bowel problem (such as ulcer or inflammation of the bowel)?	Y / N			
Have you had any muscle or joint problems?	Y / N			
Have you had any neurologic disorders?	Y / N			
Have you ever been treated for depression or anxiety?	Y / N			
Have you ever had a hormonal problem (such as thyroid disease or diabetes)?	Y / N			
Have you had any immune diseases? (such as Lupus, or immune arthritis)?	Y / N			

Do you have any other medical problems, unrelated to your fertility?

Do you have any allergies to medications? Please list medication and reaction.

Do you take medications regularly? Please list medication and dosage. Include vitamins and herbal supplements.



Female Infertility Questionnaire

Family and Genetic History

What is your ethnic background? (optional) _____

What is your religion? (optional) _____

These questions help us screen for potential genetic problems based on your background.

Is there a family history of having blood clots (strokes, DVT) ? ... Yes No _____

Is there a family history of having or carrying cystic fibrosis ? ... Yes No _____

Is there a family history of Tay-Sachs disease? Yes No _____

Is there a family history of having or carrying Sickle-cell anemia? Yes No _____

Is there a family history of thalassemia or other blood disorder? Yes No _____

Is there a family history of pregnancy loss? Yes No _____

Is there a family history of breast cancer? Yes No _____

Is there a family history of ovarian cancer? Yes No _____

Does anyone in the family have a child with birth defects
or mental retardation? Yes No _____

Are there any other diseases in the family you would like to tell us about ? _____

Social history

Do you smoke cigarettes? Yes No

If yes, cigarettes per day _____ Would you like assistance in quitting smoking? _____

Do you drink alcohol? Yes No

If yes, drinks per day _____ drinks per week _____

Do you use any recreational drugs? Yes No

If yes, would you like assistance in quitting? _____

Do you have any chemical exposures at work you are concerned about? _____

Patient Signature _____ Date _____

Office use only:

Physician Review _____ Date _____

Interim history _____

_____ Date _____

_____ Date _____

_____ Date _____

