Female Infertility Questionnaire

Today's date _____/_____/_____

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	___________________

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Please list your previous pregnancies:

#	Date	**Pregnancy outcome**: *Normal or Cesarean delivery?* *Termination or miscarriage?* *Tubal or ectopic pregnancy?*	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 / Serophone) ____

Gonadatropins (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 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_____________________