Fertility Questionnaire

Today's Date: _____Date of Birth: _____Age: _____

Name:_____

Your OB/GYN or Primary Physician:_____

Date of intended reproductive procedure/or non-assisted pregnancy_____

If applicable type of reproductive procedure:

□ Stimulated cycle without IUI □ Stimulated IUI □ Non-stimulated IUI

□ GIFT □ ZIFT □ IVF-FET □IVF-DET

Do you have a family history of the following conditions? (Please check all that apply.)

- □ Autoimmune diseases
- □ Obesity
- □ DES usage
- □ Thyroid conditions
- □ Alcoholism
- □ Fertility issues
- □ Breast cancers
- □ Ovarian cancers
- □ Other cancers
- □ Diabetes
- □ Osteoporosis

Have you ever had or experienced any of the following conditions, even if it is resolved now? (Please check all that apply.)

- □ Anemia
- □ Fibromyalgia
- □ Anxiety
- □ Depression
- □ Arthritis
- □ Lupus
- □ Visual impairment
- □ Chronic fatigue
- □ Hearing impairment
- □ Digestive problems
- □ Elevated cholesterol
- □ Constipation
- □ Diarrhea
- □ Hemorrhoids
- □ Skin cancer
- □ Other Cancers
- □ Heart disease
- □ Abnormal pap smears
- □ Endometriosis
- □ Adenomyosis
- □ Bladder infection
- □ Sexually transmitted disease
- □ Polycystic Ovarian Syndrome
- □ Ovarian cysts
- □ Uterine fibroids
- □ Vaginal infection
- □ Yeast Infection -Vaginal
- □ Yeast infection - Oral
- □ Interstitial cystitis
- □ Pelvic inflammatory disease
- □ Urinary incontinence
- □ Kidney infection
- □ Painful intercourse
- □ Diabetes Type 1 or 2

Fertility Questionnaire

Have you ever had or experienced any of the following conditions, even if it is resolved now? (Please check all that apply.)

- □ High blood pressure
- □ Thyroid disease
- □ Tuberculosis
- □ HIV/AIDS
- □ Hepatitis diseases
- □ Liver disease
- □ Gall stones
- □ Headaches
- □ Migraines
- □ Kidney stones
- □ Abdominal or Pelvic pain
- □ Uterine polyps
- □ Autoimmune diseases
- □ Neurological disease
- □ Osteoporosis
- □ Genital Herpes
- □ Oral Herpes
- □ Allergies/ sinusitis/skin conditions

	Never	Occasionally	Moderately	Frequently
Have you ever smoked?	□	□	□	□
Have you ever used alcohol?	□	□	□	□
Have you ever used caffeine?	□	□	□	□
Have you ever used marijuana?	□	□	□	□
Have you ever used recreational drugs?	□	□	□	□
Do you exercise regularly?	□	□	□	□

Do you have the following pets at home? □ Cat □ Dog □ Rabbit □ Others _____

What age did you begin to menstruate? □ <11 □ 11 □ 12-14 □ 15 □ >15

Is your menstrual cycle regular? □ Yes □ No

What is the duration of your menstrual flow? □ <3 days □ 3-6 days □ >6 days

How is your overall menstrual flow rate? □ Light □ Moderate □ Heavy

How is your clotting during menstruation? □ None □ Few/ Moderate □ Heavy

How would you rate the size of your clots? □ Small □ Medium □ Large

How are your menstrual cramps? □ None □ Medium/ Moderate □ Severe

How long do your cramps last? □ Hours (# of Hours ___) □ Days (# of Days ___)

Fertility Questionnaire

Where are your menstrual cramps? (Check all that apply)

□ None □ Pelvic □ Rectovaginal area □ Lower back □ Referring down the thighs/legs

Do you have irregular bleeding outside of your menstruation? □ Yes □ No

What are the symptoms you experience during ovulation? (Check all that apply.)

□ None □ Vaginal discharge □ Increased libido □ Pelvic twinge □ Pelvic pain

Do you experience the following symptoms pre-menstrual? (Please check all that apply.)

□ Anxiety □ Mood fluctuations □ Nervousness □ Fluid retention □ Food cravings

□ Difficulty sleeping □ Headache □ Breast tenderness □ Constipation or bowel irregularity

How many total pregnancies? □ None □ 1 □ 2 □ 3 □ 4 or more

How many pregnancies carried to term? □ None □ 1 □ 2 □ 3 □ 4 or more

How many preterm pregnancies? □ None □ 1 □ 2 □ 3 □ 4 or more

How many abortions? □ None □ 1 □ 2 □ 3 □ 4 or more

How many miscarriages? □ None □ 1 □ 2 □ 3 □ 4 or more

How many living children? □ None □ 1 □ 2 □ 3 □ 4 or more

How old are they? ____ ____ ____ ____

Do you have a history of sexual abuse or assault? □ Yes □ No

Are you satisfied with your sexual activities? □ Yes □ No

Do you have difficulties reaching orgasm? □ Yes □ No

Are you well lubricated during sexual intercourse? □ Yes □ No

Do you experience pain during sexual penetration? □ Yes □ No

What kind of contraception method have you used? (Check all that apply.)

□ Oral contraceptives □ IUD □ Condom □ Sponges □ Diaphragm

□ Withdrawal □ Rhythm □ Spermicidal gel □ NuvaRing

Fertility Questionnaire

Have you encountered any difficulties with your birth-control methods? □ Yes □ No

Have you had the following procedures/tests?

□ 2nd- or 3rd-day serum FSH/E2/Prolactin test □ Pregnancy termination

□ Pelvic/Abdominal ultrasound □ Hysterosalpingography □ Mammography

□ Hysteroscopy □ Laparoscopy □ Cervical conization □ Dilation and curettage (D&C)

Have you had the following reproductive procedures? (Please check that all apply.)

□ Stimulated cycle without IUI □ Stimulated IUI □ Non-stimulated IUI

□ GIFT □ ZIFT □ IVF-FET □IVF-DET

Please list all gynecological surgeries or procedures performed since birth:

Surgery	**Age**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Fertility Questionnaire

Please list all other surgeries or procedures performed since birth:

Surgery	**Age**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Has your partner had semen analysis? □ Yes □ No

What were the results?

□ Not applicable □ Normal □ Abnormal Morphology □ Motility Issues □ Low Count

Please provide any additional information that you deem pertinent to your treatment:

_____

_____

_____