Female Infertility Patient Questionnaire

I. Identifying Information

Date _____

Name_____ Partner's Name_____

Address_____

Telephone Number-Day (___)_____ Evening (___)_____ Cell (___)_____

Date of Birth_____ Partner's Date of Birth_____ Age _____ Partner's Age _____

Duration of Relationship _____yr. ____mo. Duration of Infertility ____yr. ____mo.

Occupation _____ Partner's Occupation _____

Who referred you? ☐ Physician _____ ☐ Former Patient/Friend _____
☐ Web Site _____ ☐ Insurance (name of insurance) _____

Who is your Ob/Gyn? _____ Who is your Primary Care Physician? _____

What are your expectations for this visit? _____

What questions do you want answered this visit?_____
_____

How many pregnancies (including abortions) have you had? _____

II. Medical History

Weight _____ Height _____ Blood Type (if known) _____

Have you lost greater than 20 lbs in the last year? **Yes** **No**

Do you follow any particular diet or have any special dietary habit? **Yes** **No**
If yes, specify_____

List the forms and frequency of regular vigorous exercise you do and how long you have been doing it

Exercise	Hrs / Wk	Since When?

Do you have or have you ever had: (circle all that apply)

Anemia	Gonorrhea	Pneumonia	Appendicitis
Heart Disease	Poor sense of Smell	Arthritis	Hepatitis
Rheumatic Fever	Blood Transfusion	Herpes	Breast Milky Discharge
Hypertension	Seizures	Breast Soreness/Tenderness	Excess Hair Growth
Syphilis	Kidney Infection	Thyroid Problems	Chlamydia
Liver Problems	Tuberculosis	Chronic Bronchitis	Loss of balance
Ulcers	Chronic Headaches	German Measles	Pelvic Infection (PID)
Colitis	Measles: Regular	Gallbladder Problems	Mycoplasma
Diabetes	Neurological Problem	Venereal Disease	Dizziness
Visual Disturbances	Endometriosis	Ovarian Cyst	Epilepsy
Nongonococcal Urethritis		Immunization to German Measles	
Sexually Transmitted Disease		Vaginitis (Trichomoniasis, yeast) # of episodes _____	

Allergies: List_____

Yes **No**

Have you ever been treated for cancer?
If yes, explain therapy: _____

Have you ever received X-rays to the pelvic area for therapy or diagnosis? **Yes** **No**
If yes, specify: _____

Within the last year, have you taken any prescription medications? **Yes** **No**
If yes, list all prescriptions and problems for which you were taking them: _____
_____ _____

Are you taking any over-the-counter medications on a regular basis? **Yes** **No**
If yes, list all medications and why you are taking them: _____
_____

Are you taking any herbal medicine? **Yes** **No**
If yes, list all herbs your taking and the reason for their use: _____
_____

When was your last GYN exam/Pap smear? Mo. ____Yr.____ Normal Abnormal Never had one

When was your last mammogram? Mo. ____Yr.____ Normal Abnormal Never had one

Do you use or have you ever used (circle all that apply):

Coffee - How many cups per day? ____ **Cigarettes** - Number of packs per day? _____

Alcohol - How many glasses per week do you usually drink? Wine_____ Beer_____ Cocktails_____

Recreational drugs (Marijuana, Cocaine, etc.) If you would feel more comfortable not writing anything down, please discuss this directly with your physician.

Specify:_____

III. Menstrual and Pregnancy History

Age at first period? ___ When was the first day of your last period? ____ Was it normal?

Do you test for ovulation? **Yes** **No**

If yes, do you use: Urine test kit Basal body temperature Check mucus Other

Are your periods regular? **Yes** **No**
If yes, how many days from the first day of one period to the first day of the next period? _____
If no, how many times per year do you menstruate? _____

Menstrual flow is: Light Moderate Heavy Very Heavy
Duration of Flow is: _____days Do you use? Tampons? # per day _____ Pads? # per day _____

Do you experience premenstrual symptoms (e.g. fluid retention, breast tenderness)? **Yes** **No**
If yes: with every cycle with most cycles with occasional cycles
List premenstrual symptoms:_____

Do you experience cramps before, during, or after your period? **Yes** **No**
If yes: cramps are Mild Moderate Severe Incapacitating

Do you take medication for menstrual cramps? **Yes** **No**
If yes, specify medication and dosage _____

Do you bleed or spot between periods? **Yes** **No**

Pregnancy History

	When? (Year)	End in Abortion?	End in Miscarriage?	Ectopic Pregnancy?	Infertility Therapy Required to Conceive?	How Long to Conceive?	Baby Born Alive?	Is Current Partner the Father?
lst Pregnancy								
2nd Pregnancy								
3rd Pregnancy								
4th Pregnancy								
5th Pregnancy								

Were there any complications during or after your pregnancies? **Yes** **No**

If yes, explain _____

IV. Contraceptive / Sexual History

What form of contraception do you use now or have you used in the past? Circle all that apply:

Pills Name:_____ IUD Name:_____ Diaphragm Rhythm

Withdrawal Foams/Jellies Condom

Tubal ligation Vasectomy None Other: _____

For each contraceptive method used, specify length of use and reason for discontinuation:

Method Length of use Reason for discontinuation

_____ _____

_____ _____

What was the last method you used and when did you discontinue use? _____

If you've ever been on oral contraceptives(pills), were your periods regular after stopping the pills **Yes** **No**

How many times per week do you and your partner have sexual intercourse? _____

Do you time intercourse around ovulation? **Yes** **No**
If yes, how? _____

Is intercourse painful or difficult for you? **Yes** **No**

Do you have bleeding during or after intercourse? **Yes** **No**

Do you use lubricants for intercourse? **Yes** **No**
If yes, which one? _____

Do you douche before or after intercourse? **Yes** **No**

V. Family History

Did your mother have any difficulty with conception or pregnancy? **Yes** **No**
If yes, explain _____

Did your mother take diethylstilbestrol (DES) when she was pregnant with you? **Yes** **No**

Is there a family history of infertility? **Yes** **No**
If yes, who (list all members and relationship to you):_____

Is there a history of hormonal disorders in your family (e.g., diabetes, thyroid): **Yes** **No**
If yes, who and what type_____
_____

Is there a family history of: (specify relationship)

Bleeding tendencies _____	Strokes _____
Cancer _____	Thyroid Disorders _____
Diabetes _____	Tuberculosis _____
Heart Disease _____	Other (Specify) _____
High Blood Pressure _____	

Your ancestry? African-American American Indian Ashkenazi Jewish Asian Caucasian
Eastern European Hispanic Northern European Southern European Other _____

Partner's ancestry? African-American American Indian Ashkenazi Jewish Asian Caucasian
Eastern European Hispanic Northern European Southern European Other _____

Circle if you'd like to be screened for: Cystic fibrosis Sickle cell anemia
Tay Sachs Disease Thalassemia Other _____

VI. Fertility Treatment History

Have you been treated for infertility before? **Yes** **No**
If yes, who was your physician? _____ Diagnosed cause? _____

What drugs have you taken for infertility? Circle all that apply: Letrozole (Femara) / clomiphene citrate (Clomid) hCG (Profasi, Pregnyl, Novarel), HMG (Repronex, Pergonal, Menopur), bromocriptine (Parlodel), progesterone, estrogen, danazol Danocrine), Prednisone, FSH (Gonal F, Follistim), GnRH agonists (Lupron, Synarel), Other-specify _____

Which of the following tests have you had performed? Check all that apply and the results if known:

Basal Body Temperature (BBT) charts	When?_____	Results:_____
Hormonal Tests (FSH, LH, prolactin, estrogen, DHEA-S, testosterone, progesterone)	When?_____	Results:_____
Endometrial Biopsy	When?_____	Results:_____
Hysterosalpingogram (X-ray of uterus/tubes)	When?_____	Results:_____
Ultrasound/Sonogram	When?_____	Results:_____
Laparoscopy	When?_____	Results:_____
Hysteroscopy	When?_____	Results:_____
Chlamydia Cultures	When?_____	Results:_____
Thyroid Tests	When?_____	Results:_____
Other-Specify_____	When?_____	Results:_____

Have you ever had surgery for reversal of tubal ligation? **Yes** **No**
If yes, specify dates:_____

Have you ever had surgery for pelvic adhesions or other pelvic surgery? **Yes** **No**
If yes, specify dates:_____

Have you ever had treatment of cervix for abnormal Pap Smear? **Yes** **No**
If yes, specify dates:_____

Have you ever had any other surgery (D&C, ovarian, appendectomy, thyroid)? **Yes** **No**
If yes, specify:_____

If you've had anesthesia, have you had problems with anesthesia? **Yes** **No**

If yes, specify: _____

Has your partner had a semen analysis? **Yes** **No**

Is your partner seeing a doctor for evaluation of infertility? **Yes** **No**
If yes, specify physician name and location:_____

Does his doctor feel that your partner has an infertility problem? **Yes** **No**
If yes, what is the diagnosis and how is he being treated?_____

Has he ever fathered a child previously, either with you or with other women? **Yes** **No**
If yes, when?_____

Prior Treatment (choose all that apply)

Intrauterine insemination	# Cycles _____	Dates __/__ to __/__	Outcome Pregnant Delivered Ectopic Miscarriage Not pregnant
Clomid/Letrozole alone maximum tablets/day? ____	_____	__/__ to __/__	Pregnant Delivered Ectopic Miscarriage Not pregnant
Clomid/Letrozole with intrauterine insemination	_____	__/__ to __/__	Pregnant Delivered Ectopic Miscarriage Not pregnant
Daily injections/ intrauterine insemination maximum # vials/day? ____	_____	__/__ to __/__	Pregnant Delivered Ectopic Miscarriage Not pregnant
Completed IVF cycles 1. # eggs____ # transferred ___ # frozen___ 2. # eggs____ # transferred ___ # frozen___	_____	__/__ to __/__	Pregnant Delivered Ectopic Miscarriage Not pregnant Pregnant Delivered Ectopic Miscarriage Not pregnant
Frozen embryo cycles 1. # transferred ___ 2. # transferred ___	_____	__/__ to __/__	Pregnant Delivered Ectopic Miscarriage Not pregnant Pregnant Delivered Ectopic Miscarriage Not pregnant
Canceled IVF attempts	_____	__/__ to __/__	
Any other treatment? (Describe)			

Emotional Status

On a scale of 1-10 (10 being worst), estimate the level of stress you feel due to infertility and other pressures. _____

Do you see a counselor? No Yes - For how long? _____ How often? _____

List any antidepressant / antianxiety medications you are currently taking _____

Describe any emotional, marital, or sexual problems caused by your infertility. _____

_____

Patient's Signature: _____ Date _____

Reviewed by: _____ Date _____

Email Address: _____

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