

## CONFIDENTIAL FERTILITY QUESTIONNAIRE

Please answer the following questions. This information is completely confidential.

There are some very personal questions and we appreciate your honesty. All the information is collected to provide you the best and most comprehensive care.

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Has your physician given you a reason for your infertility?

If so, please explain: \_\_\_\_\_

Have you ever been pregnant before?  Yes  No How many times? \_\_\_\_\_

Have you ever had any of the following?

Abortion  Ectopic Pregnancy  Miscarriage  Chemical Pregnancy  Failed IUIs/IVFs

Do you have any children?  Yes  No How many? \_\_\_\_\_ Age(s) \_\_\_\_\_

Did you have:  Vaginal Birth/s  C-Section

### FERTILITY HISTORY

1. At what age did you start menstruation? \_\_\_\_\_
2. How long did you try to get pregnant naturally? \_\_\_\_\_
3. Check all the following **surgeries/procedures** that you have undergone:  
 Hysterosalpingogram (HSG)  Dilation & Curettage (D&C)  Hysteroscopy  Myomectomy  
 Neosalpingostomy  Tuboplasty  Falloposcopy  Laparoscopy For what? \_\_\_\_\_
4. Have you had any of the following conditions?  
 Fibroids  Ovarian  Cysts  Blocked Tubes  Endometriosis  Fibromyalgia  
 Lupus  Chronic Fatigue Syndrome  Lacking Anti-Coagulant in Blood
5. Has your husband been examined by a physician?  Yes  No
6. Were any of the following problems found:  
 Low sperm count  Poor morphology  Sperm unable to penetrate egg  Varicocele
7. Are you going to be having any medical procedures performed?  
 IVF  Frozen Embryo Transfer  IUI If so, approximately when? \_\_\_\_\_
8. Are you currently on any fertility medications?  Yes  No Please list: \_\_\_\_\_
9. Have you ever tested positive for hypothyroidism or hyperthyroidism?  Yes  No
10. How many days is your cycle? (i.e., 28 days) \_\_\_\_\_ (give a range if it is erratic)
11. How long is your menses? (i.e., 5 days) \_\_\_\_\_
12. Please check the daily description of your menstrual flow:

	Light	Medium	Heavy	Color of Blood
Day 1				
Day 2				
Day 3				
Day 4				
Day 5				
More than 5 Days				

13. What color is the blood of your menstrual flow? Insert one of the five descriptions above.

1)Light, watery red 2)Bright Red 3)Dark Red 4)Brown 5)Clots

14. Do you have pain during intercourse?  Yes  No

15. Do you get PMS? Yes No  
Breast tenderness Cramps Diarrhea Acne  
Bloating Back/groin pain Food cravings Dizziness  
Constipation Fatigue Headache or Migraine Mood Swings  
Other? \_\_\_\_\_
16. Do you have spotting before or between your periods? Yes No
17. Have you ever been tested for chlamydia? Yes No Results: \_\_\_\_\_
18. Do you have a history of breast cancer? Yes No If so, please list who had breast cancer in your family \_\_\_\_\_
19. On what cycle day do you typically ovulate? \_\_\_\_\_
20. During ovulation, is your cervical mucus clear, stretchy and abundant? Yes No
21. How is your stress level?                      Low Stress    Medium Stress    High Stress
22. Do you exercise? Yes No If so, please list the type/s of exercise and how often \_\_\_\_\_
- 
23. What do you do for relaxation? \_\_\_\_\_
24. Have you had any counseling since trying to become pregnant? Yes No
25. Have you ever been molested or raped? Yes No
26. Check if you have been **diagnosed** with any of the following:
- |   |   |
|---|---|
| <input type="checkbox"/> Advanced Maternal Age                    | <input type="checkbox"/> Menorrhagia                            |
| <input type="checkbox"/> Amenorrhea                               | <input type="checkbox"/> Premature Menopause                    |
| <input type="checkbox"/> Ovarian Cyst (single)                    | <input type="checkbox"/> Premature Ovarian Failure (POF)        |
| <input type="checkbox"/> Ovarian Hyperstimulation Syndrome (OHSS) | <input type="checkbox"/> Endometriosis (mild, moderate, severe) |
| <input type="checkbox"/> Anovulation                              | <input type="checkbox"/> Resistant Ovarian Syndrome             |
| <input type="checkbox"/> Pelvic Inflammatory Disease (PID)        | <input type="checkbox"/> Unexplained Infertility                |
| <input type="checkbox"/> Anti-sperm Antibodies                    | <input type="checkbox"/> Fallopian Tube Blockage                |
| <input type="checkbox"/> Autoimmune Oopharitis                    | <input type="checkbox"/> Uterine Fibroids                       |
| <input type="checkbox"/> Phospholipid Antibodies                  | <input type="checkbox"/> Habitual Miscarriage                   |
| <input type="checkbox"/> Polycystic Ovarian Syndrome (PCOS)       | <input type="checkbox"/> Hostile Cervical Mucus                 |
| <input type="checkbox"/> Cervical Stenosis                        | <input type="checkbox"/> Hyperprolactinemia                     |
| <input type="checkbox"/> Elevated FSH                             | <input type="checkbox"/> Uterine Septum                         |
| <input type="checkbox"/> Luteal Phase Defect                      | <input type="checkbox"/> Other(s): _____                        |

Thank you for your help in answering these questions. We look forward to working with you.