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Fertility Questionnaire for Women

General Information:

1. Name______________________________ Age _______ SS# ______________
2. Husband's Name ______________________________ Age _______ SS# ______________
3. Your Occupation ______________________________
4. Name of Gynecologist ______________________________
5. Who referred you to us? ______________________________

Previous Infertility Work-up (please fill in even if you bring your records):

Hormonal Testing	**Date**	**Physician**	**Results**
Progesterone Level	______	________	________
Other Hormonal Testing	______	________	________

Procedures	**Date**	**Physician**	**Results**
Temperature Chart	______	________	________
Semen Analysis #1	______	________	________
#2	______	________	________
PCT (mucus test) #1	______	________	________
#2	______	________	________
Endometrial Biopsy	______	________	________
HSG (dye study) #1	______	________	________
#2	______	________	________
Laparoscopy #1	______	________	________
#2	______	________	________
Ultrasound	______	________	________

Treatment	**Date**	**# of Cycles**	**Results**
Clomiphene (Clomid)	______	________	________
Femara (Letrozole)	______	________	________
Glucophage	______	________	________
Insulin Lowering Meds	______	________	________
Menopur/Follistim/Gonal F	______	________	________
Other Injectable Meds	______	________	________
Intrauterine Insemination	______	________	________
In Vitro Fertilization (IVF)	______	________	________

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Gynecologic History:

1. Do you have or have you ever had (Check all that apply):

    ______ Herpes

    ______ Gonorrhea

    ______ Chlamydia

    ______ Trichomoniasis

    ______ Genital Warts

    ______ Nongonococcal Urethritis (NGU)

    ______ Any sexually transmitted (venereal) disease

    ______ Any infection in your cervix, uterus, tubes, ovaries, or pelvis

    ______ Appendicitis

	Yes	No
2. Are your periods irregular?	_____	_____
3. About how many days elapse from the start of one period to the start of the next?	_____	_____
4. Do you sometimes bleed between your periods?	_____	_____
5. Have you ever had an abnormal Pap smear?	_____	_____
6. Did your mother take DES or any other hormones while she was pregnant with you?	_____	_____
7. Do you have any discharge from your breasts?	_____	_____
8. Do you feel that you have excessive facial hair growth?	_____	_____
9. Do you feel that you have problems with acne?	_____	_____
10. Have you ever been diagnosed as having endometriosis?	_____	_____
11. Do any of your first-degree relatives have endometriosis?	_____	_____
12. Have you ever had ovarian cysts?	_____	_____
13. Have you ever had surgery involving your vagina, cervix, uterus, tubes, ovaries, pelvis, or appendix?	_____	_____
14. If you have ever been pregnant, were there any complications during the pregnancy?	_____	_____

Sexual History

	Yes	No
1. Do you feel that you or your husband have a significant problem in achieving orgasm?	_____	_____
2. Does your husband have frequent problems with impotence (inability to maintain an erection or to ejaculate)?	_____	_____
3. Do you frequently have pain or discomfort during intercourse?	_____	_____
4. Do you douche before or after intercourse?	_____	_____
5. Do you use lubricants during intercourse?	_____	_____
6. Do you feel that you and/or your husband might benefit from some form of sexual counseling?	_____	_____
7. Do you feel that infertility is putting a strain on your marital relationship?	_____	_____
8. Have you ever been a victim of rape, sexual abuse, or sexual mistreatment?	_____	_____

(Brief Description)____

____

9. If you answered "yes" to any of the above, which would you like Dr. Keenan to discuss with you at your visit? ____

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Medical History:
Do you have or have you ever had (check all that apply):

1. ______ Heart Murmur
2. ______ Mitral Valve Prolapse
3. ______ Heart Disease
4. ______ Scarlet Fever
5. ______ Rheumatic Fever
6. ______ Chronic Bronchitis
7. ______ Pneumonia
8. ______ Tuberculosis
9. ______ Lung Disease
10. ______ Hepatitis
11. ______ Jaundice
12. ______ Liver Disease
13. ______ Measles: Regular
14. ______ Measles: German
15. ______ Immunization: German Measles
16. ______ Multiple Kidney Infections
17. ______ High Blood Pressure
18. ______ Gallbladder Problems
19. ______ Ulcer
20. ______ Colitis
21. ______ Diabetes
22. ______ Appendicitis
23. ______ Anemia
24. ______ Blood Disorders
25. ______ Bleeding Tendency
26. ______ Excessive bleeding after tonsillectomy or wisdom teeth removal
27. ______ Arthritis
28. ______ Thyroid Problems
29. ______ Cancer (specify) ________________________________
    ____
30. ______ Head Injury
31. ______ Neurological Problems
32. ______ Psychological Counseling
33. ______ Seizures
34. ______ Poor sense of smell
35. ______ Allergies to medications (specify) ________________
    ____
36. ______ Non-GYN Surgery (specify) ______________________
    ____
37. ______ Been hospitalized (specify) ______________________
    ____

List all medications or vitamins and doses that you are taking on a regular or frequent basis:

____

Habits:	**Yes**	**No**
1. Do you smoke cigarettes?	_____	_____
2. Do you drink more than one caffeinated beverage per day (e.g., coffee, tea, Coke, Pepsi, etc.)?	_____	_____
3. Do you drink wine or other alcoholic beverages on a daily or almost daily basis?	_____	_____
4. In the past five years, have you used any nonprescription drugs (e.g., marijuana, cocaine, etc.)?	_____	_____
5. Do you take herbal products or high doses of any vitamins?	_____	_____

Family/Genetic History:	**Yes**	**No**
1. Has anyone in your family been born with a birth defect(s)?	_____	_____
2. Is anyone in your family mentally impaired or delayed?	_____	_____
3. Are there any inherited diseases in your family?	_____	_____
4. Has a member of your family had any of the following: albinism, hemophilia, Huntington's disease, cystic fibrosis, muscular dystrophy, or hereditary anemia?	_____	_____
5. Has a member of your immediate family had epilepsy or psychiatric disorders requiring treatment?	_____	_____
6. The risk of having a child with cystic fibrosis is at least 1 in 3300. Would you like genetic testing to determine your risk status?	_____	_____
7. Has any one in your family had breast cancer before age 50?	_____	_____
8. Is there a history of two or more Lynch syndrome cancers in the same person or on the same side of the family (colon, uterine, ovarian, stomach, kidney/urinary tract, gallbladder, intestine, pancreas, brain, or sebaceous adenoma)?	_____	_____