

Obstetrical & Gynecological Care

Fertility Questionnaire for Women

Patient's Name _____ Date _____
Age at first menses _____ Date of last menses (first day) _____
Usual menstrual interval _____ Usual duration of bleeding _____
Cramps (please Circle) Yes No Minimal Moderate Severe
Do cramps start before or after bleeding? _____
Are cramps always present? Yes No

Background Information

Please underline or circle all responses that apply and fill in blanks.

Chronic headaches, history of head trauma, seizures, disorder, problems with sense of smell; visual disturbances, dizziness, loss of balance.

Rapid or marked changes in weight, increased thirst, changes in appetite, increased sweating, chronically warm or cold, history of painful swallowing, change of voice or hoarseness, insomnia, fatigue, tremors, craving for salt, loss of scalp hair, growth of hair on face or body in new places or in excess, change in size of clitoris, diagnosis of thyroid disease, diabetes, history of breast secretions or milky discharge from nipples.

History of acquired or congenital heart disease, scarlet fever, rheumatic fever, diagnosis or treatment of high blood pressure.

History of pulmonary (lung) disease such as tuberculosis, pneumonia, chronic bronchitis, emphysema, lung cysts or tumors.

History of gall bladder problems, hiatal hernia, ulcer, appendicitis, colitis, regional enteritis, pancreatitis, jaundice, hepatitis, liver problems.

History of anemia, need for transfusion, arthritis, kidney infections, nephritis, Bright's disease, urinary tract abnormalities, frequent urination, auto-immune disease.

History of any other serious or chronic illness (describe) _____

Duration of marriage? _____ Duration of infertility? _____

Either partner previously married? Yes No

Children from prior marriage? Yes No

How long to conceive? _____ (male) _____ (female)

Outcome of pregnancies;

Delivery, Miscarriage, Abortion

Year _____

Complication: Yes No

Fever: Yes No

Delivery, Miscarriage, Abortion

Year _____

Complication: Yes No

Fever: Yes No

Previous methods of contraception: Pill Condoms Foam Diaphragm
IUD Withdrawal Rhythm None

If pills, were menses regular before? Yes No

If pills, were menses regular after? Yes No

How long to resume menses when pills stopped? _____ weeks

If IUD, was device removed to conceive? for Complications? (describe) _____
Other? (describe) _____

Usual frequency of sexual intercourse per week _____

Lubricants used: Yes No Specify: _____

Does husband ejaculate during intercourse? Yes No

Does ejaculation occur outside vagina? Yes No

Does his semen leak out when you stand? Yes No

Do you douche before or after? Yes No

Is intercourse (coitus) painful to either partner? Yes No

Do you achieve orgasms? Never Rarely Usually Always

Has artificial insemination ever been suggested? Yes No Husband or Donor

History of Syphilis Gonorrhea Pelvic Infection

Do you work? Yes No

Type of work _____

Exposure to chemicals or x-ray treatment in work or in hobbies? Yes No

Smoking Habits Yes No Packs/day _____

Alcohol: Yes No Drinks/day _____

History of marijuana, opium or other addictive drugs: Yes No

Medications used now or recently _____

History of Therapeutic x-ray treatment (not for diagnosis) or anti-cancer drugs or drugs for arthritis: Yes No

Family History: Father Alive Dead Age _____

Cause _____

Mother Alive Dead Age _____

Cause _____

Sister(s) Age(s) _____

Brother(s) Age(s) _____

History of family infertility caused by endocrine (hormonal) disorder? Yes No

Previous hospital admission (any reason) Medical/Surgical

Where	When	Reason
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Previous Infertility Studies

History of psychiatric treatment:				Yes	No
Name of Doctor	_____				
Drug treatment:	Yes	No	Hospital Admission	Yes	No
Temperature charts:	Yes	No	Normal	Yes	No
Husband had semen Analysis	Yes	No	Normal	Yes	No
Post-coital test for sperm survival in cervix::	Yes	No	Normal	Yes	No
X-ray of tubes and uterus:	Yes	No	Normal	Yes	No
D&C to examine uterine lining:	Yes	No	Normal	Yes	No
Laparoscopy (telescope in abdomen):	Yes	No	Normal	Yes	No
Hysteroscopy (telescope in uterus):	Yes	No	Normal	Yes	No
Immunologic testing for sperm allergy:	Yes	No	Normal	Yes	No
Hormonal tests:	Yes	No	Results, if known	_____	
Chromosomal (genetic) studies	Tay-Sachs screening				
Sickle Cell screening	Thyroid Studies				
Skin test for Tuberculosis	Year	_____	Skull X-ray	Year	_____
Diabetic test	Others _____				

Previous Infertility Treatment

Any procedure on cervix such as biopsy, cauterization, cryosurgery, (freezing): _____

Any procedure on uterus, vagina, tubes, ovaries, or operations for inflammatory or infections pelvic diseases, operations for adhesions or endometriosis: Yes No

Stimulation of ovulation with oral or injectable agents such as estrogens, Clomid, HCG, Personal, others: Yes No

Treatment of endometriosis with drugs: Yes No

Treatment of tubes with medication via uterus: Yes No

Artificial insemination: Husband Donor Yes No

User of fertility-promising douches: Yes No