



Name: _____

date: _____

FERTILITY SCREENING QUESTIONNAIRE

I. Medical History

Ideally a complete medical workup will begin with a screening for the following conditions. Please check all that you have been screened for, and please circle any of the following for which you have a known history. On back, please give dates and treatment.

auto immune disorders, such as thyroid, diabetes, lupus, rheumatoid arthritis

cancer

chronic illness, such as asthma, ulcers, IBS

chlamydia

endometriosis

exposure to environmental toxins?

genetic disorders

German measles (rubella)

gonorrhea

hepatitis A, B, or C

herpes

HIV

hormonal therapy of any type

human papillomavirus (genital warts)

irregular periods

mycoplasma (asymptomatic bacterial infection, will show up on pap smear)

painful periods

pelvic inflammatory disease

pelvic pain

Pelvic surgeries

polycystic ovaries

Rh incompatibility

syphilis

vaginal yeast infections

vaginitis

urinary tract infections

uterine fibroid tumors

Are you a DES baby? (born 1941 - 1971) yes? no?

II. Fertility History

Have there been any previous pregnancies, miscarriages, or abortions? yes? no?

date _____ miscarriage, abortion, ectopic, full term

date _____ miscarriage, abortion, ectopic, full term

date _____ miscarriage, abortion, ectopic, full term

any complications? yes / no

if yes, please describe:

Family history of only children, late pregnancies, difficult pregnancies? yes? no?

If yes, please elaborate:

General contraceptive history:

Please circle all types that you have used: birth control pills, IUD, diaphragm, condoms

date _____ type _____

date _____ type _____

date _____ type _____

date _____ type _____

date _____ type _____

Did you experience any difficulty with any of the above methods? yes / no

if yes, please describe:

Diagnostics:

Please circle the following that you have had, and please provide me with test results wherever possible, or the name and telephone number of the ordering physician.

1. semen analysis, possibly with 2 - 3 samples over a course of a few months, as any of the following may interfere with test results: antibiotics, lubricants, fevers, infections, viruses
2. BBT charts, or results from ovulation test kits, preferably for 4 - 6 cycles
3. Testing for hormonal imbalances, may be blood or salivary assay
4. HSG (hysterosalpingogram)
5. Post-coital test
6. Ultrasound, either pelvic or trans vaginal
7. Laparoscopy
8. any other(s)? _____

III. Gynecological Herstory:

General:

When was your last pelvic exam? _____ was it normal? yes / no
When was your last pap smear? _____ was it normal? yes / no
Who is your gynecologist? _____
phone # and address: _____

Please list any hormonal therapy that you are currently taking or have taken:

Please include birth control pills, HRT, insulin, thyroid medication, DHEA, etc.

year	hormonal therapy
_____	_____
_____	_____
_____	_____
_____	_____

Menses:

age at menarche: _____ cycles: regular? irregular? average length of cycle: _____ days
average # days bleeding: _____ days

amount of blood: light? moderate? heavy?
color of blood: pale? bright red? dark red? purple? brown?
clots: yes / no if yes: few / many? small / large? associated with cramps? yes / no?
cramping: yes / no? if yes, when: before? during? after?
is pain: mild? moderate? severe?
any pain medications: yes / no? type and dose: _____

PMS

Please circle any symptoms you experience during your cycle, and indicate approximately when in your cycle they occur:

breast distention, tenderness	irritability	mood swings
depression	abdominal bloating	water retention
headaches	changes in bowels	fatigue

Sexual history:

age you became sexually active: _____
are your partner(s): same sex? opposite sex? both?
are you currently in a monogamous relationship? yes / no?
do you have any pain with sex? yes / no?
do you have any other problems with sex? yes / no?

Family History:

Please circle any conditions that exist in your family, and indicate family member:

	mother / aunt(s) / sister(s) / maternal grandmother / paternal grandmother
fibroids	_____
endometriosis	_____
breast cancer	_____
ovarian cancer	_____
uterine cancer	_____
cervical cancer	_____
heart disease	_____
osteoporosis	_____
age at menopause	_____