# Female Infertility Questionnaire

Date_____

Name_____ Date of Birth_____

Partner's Name_____ Date of Birth_____

## Gynecological & Obstetrical History

How many periods do you have per year? _____

Do you need any medication to bring on a period? □ No □ Yes – what type?_____

How many times do you have intercourse per week? _____times

Have you ever used over-the-counter ovulation kits to time intercourse? □ No □ Yes

If yes, does it show ovulation? □ No □ Yes – what cycle day?_____ □ Unsure

Have you ever been pregnant? □ No □ Yes – if yes, please complete below:

| Date pregnancy ended or delivered | How long to conceive | Treatments to conceive | Delivery type/D&C/ Complications | Current partner? |
|---|---|---|---|---|
| 1. | | | | □ Yes □ No |
| 2. | | | | □ Yes □ No |
| 3. | | | | □ Yes □ No |
| 4. | | | | □ Yes □ No |
| 5. | | | | □ Yes □ No |
| 6. | | | | □ Yes □ No |

## Medical-Surgical History

Have you had surgery for fibroids (myomas)? □ No □ Yes – if so, when? _____

Have you had surgery for endometriosis? □ No □ Yes – if so, when? _____

Have you had surgery for an uterine abnormality? □ No □ Yes – if so, when? _____

Have you had a Tubal Ligation? □ No □ Yes – if so, when? _____

Have you had a Tubal Reversal? □ No □ Yes – if so, when? _____

Do you know your blood type? □ No □ Yes _____

## Family/Genetic History

**What is your Ancestry?**

- □ African American
- □ American Indian/Native American
- □ Ashkenazi Jewish
- □ Asian American
- □ Cajun/French Canadian
- □ Eastern European
- □ Hispanic/Caribbean
- □ Middle Eastern
- □ Northern European
- □ Southern European
- □ Other (specify _____)

**Have you been screened for:**
**(If yes, please request records)**

| | | |
|---|---|---|
| Cystic Fibrosis | □ Yes | □ No |
| Sickle Cell Anemia | □ Yes | □ No |
| Tay Sachs Disease | □ Yes | □ No |
| Thalassemia | □ Yes | □ No |
| Spinal Muscular Atrophy | □ Yes | □ No |

Are you and your partner related by blood?
□ Yes □ No

## Infertility History

Have you had any prior infertility testing or treatment elsewhere? □ No □ Yes – Please request records

How long have you been having unprotected intercourse? _____months _____years From ___/___/___ to ___/___/___

**Prior Tests** (check all that apply) (Please provide records if possible)

- □ Day 3 blood test for FSH level
- □ Thyroid blood test
- □ Prolactin blood test
- □ Progesterone blood test
- □ Rubella Immunity
- □ Basal Body Temperature chart
- □ Ovulation test kits
- □ Uterine evaluation (HSG, SIS)
- □ Hysteroscopic surgery
- □ Laparoscopic surgery

| | **# of cycles** | **Dates** (mo/yr) | **Outcome**(check all that apply) |
|---|---|---|---|
| □ Intrauterine Insemination | | From ___/___/___ to ___/___/___ | □Pregnant □Delivered □Ectopic □Miscarriage □Not Pregnant |
| □ Clomiphene citrate with timed intercourse: Maximum # tablets per day? | | From ___/___/___ to ___/___/___ | □Pregnant □Delivered □Ectopic □Miscarriage □Not Pregnant |
| □ Clomiphene citrate with insemination: Maximum # tablets per day? | | From ___/___/___ to ___/___/___ | □Pregnant □Delivered □Ectopic □Miscarriage □Not Pregnant |
| □ Daily fertility drug injections with insemination: Maximum # vials per day? | | From ___/___/___ to ___/___/___ | □Pregnant □Delivered □Ectopic □Miscarriage □Not Pregnant |
| □ Completed in vitro fertilization cycle(s): | | From ___/___/___ to ___/___/___ | □Pregnant □Delivered □Ectopic □Miscarriage □Not Pregnant |
| □ Frozen Embryo Transfers: | | From ___/___/___ to ___/___/___ | □Pregnant □Delivered □Ectopic □Miscarriage □Not Pregnant |
| □ Cancelled in vitro fertilization attempt(s): | | | |
| □ Any other prior treatment (describe) | | | |

Do you have any **personal, ethical, or religious objections** to any of our tests or treatments such as insemination, in vitro fertilization, egg donation, sperm donation, masturbation to collect a semen sample, ect.? ___No ___Yes
If yes, please explain:_____