Infertility Questionnaire – Female Portion

(Please complete and bring with you to your appointment)

Date:

Name:

Age/DOB:

Occupation:

How long have you been trying to get pregnant?

Have you ever been on birth control? If so, what type and how long?

Menstrual History:

Age at first menstrual cycle?

Are your cycles regular? What is the interval (in days) between menstrual cycles?

During a typical period, how many days do you bleed for?

On your "heavy" days, how often do you change a pad or tampon?

Do you experience severe cramps?

Additional comments?

Pregnancy History:

Have you ever been pregnant?

Please provide total number of pregnancies, number of living children:

Have you ever had a miscarriage? Elective abortion? Ectopic Pregnancy?

WOMEN'S HEALTH CARE

Past Medical History:

Have you ever had any of the following?

Exposure to chemicals: Yes/No
Exposure to radiation: Yes/No
Abdominal or pelvic surgery: Yes/No
A sexually transmitted disease: Yes/No
Pelvic inflammatory disease: Yes/No

Any other significant medical problems or surgeries?

Current medications, including over the counter medications/supplements:

Have you had any prior evaluation for infertility (labs, ultrasound, HSG, laparoscopy, etc)? If so, when and what were the results?
**If possible, bring records to your consult.*

Have you had any prior infertility treatments (clomid/letrozole, intrauterine insemination, IVF, etc.)? If so when and what were the results?

Social History:

Do you have a current or past history of smoking?

Do you have a current or past history of drug use?

Average alcohol consumption? How many drinks/week?

Do you exercise regularly?

WOMEN'S HEALTH CARE

Infertility Questionnaire – Male Portion

(Please complete and bring with you to your appointment)

Date:

Name:

Age/DOB:

Occupation:

Past Medical History:

Have you ever had any of the following?

Exposure to chemicals: Yes/No
Exposure to radiation: Yes/No
Testicular injuries or surgery: Yes/No
A sexually transmitted disease: Yes/No
Mumps after puberty: Yes/No
Pregnancies with other partners: Yes/No

Any other significant medical problems or surgeries?

Current medications, including over the counter medications/supplements:

Have you had any prior evaluation for infertility (semen analysis, etc.)? If so, when and what were the results?
**If possible, bring records to your consult.*

Social History:

Do you have a current or past history of smoking?

Do you have a current or past history of drug use?

Average alcohol consumption? How many drinks/week?

Do you exercise regularly?