WOMEN'S HEALTHCARE

Exceptional Care for Women's Health and Pregnancy

Patient Questionnaire - Infertility History **– Female**

Date:

Please complete and bring with you to your consult. Thanks.

Name: Age/DOB:

Occupation:

Have you ever been pregnant? # Living children?

Elective abortion? Miscarriages? Ectopic?

Other?

Age at first menstrual cycle:

Are cycles regular? How often?

How long? Cramps or heavy bleeding?

How long have you been currently trying for pregnancy?

Last use of contraceptives? Type?

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

** Specifics for "yes" answers

Any other significant past medical history or surgeries?

Current medications, including over the counter drugs:

Women's Health Care, SC

Patient Questionnaire - Infertility History **– Female**

(Continued)

Do you or have you used any street drugs? If so, what and how frequently?

What is your average alchol consumption (daily/weekly)?

Do you smoke? How much?

Do you exercise regularly?

Have you had any prior evaluation for infertility such as :

Date: Results (if known)

BBT's

HSG (hysterosalpingogram)

Pelviscopy/Laparoscopy

Lab tests/endocrine evaluation

Other?

**If possible, obtain and bring records to your consult.*

Have you had any prior treatments?

Artificial Insemination?		Date:	Outcome:
Serophene/Clomid?		Dose:	# of cycles:
Injectable ovulation drugs HMG/FSH (ie. Pergonal, ect)		Dose:	# of cycles:
IVF/GIFT	Date:	Outcome:	Other?

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Patient Questionnaire - Infertility History **– Male**

Date:

Please complete and bring with you to your consult. Thanks.

Name: Age/DOB:

Ocucupation:

Have you ever had any of the following?

Exposure to chemical	Yes/No
Exposure to radition	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

*Specifics for "yes" answers

Current medication, including over-the-counter drugs:

Do you use any street drugs? If so what and how frequently?

What is your average alcohol consumption (daily/weekly)?

Do you exercise regularly? Use a hot tub or whirlpool?

Have you had any prior evaluation for infertility such as:

Semen Analysis	Yes/No
Antisperm Antibodies	Yes/No
HEPA (hamster egg)	Yes/No
Urology Examination	Yes/No
Other?	Yes/No

Have you had any prior treatment, including medications or surgeries?