Heartland Center for Reproductive Medicine

# Fertility Questionnaire

## General Information

Legal Name_____ Preferred First Name_____ Date _____

Pronouns: he/him/his ____ she/her/hers ____ they/them/their ____ zie/hir ____ other _____

Gender Identity: (cis)female ____ (cis)male ____ transmale ____ transfemale ____ nonbinary ____ other _____

Sexual Orientation _____ Sex Assigned at Birth _____ Birthdate _____

Age _____ Occupation _____ Employer _____ SSN _____

Address _____

Phone # _____ Height _____ Weight _____ Ethnic Background _____

Partners Name_____ Married ☐ Yes ☐ No Who lives in the home with you?_____

Who referred you? _____ Self Referred: ☐

Reason for appointment today? _____

## Gynecologic History

Age of first period _____. Date of first day of last period _____. Usual cycle length _____days _____ range (interval from start of one period to start of next). Usual duration of bleeding _____ days

Do you have any symptoms at time of ovulation (i.e., pain)? _____ yes _____ no

Amount of flow ___ Light ___ Moderate ___ Heavy. Is cramping ___ None ___Minimal ___ Moderate ___ Severe

Bleeding between periods? ___ Never ___Sometimes ___ Always. Do you skip periods? ___ Never ___ Sometimes ___ Always

Circle symptoms preceding period: None Breast soreness Irritability.

History of: Pelvic Pain _____

Last PAP _____ Mammogram _____

| | | | Dates Treated |
|---|---|---|---|
| Have you ever been treated for: | Syphilis | _____yes _____no | _____ |
| | Gonorrhea | _____yes _____no | _____ |
| | Chlamydia | _____yes _____no | _____ |
| | Genital Warts | _____yes _____no | _____ |

Do you have a history of genital herpes _____ yes _____ no. Did your mother take any medications while pregnant with you? _____ yes _____ no _____don't know _____ What? Was DES taken _____ yes _____ no

## Sexual History

Frequency of sexual intercourse per week _____. Use of lubricants? ____ yes ____ no

Name of lubricants _____ Does partner ejaculate in the vagina during intercourse ___ yes ___ no

Is intercourse painful to you? _____ yes _____ no. Is intercourse painful to your partner? _____ yes _____ no

Have you ever been: physically / emotionally / verbally / sexually .....Abused? In the past ____ currently ____

## Contraceptive History

Birth control pills/ring ____ yes ____ no # of years used_____. Date stopped birth control pills _____

Were menses regular before birth control pills ____ yes ____ no. Were menses regular after stopping the pills _____ yes _____ no

How long after stopping the pills did menses start _____

Previous use of IUD (intrauterine device) _____ yes _____ no _____ # years.

When was IUD removed (date) _____ reason _____

Circle previous use of: diaphragm condom foam rhythm sponge other_____

## Name:

### Obstetrical History

Have you been pregnant before? ___ yes ___ no. Do you have children: ___ yes ___ no _____ ages

How long to conceive: _____

| RECORD ALL PREGNANCIES | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Year | Full term | Preterm | Miscarriage | Terminations | Complications | Fertility Treatment |
| 1 | | | | | | | |
| 2 | | | | | | | |
| 3 | | | | | | | |
| 4 | | | | | | | |

| Your Medical/Surgery History | Yes | No | Dates/Comments |
|---|---|---|---|
| Elevated Blood pressure | _____ | _____ | _____ |
| Blood clots (deep vein thrombosis, pulmonary embolism) | _____ | _____ | _____ |
| Heart murmur | _____ | _____ | _____ |
| Heart disease | _____ | _____ | _____ |
| Diabetes | _____ | _____ | _____ |
| Lung disease | _____ | _____ | _____ |
| Liver or gall bladder disease | _____ | _____ | _____ |
| Jaundice | _____ | _____ | _____ |
| Kidney infections | _____ | _____ | _____ |
| Hepatitis | _____ | _____ | _____ |
| Kidney stones | _____ | _____ | _____ |
| Gout | _____ | _____ | _____ |
| Urinary tract abnormalities | _____ | _____ | _____ |
| Thyroid disease | _____ | _____ | _____ |
| Arthritis | _____ | _____ | _____ |
| Auto immune diseases (lupus, rheumatoid arthritis, etc.) | _____ | _____ | _____ |

Other serious or chronic diseases _____

Any surgery (list type and year) _____

Any history of therapeutic x-ray treatment or anti-cancer drugs? Current: _____ Past: _____

_____ _____

_____ _____

Have you ever been involved in psychotherapy or counseling? Yes _____ No _____

If yes, please indicate why, when, with whom, and any other pertinent information. _____

_____

Please fill in a review of any **current** or **recent** symptoms:

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Chronic headaches | ____ | ____ | Increased thirst | ____ | ____ | Excessive Fatigue | ____ | ____ |
| History of head injury | ____ | ____ | Increased sweating | ____ | ____ | Tremors | ____ | ____ |
| Convulsion history | ____ | ____ | Intolerance to heat | ____ | ____ | Desire for extra salt | ____ | ____ |
| Visual problems | ____ | ____ | Intolerance to cold | ____ | ____ | Excess Loss of scalp hair | ____ | ____ |
| Dizziness | ____ | ____ | Difficulty swallowing | ____ | ____ | Growth of hair on face | ____ | ____ |
| Rapid weight change | ____ | ____ | Change in voice or | | | or body in new places | ____ | ____ |
| Acne | ____ | ____ | hoarseness | ____ | ____ | Change in size of clitoris | ____ | ____ |
| Change of appetite | ____ | ____ | Difficulty sleeping | ____ | ____ | Discharge from nipples | ____ | ____ |

## Name:

### Allergies

Do you have any allergies (medications, food, latex, iodine, contrast dye): Yes _____ No _____

If yes, list the specific allergies and reactions experienced: _____

_____

### Medications

Please list any medications you are now taking or have taken in the past.

Current: _____ Past: _____

_____ _____

_____ _____

### Family History

Father's age if alive _____ If no longer living, cause of death / age _____

Medical problems: _____

Mother's age if alive _____ If no longer living, cause of death / age _____

Medical problems: _____

Sister(s) ages _____ medical problems:_____

Brother(s) ages _____ medical problems:_____

| Is there a family history of: | Yes | No | Comments |
|---|---|---|---|
| Birth defects or genetic diseases | ____ | ____ | _____ |
| Mental Retardation | ____ | ____ | _____ |
| Infertility | ____ | ____ | _____ |
| Early Menopause (before age 40) | ____ | ____ | _____ |
| Hormone problems | ____ | ____ | _____ |
| Miscarriages/stillbirths | ____ | ____ | _____ |
| Pregnancy problems | ____ | ____ | _____ |
| Cancer: ___ Breast ___Ovarian ___Other | ____ | ____ | _____ |
| Stroke | ____ | ____ | _____ |
| Heart Disease | ____ | ____ | _____ |
| Lung disease | ____ | ____ | _____ |
| Diabetes | ____ | ____ | _____ |
| Thyroid/endocrine problems | ____ | ____ | _____ |
| High blood pressure | ____ | ____ | _____ |
| Blood clots (deep vein thrombosis, pulmonary embolism) | ____ | ____ | _____ |
| Any women who have never menstruated | ____ | ____ | _____ |
| Any men who have never had to shave | ____ | ____ | _____ |

**Any additional comments you would like to make that you feel may be pertinent and have not already been addressed:** _____

_____

| Occupation/Leisure History | Yes | No | Dates/Comments |
|---|---|---|---|
| Exposed to chemicals or x-rays in work or hobby | ____ | ____ | _____ |
| Please list | | | **Amount per day or week** |
| Caffeine | ____ | ____ | _____ |
| Smoking | ____ | ____ | _____ |
| Alcohol | ____ | ____ | _____ |
| Marijuana | ____ | ____ | _____ |
| Nutritional supplements, herbs, etc. | ____ | ____ | _____ |
| Drugs - Use: Current / History | ____ | ____ | _____ |

Please describe recreational/sports activities, exercise (frequency, length of time, etc.) _____

THIS PAGE IS INTENTIONALLY LEFT BLANK

**Name: _____**

**I have never had any previous fertility testing: ☐**

## Previous Infertility Testing

Length of time currently attempting pregnancy _____Years _____ Months

Length of time not using contraceptives _____

| | Yes | No | Year | Normal | Abnormal | If yes, give dates/results |
|---|---|---|---|---|---|---|
| Temperature charts | ☐ | ☐ | ____ | ☐ | ☐ | _____ |
| Hysterosalpingogram (x-ray of tubes and uterus) | ☐ | ☐ | ____ | ☐ | ☐ | _____ |
| Hysteroscopy (looking inside uterus) | ☐ | ☐ | ____ | ☐ | ☐ | _____ |
| Endometrial biopsy (taking tissue from inside uterus) | ☐ | ☐ | ____ | ☐ | ☐ | _____ |
| Semen Analysis | ☐ | ☐ | ____ | ☐ | ☐ | _____ |
| Laparoscopy (looking inside the abdomen) | ☐ | ☐ | ____ | ☐ | ☐ | _____ |
| Hormone Tests | | | | | | |
| Day 3 FSH | ☐ | ☐ | _____ | ☐ | ☐ | _____ |
| Day 3 Estradiol | ☐ | ☐ | _____ | ☐ | ☐ | _____ |
| Clomid Challenge Test | ☐ | ☐ | _____ | ☐ | ☐ | _____ |
| Anti Mullenan Hormone (AMH) | ☐ | ☐ | _____ | ☐ | ☐ | _____ |
| Prolactin Level | ☐ | ☐ | _____ | ☐ | ☐ | _____ |
| Thyroid tests | ☐ | ☐ | _____ | ☐ | ☐ | _____ |
| Chromosome tests | ☐ | ☐ | _____ | ☐ | ☐ | _____ |
| Genetic testing | ☐ | ☐ | _____ | ☐ | ☐ | _____ |

**PLEASE HAVE ANY TESTING RESULTS RELEASED TO HCRM PRIOR TO YOUR INITIAL VISIT.**

## Name:

### Previous Infertility Treatment

Treatment with Clomiphene (Clomid, Serophene) or Letrozole (Femara) ☐ Yes ☐ No

**If Yes:**

Cycles **without** Intrauterine Insemination (IUI) ☐ Yes ☐ No #Cycles / Dates _____

Cycles **with** Intrauterine Insemination (IUI) ☐ Yes ☐ No #Cycles / Dates _____

Pregnant ☐ Yes ☐ No Dates _____

Treatment with Gonadotropins (Follistim, Gonal-F, Bravelle, Menopur, Repronex, Humegon, Pergonal) ☐ Yes ☐ No

**If Yes:**

Cycles **without** Intrauterine Insemination (IUI) ☐ Yes ☐ No #Cycles / Dates _____

Cycles **with** Intrauterine Insemination (IUI) ☐ Yes ☐ No #Cycles / Dates _____

Pregnant ☐ Yes ☐ No Dates _____

Treatment with IVF or other Reproductive Technologies (GIFT, ZIFT)

| Cycle # | Protocol (if known) | Dose of FSH or LH | Estrogen Level at retrieval | # Eggs Retrieved | # Embroys Transferred | Pregnant? | Delivery? |
|---|---|---|---|---|---|---|---|
| | | | | | | ☐Yes ☐No | ☐Yes ☐No |
| | | | | | | ☐Yes ☐No | ☐Yes ☐No |
| | | | | | | ☐Yes ☐No | ☐Yes ☐No |
| | | | | | | ☐Yes ☐No | ☐Yes ☐No |
| | | | | | | ☐Yes ☐No | ☐Yes ☐No |

**Other comments on infertility treatments:**

_____

_____

_____

**Please indicate any other information which you believe may be pertinent to your infertility problem** _____

_____

_____

_____