INFERTILITY PATIENT QUESTIONNAIRE

General Fertility History

1. What is your age? _____ What is your partner's age?_____
2. How long have you been trying to get pregnant?_____
3. Have you been treated for infertility in the past?_____
   Have you had a HSG?_____ Lab work?_____ Were they normal? _____
   Were you ever treated with Clomid? _____ Femara? _____ Injectables? _____
4. How many times have you been pregnant? _____# of deliveries _____ Miscarriages _____
5. How many vaginal deliveries? _____ How many c-sections? _____ Preterm delivery? _____
6. Have you noticed any abnormal hair growth or hair loss/thinning of hair? _____
7. Have you had any breast discharge? _____Acne? _____ Weight changes? _____

Menstrual History

1. When was the first day of your last period?_____
2. Do you have a period every month? _____
3. How many days do your periods last? _____Are they heavy?_____
4. Do you have painful periods? _____
5. Do you have bleeding between your periods? _____

Sexual History

1. Does you or your partner have any problems during sexual intercourse? _____
2. Do you have significant pain during intercourse? _____
3. Do you experience bleeding after intercourse? _____Do you use lubricants? _____
5. Approximately how many times each month do you have intercourse? _____

Gynecological History

1. Have you been diagnosed or treated for endometriosis? _____
2. Have you ever had a pelvic infection (PID, gonorrhea, chlamydia, trichamoniasis, genital herpes, syphilis)? _____
3. Have you ever had pelvic surgery? _____
4. Have you ever had an abnormal pap smear? _____
5. Have you ever had a surgery on your cervix such as LEEP, cone biopsy, cryotherapy? _____
6. Have you ever been diagnosed with polycentric ovaries (PCOS)? _____

Medication/Dietary History

1. Do you take any prescription drugs, vitamins, dietary/herbal supplements? _____
   _____
2. When is the last time you took birth control pills, Mirena IUD, Depo Provera? _____
3. Do you have any allergies? _____

Male History

1. Has your partner ever fathered any children?_____
2. Has your partner had a semen analysis? _____Was it normal? _____
3. Does your partner take any medications/herbal supplements? _____
4. What is your partner's occupation? _____Has he ever had a genital injury?_____

Patient Signature _____ **Date** _____