Freyja Medical Clinic
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# Fertility Questionnaire

Please complete and bring this questionnaire with you to your first visit.

## MEDICAL ALLERGIES

Which drugs or medicines are you allergic or sensitive to?

| Drug | Reaction |
|---|---|
| | |
| | |
| | |

## PATIENT INFORMATION

Name:_____ _____

Address:_____ _____

Phone: Day (___) ____- _____ Evening (___) ____- _____ Cell (___) ____- _____

Age: ____ Date of Birth: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Ethnic Group/Race: _____ Religion: _____

Occupation: _____ Yrs of Education: _____

Emergency Contact: _____ Relationship: _____ Phone: (____) ____- _____

## SPOUSE/SIGNIFICANT OTHER INFORMATION

Name of Spouse/Significant Other: _____ _____

Age: _____

Phone numbers: Day (___) ____- _____ Evening (___) ____- _____ Cell (___) ____- _____

Ethnic Group/Race: _____ Religion: _____

Occupation: _____ Yrs of Education: _____

**GYNECOLOGICAL HISTORY**

How old were you when you had you first period _____

How frequently do your periods come? Every __days

How long do your periods last? _____days. When did your last period start? _____

Was there a time in the past, when you cycles were irregular while not on the "Pill"?

If so, please describe: _____

Have you ever taken the "Pill"? ☐ Yes ☐ No

If so, for how many years in total: _____

Do you experience cramping with your periods? ☐ Yes ☐ No

If yes, when during your cycles do you have pain (check all that apply):

☐ Before ☐ During ☐ After

How would you describe the cramps? ☐ Mild ☐ Moderate ☐ Severe

Do you take pain medication for the cramps? ☐ Yes ☐ No

If yes, specify medication: _____

Do you bleed or spot between periods? ☐ Yes ☐ No

If yes, please describe:_____

Have you ever had an abnormal Pap smear result? _____

If yes, what therapy was required: ☐ Cryotherapy (freezing of cervix) ☐ Laser therapy

☐ Cone biopsy ☐ LEEP ☐ Other: _____

Have you ever had any of the following infections involving any part of the reproductive tract?

(Check all that apply)

☐ Chlamydia ☐ Trichomonas ☐ Gonorrhea ☐ Herpes ☐ Genital warts

What treatment did you receive? _____Year:____

Do you have pain with intercourse? ☐ Never ☐ Sometimes ☐ Frequently ☐ Always

If yes, does the pain remain in your lower abdomen or back after intercourse if over?

☐ Yes ☐ No if yes, for how many minutes? : _____

How frequently do you and your partner have intercourse? ___Per ☐ week ☐ month

How frequently do you and your partner have intercourse around ovulation?

____times per month

Do you usually use lubrication during intercourse? ☐ Yes ☐ No

If yes, please specify: _____

Have you experienced any difficulties with intercourse that may be contributing to not getting pregnant?

☐ Yes ☐ No If yes, please explain: _____

_____

Have you ever used contraception in the past? ☐ Yes ☐ No

if yes, please check all that apply:

☐ Contraceptive pills ☐ Condoms ☐ IUD ☐ Foam/Sponge ☐ Rhythm

☐ Withdrawal ☐ Other: _____

**PAST FERTILITY EVALUATION**

How long have you and your partner been attempting to achieve pregnancy? _____

Have you been using temperature charts? ☐ Yes ☐ No

If yes, for how long?___ ___ months

Have you been using urine ovulation predictor kits? ☐ Yes ☐ No

if yes, what kind and for how long? _____

Have you ever tried to achieve a pregnancy with a different partner ☐ Yes ☐ No

Have you ever conceived with a different partner? ☐ Yes ☐ No

Has your male partner ever gotten someone else pregnant? ☐ Yes ☐ No

Have you been treated for infertility previously ☐ Yes ☐ No

If yes, where & when: _____

What was the cause of infertility? _____

Which of the following tests have already been performed?

☐ Infection test (mycoplasma,Chlamydia) ☐ Postcoital test ☐ Endometrial biopsy

☐ Hysteroscope ☐ Hormonal tests (FSH, Prolactin, TSH) ☐ Antichlamydia Antibody ☐ Ultrasound

☐ Sonohysterogram ☐ Hysterosalpingogram (HSG) ☐ Antisperm antibody ☐ Laparoscopy

If done, indictate date and findings of the Laparoscopy: _____

Have you ever taken any of the medications listed below?

☐ Clomiphene (Clomid,Serophene) ☐ Letrozole (Femara) ☐ Injectable gonadotropins

(Menopur, Repronex, Humagon, Gonal-F, Follistim)

☐ HCG (Profasi, Pregnyl) ☐ GnRH agonist (Lupron,Synarel,Zoladex) ☐ Estrogens

☐ Steroids (prednisone, dexamethasone) ☐ GnRH Antagonist (Antagon)

☐ Bromocriptine (Parlodel, Dostinex) ☐ Baby aspirin

☐ Glucophage (Metformin) ☐ Progesterone ☐ Heparin or Lovenox

Have you ever had intrauterine inseminations (IUI)? ☐ Yes ☐ No

if yes, for how many cycles? _____

If yes, sperm specimen was provided by: (Check all that apply) ☐ Partner ☐ Donor

How many cycles of IUI without any medications? _____

How many cycles of IUI with Clomid? _____

How many cycles of IUI with Letrozole (Femara)? _____

Home many cycles of IUI with Injectable medications (Menopur, Repronex, Humagon, Gonal-F, Follistim): _____

Have you ever attempted in vitro fertilization? ☐ Yes ☐ No if yes, please put more details below:

_____

_____

**OBSTETRICAL HISTORY**

Have you ever been pregnant (including elective terminations, miscarriages, and births)? ☐ Yes ☐ No

If yes, please describe:

_____

_____

_____

**PAST MEDICAL HISTORY**

Do you have or have you ever had any of the following (check all that apply):

☐ Ovarian cyst ☐ Anemia ☐ Endometriosis ☐ Gallbladder disease ☐ Arthritis

☐ Heat or cold intolerance ☐ Hair loss ☐ Seizures ☐ Mumps

☐ High blood pressure ☐ Hirsutism (excess hair growth) ☐ Hot flashes ☐ Vision problems

☐ Cystic Fibrosis ☐ Diabetes ☐ Breast (Nipple discharge)

☐ Colitis ☐ Acne ☐ Chronic headaches ☐ Kidney or Liver problems ☐ German Measles

☐ Regular Measles ☐ Neurological problems ☐ Autoimmune disease (e.g. Lupus Multiple Sclerosis, Arthritis)

**PAST SURGICAL HISTORY**

Have you ever had any surgeries besides laparoscopies in the past? ☐ Yes ☐ No

If yes, please indicate date, type, and findings of the surgery:

_____

**FAMILY HISTORY**

Have any of these problems occurred in your family? Check all that apply and indicate relationship to you:

☐ High blood pressure _____ ☐ Ovarian cancer _____

☐ Infertility _____ ☐ DES exposure in utero _____

☐ Early menopause _____

☐ Heart disease _____ ☐ Colon or Breast Cancer_____

☐ Diabetes _____ ☐ Thyroid disease _____

☐ Autoimmune disease (Lupus, Multiple Sclerosis, Rheumatoid Arthritis) _____

**REVIEW OF SYSTEMS**

Have you noted any significant:

Heat or Cold intolerance recently? ☐ Yes ☐ No

if yes, please explain: _____

Unusual hair distribution changes or breast nipple discharge? ☐ Yes ☐ No

if yes, please explain: _____

Significant weight change in the last year? If so, please describe how many lbs

and over what time: _____

**HABITS**

Do you smoke? ☐ Yes ☐ No if yes, how many packs per day? _____

Do you drink alcohol? ☐ Yes ☐ No if yes, how many alcoholic beverages per week: _____

Do you smoke marijuana? ☐ Yes ☐ No if yes, how much per week: _____

Do you exercise regularly? ☐ Yes ☐ No if yes, please indicate type of exercise and estimate hours per week spent

_____

_____

_____

**MEDICATIONS:**

Are you currently taking any prescription medications? ☐ Yes ☐ No

| **Medications** | **Reason** |
|---|---|
| _____ | _____ |
| _____ | _____ |

Do any of you use herbal medications? ☐ Yes ☐ No

if yes, types of medications used: _____

Are you using Acupuncture or Chinese Herbal Medicine Currently? ☐ Yes ☐ No

If yes, please describe: _____

_____

**SECTION FOR MALE PARTNER FERTILITY EVALUATION**

**Which of the following test have already been performed?**

☐ Semen analysis ☐ Chromosome test ☐ Blood tests (FSH, LH, AMH, Prolactin, TSH, Testosterone)

☐ Ultrasound of testis ☐ Antisperm antibody test ☐ Mycoplasma and Ureaplasma culture

☐ Testicular biopsy ☐ Hysterosalpingogram (HSG) If yes, indicate findings: _____

Have you ever had any of the following procedures done? (Check all that apply)

☐ Varicocele repair ☐ hernia repair ☐ Prostate surgery ☐ Testicular torsion repair

☐ Testicular biopsy ☐ Vasectomy reversal ☐ Other (please specify): _____

Have you ever had any significant testicular injury? ☐ Yes ☐ No

If yes, please describe: _____

Have you ever taken any of the medications listed below?:

☐ Clomiphene (Clomid,Serophene) ☐ Proxeed ☐ Testosterone ☐ Viagra/Viagra like medications

☐ GnRH agonist (Lupron,Synarel,Zoladex ☐ Bromocriptine (Parlodel, Dostinex)

☐ Other (please list): _____

Do you have or have you ever had any of the following (check all that apply):

☐ Cystic Fibrosis ☐ Delay of puberty ☐ Anemia ☐ Arthritis ☐ Cancer

☐ Autoimmune disease ☐ Heat or cold intolerance ☐ Seizures ☐ Neurological problems

☐ High blood pressure ☐ Vision problems ☐ Testicular tumor

☐ Chronic headaches ☐ Kidney /Liver problems ☐ Colitis ☐ Cystic Fibrosis ☐ Diabetes

☐ Regular Measles ☐ German Measles ☐ Mumps ☐ Mumps with testes involved

**PAST SURGICAL HISTORY**

Have you ever had any surgeries in the past? ☐ Yes ☐ No

If yes, please indicate date, type, and findings of surgery:

_____

**FAMILY HISTORY**

Have any of these problems occurred in your family? Check all that apply and indicate relationship to you:

☐ High blood pressure _____ ☐ Ovarian cancer _____

☐ Infertility _____ ☐ Prostate CA _____

☐ Heart disease _____ ☐ Colon/breast CA _____

☐ Diabetes _____ ☐ Other _____

**REVIEW OF SYSTEMS**

Have you noted any significant:

Heat/Cold intolerance recently? ☐ Yes ☐ No

if yes, please explain: _____

Unusual hair distribution changes? ☐ Yes ☐ No

if yes, please explain:_____

Significant weight change in the last year? ☐ Yes ☐ No

If so, please describe how many lbs and over what time: _____

**HABITS**

Do you smoke? ☐ Yes ☐ No If yes, how many packs per day? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how many alcoholic beverages per week: _____

Do you smoke marijuana? ☐ Yes ☐ No If yes, how much per week: _____

Do you take hot baths? ☐ Yes ☐ No If yes, how much per week: _____

Do you exercise regularly? ☐ Yes ☐ No If yes, please indicate type of exercise and estimate hrs per week spent:

_____

_____

**MEDICATIONS:**

Are you currently taking any prescription medications? ☐ Yes ☐ No

If yes, please describe:

Medications: _____ Reason: _____

Do any of you use herbal medications? ☐ Yes ☐ No

If yes, types of medications used: _____