

*Southeastern Fertility Center
&
Center for Reproductive Surgery*

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Fertility Questionnaire for Women

General Information:

1. Name _____ Age _____ SS# _____
2. Husband's Name _____ Age _____ SS# _____
3. Your Occupation _____
4. Name of Gynecologist _____
5. Who referred you to us? _____

Previous Infertility Work-up (please fill in even if you bring your records):

<u>Hormonal Testing</u>	<u>Date</u>	<u>Physician</u>	<u>Results</u>
Progesterone Level	_____	_____	_____
Other Hormonal Testing	_____	_____	_____
<u>Procedures</u>	<u>Date</u>	<u>Physician</u>	<u>Results</u>
Temperature Chart	_____	_____	_____
Semen Analysis #1	_____	_____	_____
#2	_____	_____	_____
PCT(mucus test) #1	_____	_____	_____
#2	_____	_____	_____
Endometrial Biopsy	_____	_____	_____
HSG (dye study) #1	_____	_____	_____
#2	_____	_____	_____
Laparoscopy #1	_____	_____	_____
#2	_____	_____	_____
Ultrasound	_____	_____	_____
<u>Treatment</u>	<u>Date</u>	<u># of Cycles</u>	<u>Results</u>
Clomiphene (Clomid)	_____	_____	_____
Femara (Letrozole)	_____	_____	_____
Glucophage	_____	_____	_____
Insulin Lowering Meds	_____	_____	_____
hMG	_____	_____	_____
Other Injectable Meds	_____	_____	_____
Intrauterine Insemination	_____	_____	_____
IVF	_____	_____	_____

Gynecologic History:

	Yes	No
1. Are your period's <i>irregular</i> ?	_____	_____
2. About how many days elapse from the start one period to the start of the next?	_____	_____
3. Do you sometimes bleed between your periods?	_____	_____
4. Do you have or have you ever had (Check all that apply):		
Herpes	_____	_____
Gonorrhea	_____	_____
Chlamydia	_____	_____
Trichomonas	_____	_____
Genital Warts	_____	_____
Nongonococcal Urethritis	_____	_____
Any sexually transmitted (venereal) disease	_____	_____
Any infection in your cervix, uterus, tubes, ovaries, or pelvis	_____	_____
Appendicitis	_____	_____
5. Have you ever had an abnormal Pap smear?	_____	_____
6. Did your mother take DES or any other hormones while she was pregnant with you?	_____	_____
7. Do you have any discharge from your breasts?	_____	_____
8. Do you feel that you have excessive facial hair growth or problems with acne?	_____	_____
9. Have you ever been diagnosed as having endometriosis?	_____	_____
10. Do any of your first-degree relatives have endometriosis?	_____	_____
11. Have you ever had ovarian cysts?	_____	_____
12. Have you ever had surgery involving your vagina, cervix, uterus, tubes, ovaries, pelvis, or appendix?	_____	_____
13. If you have ever been pregnant, were there any complications during the pregnancy?	_____	_____

Sexual History

	Yes	No
1. Do you feel that you or your husband have a significant problem in achieving orgasm?	_____	_____
2. Does your husband have frequent problems with impotence (inability to maintain an erection or to ejaculate)?	_____	_____
3. Do you frequently have pain or discomfort during intercourse?	_____	_____
4. Do you douche before or after intercourse?	_____	_____
5. Do you use lubricants during intercourse?	_____	_____
6. Do you feel that you and/or your husband might benefit from some form of sexual counseling?	_____	_____
7. Do you feel that infertility is putting a strain on your marital relationship?	_____	_____
8. Have you ever been a victim of rape, sexual abuse, or sexual mistreatment? (Brief Description)	_____	_____
9. If you answered "yes" to any of the above, which would you like Dr. Keenan to discuss with you at your visit? _____		

Medical History:

Do you have or have you ever had (check all that applies):

- | | |
|---|---|
| 1. <input type="checkbox"/> Heart Murmur | 22. <input type="checkbox"/> Appendicitis |
| 2. <input type="checkbox"/> Mitral Valve Prolapse | 23. <input type="checkbox"/> Anemia |
| 3. <input type="checkbox"/> Heart Disease | 24. <input type="checkbox"/> Blood Disorders |
| 4. <input type="checkbox"/> Scarlet Fever | 25. <input type="checkbox"/> Bleeding Tendency |
| 5. <input type="checkbox"/> Rheumatic Fever | 26. <input type="checkbox"/> Excessive bleeding after tonsillectomy or wisdom teeth removal |
| 6. <input type="checkbox"/> Chronic Bronchitis | 27. <input type="checkbox"/> Arthritis |
| 7. <input type="checkbox"/> Pneumonia | 28. <input type="checkbox"/> Thyroid Problems |
| 8. <input type="checkbox"/> Tuberculosis | 29. <input type="checkbox"/> Cancer (specify) _____ |
| 9. <input type="checkbox"/> Lung Disease | |
| 10. <input type="checkbox"/> Hepatitis | 30. <input type="checkbox"/> Head Injury |
| 11. <input type="checkbox"/> Jaundice | 31. <input type="checkbox"/> Neurological Problems |
| 12. <input type="checkbox"/> Liver Disease | 32. <input type="checkbox"/> Psychological Counseling |
| 13. <input type="checkbox"/> Measles: Regular | 33. <input type="checkbox"/> Seizures |
| 14. <input type="checkbox"/> Measles: German | 34. <input type="checkbox"/> Poor sense of smell |
| 15. <input type="checkbox"/> Immunization: German Measles | 35. <input type="checkbox"/> Allergies to medications (specify) _____ |
| 16. <input type="checkbox"/> Multiple Kidney Infections | 36. <input type="checkbox"/> Non-GYN Surgery (specify) _____ |
| 17. <input type="checkbox"/> High Blood Pressure | 37. <input type="checkbox"/> Been Hospitalized (specify) _____ |
| 18. <input type="checkbox"/> Gallbladder Problems | |
| 19. <input type="checkbox"/> Ulcers | |
| 20. <input type="checkbox"/> Colitis | |
| 21. <input type="checkbox"/> Diabetes | |

List all medications or vitamins that you are taking on a regular or frequent basis:

Habits:	Yes	No
1. Do you smoke cigarettes?	_____	_____
2. Do you drink more than one caffeinated beverage per day (e.g., coffee, tea, coke, pepsi, etc.)?	_____	_____
3. Do you drink wine or other alcoholic beverages on a daily or almost daily basis?	_____	_____
4. In the past five years, have you used any nonprescription drugs (e.g., marijuana, cocaine, etc.)?	_____	_____
5. Do you take high doses of any vitamins?	_____	_____

Family/Genetic History:

- | | | |
|---|-------|-------|
| 1. Has anyone in your family been born with a birth defect(s) | _____ | _____ |
| 2. Is anyone in your family mentally impaired or slow? | | |
| 3. Are there any inherited diseases in your family? | _____ | _____ |
| 4. Has a member of your family had any of the following: color blindness, albinism, hemophilia, Huntington's disease, cystic fibrosis, muscular dystrophy, hereditary anemia? | _____ | _____ |
| 5. Has a member of your immediate family had epilepsy or psychiatric disorders requiring treatment? | _____ | _____ |
| The risk of having a child with cystic fibrosis is at least 1 in 3300. Would you like genetic testing to determine your risk status? | _____ | _____ |

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Fertility Questionnaire for Men

General Information:

1. Name _____ Age _____
2. Spouse's Name _____ Age _____
3. Your Social Security Number ____-____-____
4. Occupation _____

Urologic History:

- | | Yes | No |
|--|-----|-----|
| 1. Do you have or have you ever had (check all that apply): | | |
| Herpes | ___ | ___ |
| Gonorrhea | ___ | ___ |
| Chlamydia | ___ | ___ |
| Trichomonas | ___ | ___ |
| Nongonococcal Urethritis (NGU) | ___ | ___ |
| Any sexually transmitted
(Venereal) disease | ___ | ___ |
| Any infection in your penis,
Testicles, epididymis, or
Seminal vesicles? | ___ | ___ |
| 2. Did your mother take DES or any other hormones
while pregnant with you? | ___ | ___ |
| 3. Have you ever fathered a child or caused a pregnancy? | ___ | ___ |
| 4. Have you ever had any problems with your penis or testicles? | ___ | ___ |
| 5. Have you ever had any surgery on your penis or testicles? | ___ | ___ |
| 6. Have you ever had a hernia repair? | ___ | ___ |
| 7. Have you ever had any injury to your penis or testicles? | ___ | ___ |
| 8. Is urination, ejaculation, or intercourse painful? | ___ | ___ |

- | | | |
|---|-----|-----|
| 9. Have you ever had difficulty or slowness in growing a beard or facial hair? | ___ | ___ |
| 10. Did you have mumps after age 12? | ___ | ___ |
| 11. Do you wear jockey shorts (tight underwear)? | ___ | ___ |
| 12. Have you ever been told you had a fertility problem or decreased sperm count? | ___ | ___ |
| 13. Do you ever have orgasm without ejaculation during masturbation? | ___ | ___ |

Sexual History:

Yes No

- | | | |
|---|-----|-----|
| 1. Do you feel that you or your wife have a significant problem in achieving orgasm? | ___ | ___ |
| 2. Do you have difficulty in maintaining an erection? | ___ | ___ |
| 3. Do you have difficulty ejaculating in the vagina? | ___ | ___ |
| 4. Do you have problems with premature ejaculation? | ___ | ___ |
| 5. Do you masturbate more than once per week? | ___ | ___ |
| 6. Do you feel that you and/or your wife might benefit from some form of sexual counseling? | ___ | ___ |
| 7. Do you feel that infertility is putting a strain on your marital relationship? | ___ | ___ |

Medical History:

1. Do you have or have you ever had (check all that apply):
- ___ Breast Discharge
 - ___ Breast Enlargement
 - ___ Liver Disease
 - ___ Neurological Problems
 - ___ Psychological Problems
 - ___ Tuberculosis
 - ___ Cancer (specify) _____

2. Have you ever been exposed to medicines, chemicals, or other substances that you think may have affected your fertility?
- (Specify) _____

3. Do you have any medical conditions which you think I should be aware of?
(Specify) _____
4. Do you take any medicines on a frequent or regular basis?
(Specify) _____

Habits:

- | | Yes | No |
|--|------------|-----------|
| 1. Do you smoke cigarettes or chew tobacco? | _____ | _____ |
| 2. Do you drink wine or other alcoholic beverages on a daily or almost daily basis? | _____ | _____ |
| 3. In the past five years, have you used any nonprescription drugs (e.g., marijuana, cocaine, etc.)? | _____ | _____ |
| 4. Do you take high doses of any vitamins? | _____ | _____ |

Family/Genetic History:

- | | Yes | No |
|---|------------|-----------|
| 1. Has anyone in your family been born with a birth defect(s)? | _____ | _____ |
| 2. Is anyone in your family mentally retarded or slow? | _____ | _____ |
| 3. Are there any inherited diseases in your family? | _____ | _____ |
| 4. Has a member of your family had any of the following:
color blindness, albinism, hemophilia, Huntington's disease,
cystic fibrosis, muscular dystrophy, hereditary anemia, | _____ | _____ |
| 5. Has a member of your immediate family had epilepsy or psychiatric disorders requiring treatment? | _____ | _____ |
| 6. The risk of having a child with cystic fibrosis is 1 in 3300. Would you like genetic testing to determine your risk status? | _____ | _____ |