FERTILITY QUESTIONNAIRE

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Name : ________________________________Age: ____ Date of Birth:___________________

Tel. Home: (_____)________-___________
Cell : (______)________-_________

Partner's Name: ______________________Age_____ Partner's date of birth:______________

PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR ABILITY.

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? ______

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?

(Vagina, cervix, uterus, ovaries)? Circle 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 after intercourse if over ?

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

How frequently do you and your partner have intercourse? _____per week/Month (circle)

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 infertility?

☐ 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 ______________

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 predictors?

☐ 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

☐ Hormonal tests ☐ Antichlamydia Antibody ☐ Ultrasound ☐ Sonohysterogram

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

Have you ever taken any of the medications listed below?

☐ Clomiphene (Clomid, Serophene) ☐ Injectable gonadotropins

(Pergonal, Repronex, Humagon, Fertinex,Gonal-F, Follistim)

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

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

☐ Bromocriptine (Parlodel, Dostinex) ☐ Progesterone ☐ Heparin

☐ Glucophage (Metformin) ☐ Baby aspirin ☐ Danazol

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

if so, for how many cycles? _____________cycles

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

Have you ever attempted in vitro fertilization(IVF)? ☐ Yes ☐ No
if yes, please specify below:

____
____

OBSTETRICAL HISTORY

Have you ever been pregnant (including elective terminations, miscarriages, births?

☐ Yes ☐ No

Date	Outcome	How long to conceive	Infertility treatment?	pregnancy complications?	Is current partner the father

PAST MEDICAL HISTORY

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

☐ Ovarian cysts ☐ Anemia ☐ Endometriosis ☐ Gallbladder disease ☐ Arthritis

☐ Heat/cold intolerance ☐ hair loss ☐ Seizures ☐ high blood pressure ☐ mumps

☐ Hirsutism (excess hair growth) ☐ hot flashes ☐ vision problem☐ Colitis ☐ Acne

☐ Cystic Fibrosis ☐ Diabetes ☐ Breast (Nipple discharge)
☐ Chronic headaches☐ skin problems

☐ German Measles ☐ Regular Measles ☐ Neurological problems
☐ Autoimmune disease (e.g. Lupus)

Immunizations: ☐ Tetanus ☐ Hepatitis B ☐ German measles
☐ Polio

☐ Mumps ☐ Chicken Pox ☐ Hepatitis B or C ☐ Kidney /Liver problems

PAST SURGICAL HISTORY

Have you ever had any surgeries in the past?

☐ Yes ☐ No If yes, please indicate date, type, 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 ________________ ☐ Early menopause ___________

☐ Heart disease _______________ ☐ colon/breast CA ___________

☐ Diabetes _______________ ☐ Thyroid disease __________

REVIEW OF SYSTEMS

Have you noted any significant:

Heat/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 take hot baths? ___

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 hrs per week spent

____

____

ALLERGIES to medication

Are you allergic to any medication? ☐ Yes ☐ No

if yes, please indicate name of medication and type of reaction

Medication Reaction

__________ ________

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: ________

SECTION FOR MALE PARTNER

FERTILITY EVALUATION

Which of the following test have already been performed?

☐ Semen analysis ☐ Chromosome test ☐ Hamster egg penetration test

What is the structure of your semen? ☐ Thick ☐ Watery

☐ Test (Testosterone levels) No.________

☐ Ultrasound of testis ☐ Anti-sperm antibody test ☐ myco/Urea-plasma culture☐ Testicular biopsy

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 had any road accidents? ○ Yes ○ No

If so, please furnish
detail____

ORGAN EVALUATION

Do you feel like passing of semen or any abnormal fluids
○ Before Urination ○ After Urination ○ After Stool
Does the discharge of semen occur during sleep?
○ Yes ○ No
Do you feel your penis is bent or loose towards the left side?
○ Yes ○ No
Do you get perfect erection before intercourse?
○ Yes ○ No
Do you feel weakness after the intercourse?
○ Yes ○ No
Are you suffering from premature ejaculation?
○ Yes ○ No

What is your usual duration of intercourse with current partner/wife?
○ Less than 5 minutes.
○ More than 5 minutes.
○ More than 10 minutes.
What was your usual duration of intercourse with previous partner if any?

- Do not apply.
- Less than 5 minutes.
- More than 5 minutes.
- More than 10 minutes.

Do you ever had the habit of masturbation Yes No
If so, since how long? ___________How often_____

What is the approx. length of your organ?

Before erection?

After erection?

How many times a month you do intercourse?

How many times night discharge occurs in a week?

Do you read vulgar & obscene literature? Yes No

Do you watch vulgar & obscene movies? Yes No

Do you imagine romantic fantasies Yes No

Does your underwear get wet when you see nude photographs Yes No

HABBITS:

Are you a Vegetarian Non Vegetarian?

Which types of food do you like? Spicy Mild?

Do you have Gastric Problem ? Yes No

Do you have constipation? Yes No

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 ____

How many times you wake up to urinate during night?

○ I don't wake up.

○ 1-3 times.

○ 4-6 times.

○ More than 6 times.

Do you feel pain after urination? ○ Yes ○ No

Do you take your food timely? ○ Yes ○ No

Do you take hot milk at bed time? ○ Yes ○ No

Is your wife older than you? ○ Yes ○ No
If so how many years? _____

How about your memory? ○ Sharp ○ Weak

Did you ever taken any street drugs? ○ Regular

○ occasionally ○ Never

Do you take any alcoholic drinks? ○ Daily

○ Occasionally ○ Never

Have you ever been treated in past? ○ Yes ○ No

Homeopathic ○ Allopathic ○ Ayurvedic ○ others

If so details_____________________________

How long?_____________________________

What are your expectations from our treatment?

○ I don't expect good results.

○ I expect good results.

- I would be happy if I improve.
- I am confident.

Are you willing to make changes to your life style or diet modifications?

- I can not change my lifestyle.
- I have tried nothing works for me,
- I am willing to change my lifestyle if needed.
- I am willing to do what ever is needed to get results,

MEDICATIONS:

Are you currently taking any prescription medications?

☐ Yes ☐ No Medications: ___________ Reason: _____________

Do any of you use herbal medications? ☐ Yes ☐ No if yes,

Have you ever taken any of the medications listed below?

☐ Clomiphene (Clomid,Serophene) ☐ Proxeed ☐ Testosterone
☐ Viagra

☐ 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):

☐ Undecesended testis ☐ Delay of puberty ☐ Anemia
☐ Arthritis ☐ Cancer

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

☐ High blood pressure ☐ vision problems ☐ Testicular tumor

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

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

Immunizations:

☐ Tetanus ☐ Hepatitis B ☐ German measles ☐ Polio ☐ Mumps
☐ Chicken Pox

☐ Hepatitis B or C

PAST SURGICAL HISTORY

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

If yes, please indicate date, type, 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 gain or loss in the last year? If so, please describe how many lbs

and over what time: ______________________

ALLERGIES TO MEDICATIONS

Are you allergic to any medication? ☐ Yes ☐ No

if yes, please indicate name of medication and type of reaction

Medication Reaction

__________ ________

__________ ________

(This information is for evaluation purposes only and will not be shared with anyone under normal conditions)