THE FERTILITY CENTER OF OREGON
Women's Care
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Eugene, Oregon 97401
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REPRODUCTIVE ENDOCRINOLOGY – INFERTILITY
FEMALE QUESTIONNAIRE

Name: ______________________ Preferred name: __________ Date of Birth: _______ Age: ___ Today's Date: ______

Primary Care Physician: _________________________ OB-GYN Physician: __________________________________

Who referred you to us for care: _____________________________

Main reason for visit (*in your own words*) ____

____

____

INFERTILITY

Have you been trying to get pregnant?

____ No *(go to the next section)*
____ Yes. Unprotected intercourse for ______ years / months *(please circle years or months)*

Have you done Basal body temperature charting? ___ Yes ___ No Biphasic temperature ___ Yes ___ No

Have you done LH monitoring? ___ Yes ___ No

Do you have positive (+) test? ___ Yes ___ No If yes, what day of cycle: _________

How have you timed intercourse? ____

Have you consulted another doctor about infertility?

____ No *(please go to the next section)*

____ Yes. Doctor's name, dates of treatment, and diagnosis:

____

____

Have you had any of these tests:

____ Hysterosalpingogram (X-ray of uterus and tubes)
Date _______ Result ____________________________
____ Laparoscopy (visual examination of pelvic organs through an instrument placed through the abdominal wall)
Date _______ Result ____
____ Endometrial biopsy (removal of samples of uterine lining)
Date _______ Result ____
____ Endocrine hormone laboratories
Date _______ Result ____

Have you had previous infertility treatments? *(check if yes)*

____ Infertility surgery
Date _______ Procedure ____
Date _______ Procedure ____
____ Artificial inseminations - Dates ____

____ Medical therapy

	Dose	# Months	Outcome
Metformin/Glucophage …………………………..			
Clomid …………………………………………..			
Letrozole ………………………………………..			
Gonadotropin (Pergonal / Repronex / Follistim / Poravella / Menopur) ………………………..			

____ IVF (In Vitro Fertilization)
Date ________ Outcome ___________________________
Date ________ Outcome ___________________________

Have you and your partner considered adoption? ____ No ____ Yes

Have you consulted an adoption agency? ____ No ____ Yes

Name of agency ____

How long have you been with your present partner? ________________

C. Have you attempted pregnancy with past partners?

____ No *(please go to next section)* ____ Yes

Any pregnancy? ____ No ____ Yes *(list in chart)*

Do you use contraception? ___ No ___Yes

If yes, years used ____ to ____ Type ______________________________

GYNECOLOGICAL HISTORY

First day of last normal menstrual period: _______________

How old were you when your menstrual period started: ________

Have you ever had irregular cycles? ____ No ____ Yes

What is the usual number of days from the start of one period to the start of the next: __________________

How many days do you flow: _____________

Flow is usually: ___ Light ___ Moderate ___ Heavy

Do you have any discomfort during your period (menstrual cramps)?

___ Never ___ Rarely ___ Usually *(If you checked "never", please skip to the next question)*

Onset: ____ years old
Severity: ____ severe *(have to stop usual activities)*
____ moderate
____ mild
Changes: ____ getting worse
____ about the same
____ getting better
Location: ____ midline lower abdomen
____ both sides lower abdomen
____ one side of abdomen
Timing: ____ starts before flow
____ starts on first day
____ starts on subsequent day

Have you ever had any of the following: *(Check if yes)*

Bleeding, staining, or spotting between periods _____
Bleeding or spotting after intercourse ____
Heavy bleeding, gushing, large clots (blood runs down leg, requires two pads at once) _____
Recent change in periods *(Please describe)* ____

Do you have PMS symptoms which generally interfere with normal activities: ____ No ____ Yes

What symptoms do you experience? ____

Have you ever had a Pap smear? ___ Yes ___ No

If yes, date: ____________ Doctor: __________________________________

Do you have a history of abnormal Pap smears? ____ Yes ____ No

If yes: Date _____________ Treatment ____

Have you ever had a mammogram? ____ Yes ____ No

If yes, date of last mammogram: ____________ Location: _______________________________________

Do have a history of abnormal mammogram? ____ Yes ____ No

Current method of birth control: ____

Have you ever had: *(check if yes and please tell us when)*

____ Chlamydia ____
____ Gonorrhea (clap, GC) ___________________________________
____ Infected tubes or ovaries _________________________________
____ Vaginal infections ______________________________________
____ Blood in urine ____
____ Infection of bladder or kidney ____________________________
____ Trouble starting to urinate _______________________________
____ Loss of urine with cough or sneeze ________________________
____ Any other problems with female organs: _____________________
____

Intercourse and contraception

Have you ever had sexual intercourse?

____ No (*please skip to the next section)*
____ Yes *(please continue this section)*

How often do you have sexual intercourse?

____ Times per day / week / month *(please circle one)*

Do you have orgasms (climax)? ____ No ____ Yes

If yes, how often?

____ Rarely or less than half the time
____ Usually or more than half the time
____ Almost always

Do you have any discomfort or pain with intercourse?

____ No ____ Yes *(please answer the following)*

Frequency: ____ Rarely or less than half the time
____ Usually or more than half the time
____ Almost always

Type: ____ Only with deep penetration
____ Both of the above
____ Persists after intercourse

Severity: ____ Mild ____ Moderate ____ Severe

Change: ____ Getting worse
____ Getting better
____ The same

Do you have a happy sex life? *(check one)* ____ great ____ good ____ fair ____ poor

Do use a lubricant? ____ No ____Yes

If yes, which one? ______________________________

Have you ever had any problems with any methods of contraception?
____ No ____ Yes *(please explain)* ____

Are you troubled by excessive hair growth? ___ No ___ Yes
If yes, please describe: ____

Do you have acne? ________

Have noticed hair loss from your scalp? ___ No ___ Yes
If yes, please describe: ____

PREGNANCY

A. Have you ever been pregnant? ___ No *(If no, please skip to the next section)*
___ Yes

Fill in the number of:
____ Term deliveries (baby weighed over 5½ pounds at birth and was born at least 37 weeks of pregnancy)
____ Premature deliveries (over 5 months pregnancy but baby weighed under 5½ pounds)
____ Miscarriages (before 5 months)
____ Abortions
____ Ectopic pregnancies
____ Children now living
____ Multiple gestations

B. If you have had any TERM or PREMATURE deliveries, please fill in this section *(Attach additional pages if needed)*

1. Delivery Date ____________ Weeks of pregnancy* _______________________
Length of labor __________ Type of anesthesia _______________ Delivery Type ______________________
Hospital ____
Boy or girl *(circle)* Weight (pounds, ounces) _____________
Any problems with delivery or pregnancy? ____

2. Delivery Date ____________ Weeks of pregnancy* _______________________
Length of labor __________ Type of anesthesia _______________ Delivery Type ______________________
Hospital ____
Boy or girl *(circle)* Weight (pounds, ounces) _____________
Any problems with delivery or pregnancy? ____

*Your due date was 40 weeks. If you delivered one week late, write 41. If you delivered three weeks early, write 37, etc.

C. If you have had any ABORTIONS or MISCARRIAGES, fill in this section

1. Month/Year ____________ Weeks of pregnancy* _______________________
Doctor's name ____
Hospitalized? ______________ D&C (scrape uterus) ____________

2. Month/Year ____________ Weeks of pregnancy* _______________________
   Doctor's name ____
   Hospitalized? ______________ D&C (scrape uterus) ____________

*Weeks between last normal menstrual period and termination of pregnancy.

MEDICAL HISTORY

Current medical problems: ____

Have you ever had any serious illnesses, injuries, or hospitalizations other than listed above: ________________________

Date __________ Problem ________________________ Treatment ____

Date __________ Problem ________________________ Treatment ____

SURGERIES

Date: ___________ **Procedure:** ____

___________ ____

___________ ____

___________ ____

MEDICATIONS

Med:_____________________________ **Dose:** __________________ **Prescriber:** _________________________

_____________________________ __________________ _________________________

_____________________________ __________________ _________________________

_____________________________ __________________ _________________________

ALLERGIES

Allergy to: _______________________ **Reaction:** ____

_______________________ ____

_______________________ ____

SOCIAL HISTORY

Occupation ___________________________________ Are you satisfied with your work? _________________________

Please check: ___ Single ___ Married ___ Same sex ___ Partnered ____ Widowed ___ Divorced

Partner's name: ______________________________ Years with current partner ____________

Do you smoke tobacco? ____ No ____ Yes *(if yes, please answer the following)*

If yes, how many packs per day _____ For how many years? ______

Previous tobacco use: Start date ___________ Quit date __________ Packs per day ______

Do you use any other tobacco products? ____ No ____ Yes

Do you drink alcohol? ____ No ____ Yes *(f yes, please answer the following)*

____ oz. liquor per *(circle one)* day / week / month

____ 12 oz. glasses beer per day / week / month

____ 6 oz. glasses wine per day / week / month

Have you ever used any non-prescription drugs such as: *(if yes, please indicate when last used)*

____ Marijuana ___________________________
____ LSD, STP, etc. _______________________
____ Heroin, etc. __________________________
____ Morphine, Demerol, etc. _______________
____ Barbiturates __________________________
____ Injected drug of any kind _______________

Have you ever been treated or diagnosed for anorexia or bulimia? ____ No ____ Yes

If yes, when ____

Have you ever been the victim of sexual, physical, or emotional abuse? ______________________________________

Hobbies / Activities? ____

FAMILY HISTORY

Please list any members of your family including parents, grandparents, brothers and sisters who have had significant medical problems (such as diabetes, high blood pressure, heart attack, cancer):

Relationship	Medical Problem
Maternal grandmother………………..	____________________________
Maternal grandfather ………………...	____________________________
Paternal grandmother ……………….	____________________________
Paternal grandfather …………………	____________________________
Mother …………………………………	____________________________
Father …………………………………	____________________________
Siblings: Brother / Sister *(please circle)*	____________________________
Brother / Sister	____________________________
Brother / Sister	____________________________
Children ……………………………….	____________________________

Has anyone in your immediate family or among grandparents, aunts, uncles and first cousins had any of the following diseases or problems? *(check if yes)*

____ Congenital abnormalities – i.e., any defects present at birth or any disorders which "run in the family"
____ Infertility – i.e., difficulty getting pregnant for any reason
____ Delayed puberty (didn't shave; didn't menstruate or develop breasts)
____ Breast, ovarian, or endometrial cancer
____ Frequent miscarriages

REVIEW OF SYSTEMS

Are you currently experiencing any of the following symptoms? *(Check if yes)*

_____ Weight change
_____ Fatigue
_____ Change in vision
_____ Difficulty swallowing
_____ Chest pain
_____ Racing or irregular heartbeat
_____ Fainting or blackout spells
_____ Shortness of breath
_____ Snoring
_____ Nausea
_____ Constipation
_____ Diarrhea
_____ Vomiting
_____ Urinary incontinence
_____ Vaginal discharge
_____ Vaginal odor
_____ Vaginal itching or irritation
_____ Pain with intercourse
_____ Irregular menstrual periods
_____ Heavy menstrual periods
_____ Neck or back pain
_____ Muscle aches or cramps
_____ Joint pain
_____ Acne
_____ Rash or skin lesion
_____ Headaches
_____ Numbness or tingling
_____ Dizziness
_____ Thoughts of Suicide
_____ Anxiety / Excessive worrying
_____ Depression
_____ Feeling excessive cold or warmth
_____ Unwanted hair growth
_____ Discharge from nipples
_____ Excessive bleeding or bruising
_____ Runny nose
_____ Sore throat
_____ Cough
_____ Pain. Location ______________________
_____ Other ______________________________