

Infertility Questionnaire

Date: _____

Please answer all questions thoroughly and accurately. Fee free to use a separate page, if you need additional room.

Patient name		Date of birth		Blood type	
Husband/Partner name		Date of birth		Blood type	
How long have you been trying to get pregnant?		_____ Years			
MENSTRUAL HISTORY					
Date of onset of your last menstrual period					
Date of onset of your previous menstrual period					
Recent change to cycle lengths					
Age when your first period started		How long do they usually last			
How many days occur between your menses, usually					
What is the average amount of flow (<6 or >6 pads or tampons per day)					
Do you have cramps with menses		<input type="checkbox"/> Yes		<input type="checkbox"/> No	
Cramps are:	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe (require pain meds and bed rest)		
BIRTH CONTROL INFORMATION					
Have you ever taken birth control pills?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	When?	
Difficulties with birth control pills?					
Have you ever had an intrauterine device (IUD)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	When?	
Difficulties with IUD?					
How often do you have intercourse?		_____ Week		_____ Month	
Do you use vaginal lubricants during intercourse?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
PREVIOUS PREGNANCIES INFORMATION					
Have you ever been pregnant before?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how many times?	
What were the outcomes of these pregnancies?					
# of deliveries _____		# of miscarriages _____		# of tubal pregnancies _____	
# of abortions _____					
PAST HISTORY (please check if any are applicable)					
<input type="checkbox"/> Acne problems	<input type="checkbox"/> Excessive hair growth	<input type="checkbox"/> Loss of libido			
<input type="checkbox"/> Anemia	<input type="checkbox"/> Excessive sweating	<input type="checkbox"/> Pain with intercourse			
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Excessive weight change	<input type="checkbox"/> Pelvic infections			
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Frequent headaches	<input type="checkbox"/> Polycystic ovarian syndrome			
<input type="checkbox"/> Breast masses	<input type="checkbox"/> Gallbladder disease	<input type="checkbox"/> Psychiatric			
<input type="checkbox"/> Breast secretions	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Seizures			
<input type="checkbox"/> Chronic cough	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Transfusion			
<input type="checkbox"/> Chronic pelvic pain	<input type="checkbox"/> Intolerance to hot or cold	<input type="checkbox"/> Ulcers			
<input type="checkbox"/> Colitis	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Loss of scalp hair			
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Endometriosis			

Have you ever had any type of pelvic surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when?
Results of surgery if known:	
Have you ever had surgery or treatments for an abnormal PAP smear? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, when and what type of treatment?	
Do you have any allergies to medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please list:	
Are you currently taking any medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Which ones?	

SOCIAL HISTORY		
Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of drinks per week	
Do you smoke cigarettes? <input type="checkbox"/> Yes <input type="checkbox"/> No	Packs per day	
Have you used addictive drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when did you quit?	
Do you exercise excessively? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you been exposed to any toxins? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Your height		Your weight	
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PREVIOUS INFERTILITY STUDIES		
Basal body temperatures <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, did they indicate ovulation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Hormone Blood testing? <input type="checkbox"/> Yes <input type="checkbox"/> No	When?	
Results if known:		
Day 3 FSH		
LH		
TSH		
T3		
T4		
Prolactin level		
Progesterone level		
Other:		
Urine ovulation prediction kits: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, did they indicate ovulation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has a post-coital test (PCT) been performed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Results if known:		
Has a hysterosalpingogram (X-ray of fallopian tubes) ever been performed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Results if known:		
Have you had an endometrial biopsy performed: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Results if known:		
Have you ever had a hysteroscopy? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Results if known:		
Have you ever had chromosomal studies performed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Results if known:		
Have you had other infertility studies performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please list:	

PREVIOUS INFERTILITY TREATMENT	
Clomiphene citrate (Clomid, Serophene) with timed intercourse	<input type="checkbox"/> Yes <input type="checkbox"/> No
Clomiphene citrate with intrauterine insemination	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gonadotropins (Pergonal, Metrodin, Repronex, Gonal F, Follistim) with timed intercourse	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gonadotropins with intrauterine insemination	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bromocriptine (Parlodel, Cabergolide)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Prednisone or Dexamethasone	<input type="checkbox"/> Yes <input type="checkbox"/> No
Metformin (Glucophage) or Troglitazon	<input type="checkbox"/> Yes <input type="checkbox"/> No
In vitro fertilization	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blastocyst transfer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Donor oocytes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gestational carrier	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please document in chronological order information regarding your treatment cycles. Please be detailed as possible.

#	Date	Location	Protocol (Clomid, FSH/IUI, IVF, etc)	Medication Dosage	# Follicles on Scan	# Eggs (if IVF)	# Fertilized	ICSI, AH?	# Transfer	Preg ?

Surgical History

Date	Location	Procedure	Findings

Medical History

Problem	Date Diagnosed	Treatment

FAMILY HISTORY	
Is there a history of breast, colon or ovarian cancer in your family?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please list:	
Any females with infertility problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please list:	
Any females with excessive hair growth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please list:	
Any females with ovarian cysts formation problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please list:	
Any females with a problem with uterine fibroids?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please list:	
Any males with infertility problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please list:	
Any chromosomal abnormalities in the family?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please list:	
Sibling or family history of infertility disorder (please check): <input type="checkbox"/> Endometriosis <input type="checkbox"/> Fibroids	
<input type="checkbox"/> Premature menopause <input type="checkbox"/> Miscarriage <input type="checkbox"/> Thyroid disease <input type="checkbox"/> Excess facial/body hair	

Do any diseases run in your family? Do any of your relatives suffer from a major illness?

	Check one		Comments
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you have allergies to any medications?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you currently taking any medication, vitamins or supplements and if so, what kind?			

MALE PARTNER DATA

Name: _____
Last
First
MI

Date of Birth: ____ / ____ / ____ Age: _____

Marriage #: _____

Number of pregnancies conceived with current partner: _____

Number of pregnancies conceived with previous partners: _____

Please give approximate dates and outcomes of any pregnancies conceived with a previous partner:

If you have had a semen analysis, please indicate date and results:

Date	Location of Analysis	Concentration (million/ml)	Motility (%)	Morphology (%)

Medical History

Problem	Date Diagnosed	Treatment

Surgical History

Date	Location	Procedure	Findings

Family History (Do any diseases run in your family? Do any of your relatives suffer from a major illness?)

	Check one		Comments
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Does anyone in your family have a history of birth defects?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you have a family history of recurrent pregnancy loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Additional Male Partner Information

	Check One		Comments
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you smoke cigarettes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, packs per day: <input type="text"/>
Do you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Average number of drinks per day <input type="text"/>
Do you use recreational drugs or steroids?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you have difficulties with erection?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you have difficulties with ejaculation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Are your genitals exposed to excessive heat?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Are you exposed to chemicals or toxins?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you had an injury to your genitals?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you had any infections of your penis or testicles?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you had an infection of your prostate gland?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you ever had a hernia operation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you had an undescended testicle as a child?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Are you allergic to any medications?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, which meds: <input type="text"/>
Do you currently take medications?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, which meds: <input type="text"/>

PREVIOUS DIAGNOSES WITH EXPECTATIONS

What has been your understanding of your previous diagnoses and expectations for successful treatment?
What is your expectation with our office?

Thank you for taking your time to fill out this form!

RIST Team