INFERTILITY PATIENT QUESTIONNAIRE

General Fertility History
1. What is your age? ___________________ What is your partner’s age? ___________________
2. How long have you been trying to get pregnant? ________________________________________
3. Have you been treated for infertility in the past? ________________________________________
   Have you had a HSG? __________ Lab work? __________ Were they normal? __________
   Were you ever treated with Clomid? ________ Femara? __________ Injectables? __________
4. How many times have you been pregnant? ________ # of deliveries ________ Miscarriages ________
6. Have you noticed any abnormal hair growth or hair loss/thinning of hair? _______________________
7. Have you had any breast discharge? __________ Acne? __________ Weight changes? __________

Menstrual History
1. When was the first day of your last period? ____________________________________________
2. Do you have a period every month? _________________________________________________
3. How many days do your periods last? __________ Are they heavy? __________________
4. Do you have painful periods? _______________________________________________________
5. Do you have bleeding between your periods? ___________________________________________

Sexual History
1. Does you or your partner have any problems during sexual intercourse? _______________________
2. Do you have significant pain during intercourse? _________________________________________
3. Do you experience bleeding after intercourse? __________________ Do you use lubricants? _________
5. Approximately how many times each month do you have intercourse? _________________________

Gynecological History
1. Have you been diagnosed or treated for endometriosis? _________________________________
2. Have you ever had a pelvic infection (PID, gonorrhea, chlamydia, trichomoniasis, genital herpes,
   syphilis)? _______________________________________________________________________
3. Have you ever had pelvic surgery? _____________________________________________________
4. Have you ever had an abnormal pap smear? _____________________________________________
5. Have you ever had a surgery on your cervix such as LEEP, cone biopsy, cryotherapy? _________
6. Have you ever been diagnosed with polycyclic ovaries (PCOS)? ___________________________

Medication/Dietary History
1. Do you take any prescription drugs, vitamins, dietary/herbal supplements? ___________________
2. When is the last time you took birth control pills, Mirena IUD, Depo Provera? _______________
3. Do you have any allergies? ___________________________________________________________

Male History
1. Has your partner ever fathered any children? ___________________________________________
2. Has your partner had a semen analysis? ________ Was it normal? _________________________
3. Does your partner take any medications/herbal supplements? _____________________________
4. What is your partner’s occupation? __________________________________ Has he ever had a genital injury? ______

Patient Signature ___________________________ Date ___________________