

FERTILITY QUESTIONNAIRE – WIFE

Name: _____ Date: ____/____/____

D.O.B. ____/____/____ Weight: _____ Height: _____

A. GENERAL INFORMATION:

- 1) How long have you been married?
- 2) How long have you been seeking a pregnancy?
- 3) Is this your first marriage? **Yes / No**
- 4) Do you have children from this marriage? **Yes / No**
How many children? _____ Adopted _____ Biological _____
- 5) Do you have children from previous marriage(s) or relationship? **Yes / No**
How many children? _____ Adopted _____ Biological _____

B. MENSTRUAL CYCLE:

- 1) What age were you when your menses started? _____
- 2) Are your menses regular? **Yes / No** Number of days in cycle? _____
- 3) How many days of flow do you have in an average period? _____
- 4) What was the date of your last menstrual period? ____/____/____
- 5) Do you have spotting prior to the onset of a brisk menstrual flow? **Yes / No**
- 6) Do you have pain with your menstrual flow? **Yes / No**
- 7) How do you decide that ovulation is occurring? _____
- 8) Do you have pain when ovulating? **Yes / No**
- 9) Do you have bleeding near ovulation? **Yes / No**
- 10) What is your frequency of intercourse near ovulation? _____
- 11) Have you taken your basal body temperature during a menstrual cycle(s)?

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C. INTERCOURSE:

- 1) How frequently do you have intercourse? _____
- 2) Do you use lubricants with intercourse? **Yes / No**
- 3) Do you use douches near intercourse? **Yes / No**
- 4) Do you have pain with intercourse? **Yes / No**

D. PREVIOUS PREGNANCIES:

- 1) How many times have you been pregnant? _____
Dates? _____
- 2) What was the outcome and how many?
____ live birth [____ full term (≥ 37 wks), ____ preterm (< 37 wks)]
____ stillborn ____ therapeutic abortion
____ ectopic pregnancy ____ spontaneous abortion (< 20 wks)
- 3) How long did it take to conceive in previous attempts at pregnancy?

E. CONTRACEPTION:

- 1) Have you previously used contraception? **Yes / No**
If yes, what form(s) of contraception?
() contraceptive pill () intrauterine device
() diaphragm () other
() condom
- 2) Surgical sterilization? **Yes / No** Date: _____

F. MEDICAL-SURGICAL:

- 1) Have you ever had surgery? **Yes / No**
Procedure Date Place

- 2) Have you recently lost or gained over 20 pounds? **Yes / No**
- 3) Do you exercise regularly? **Yes / No** If yes, how often and what type?
- 4) Do you follow any special dietary regimen? **Yes / No** If yes, what type?
- 5) Are you allergic to any medications? **Yes / No** If yes, please list:

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6) Do you use or have used:

a. Prescription drugs or medications? **Yes / No** If yes, please list:

b. Non-prescription drugs or medications? **Yes / No** If yes, please list:

c. Marijuana or other addictive drugs? **Yes / No**

d. Tobacco products? **Yes / No** If yes,

At least 100 cigarettes in your entire lifetime **Yes / No**

Smoked any cigarette in the last three months **Yes / No**

e. Alcoholic beverages? **Yes / No** If yes,

What? How much?

7) Do you have or ever had:

- | | | |
|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Allergies | <input type="checkbox"/> Auto Immune Disease |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Blood Product Transfusions |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Epilepsy Seizures |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Colitis | <input type="checkbox"/> Color Blindness |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Headache | <input type="checkbox"/> Excess Body or Facial Hair |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Breast Discharge |
| <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Hirsutism | <input type="checkbox"/> Intolerance to Heat or Cold |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Herpes | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Syphilis | <input type="checkbox"/> Urinary Tract Infection |
| <input type="checkbox"/> Ovarian Cysts | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Measles (Regular or German) |
| <input type="checkbox"/> Pelvic Infection | <input type="checkbox"/> Vaginitis | <input type="checkbox"/> Gall Bladder Problem |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Visual Problems | <input type="checkbox"/> Immunizations | <input type="checkbox"/> Poor Sense of Smell |
| <input type="checkbox"/> Excess Sweating | | |

G. PREVIOUS FERTILITY EVALUATION AND TREATMENT:

Have you had:

- | | |
|--|---|
| <input type="checkbox"/> Hysterosalpingogram | <input type="checkbox"/> Laparoscopy |
| <input type="checkbox"/> Cervical cauterization | <input type="checkbox"/> Hysteroscopy |
| or cervical laser surgery | <input type="checkbox"/> Dilatation and curettage |
| <input type="checkbox"/> Fallopian tube surgery | <input type="checkbox"/> Post coital examination |
| <input type="checkbox"/> Endometrial biopsy | <input type="checkbox"/> Ultrasound monitoring of ovulation |
| <input type="checkbox"/> Hormonal testing | <input type="checkbox"/> Insemination with husband semen |
| <input type="checkbox"/> Urinary LH testing | <input type="checkbox"/> Insemination with donor semen |
| <input type="checkbox"/> Chromosome studies | <input type="checkbox"/> Clomiphene cycles |
| <input type="checkbox"/> Gonadotropin (Repronex, Gonal-F, Follistim, Pergonal...) for follicle stimulation, how many cycles? _____ | |
| <input type="checkbox"/> Previous attempts with Assisted Reproductive Technology, how many? | |
| IVF _____ GIFT _____ ZIFT _____ | Frozen embryo transfers _____ |