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ADVANCED GYNECOLOGIC ENDOSCOPY

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FERTILITY QUESTIONNAIRE - WIFE

Name: _____ Age: _____ Date: _____

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?
- 4) Do you have children from this marriage?
If yes, how many children? Adopted _____ Biological _____
- 5) Do you have children from a previous marriage(s) or relationship?
If yes, how many children? Adopted _____ Biological _____

B. MENSTRUAL CYCLE

- 1) What age were you when menses started?
- 2) Are your menses regular? _____ Number of days in your 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) How do you decide that ovulation is occurring?
- 6) Do you have pain when ovulating?
- 7) Do you have bleeding near ovulation?
- 8) What is your frequency of intercourse near ovulation?
- 9) Do you have mid-cycle bleeding?
- 10) Do you have pain with your menstrual flow?
- 11) Do you have spotting prior to the onset of a brisk menstrual flow?
- 12) Have you taken your basal body temperature during a menstrual cycle?

C. INTERCOURSE

- 1) How frequently do you have intercourse?
- 2) Do you use lubricants with intercourse?
- 3) Do you use douches near intercourse?
- 4) Do you have pain with intercourse?

D. PREVIOUS PREGNANCIES

- 1) How many times have you been pregnant? _____
Dates?

- 2) What was the outcome?
 live birth therapeutic abortion
 ectopic pregnancy spontaneous abortion
 stillborn miscarriage

- 3) How long did it take to conceive in previous attempts at pregnancy?

E. CONTRACEPTION

- 1) Have you previously used contraception?

- 2) If yes, what form(s) of contraception?
 contraceptive pill intrauterine device
 diaphragm other
 condom

F. MEDICAL/SURGICAL

1. Have you ever had surgery?
If yes, Procedure Date Place

2. Have you recently lost or gained over 20 pounds?
3. Do you exercise regularly?
If yes, how often and what type?
4. Do you follow any special dietary regimen?
5. Are you allergic to any medications?
If yes, please list:
6. Do you take any herbal supplements or alternative medications?
If so, please list:

7) Do you use or have you used:

Prescription drugs or medications? If yes, please list:

Non-prescription drugs or medications? If yes, please list:

Marijuana or other drugs?

Tobacco products?

What?

How much?

Alcoholic beverages?

What?

How much?

8) Do you have or have you ever had:

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

G. PREVIOUS FERTILITY EVALUATION AND TREATMENT

1) Have you had:

- | | |
|--|---|
| <input type="checkbox"/> Hysterosalpingogram | <input type="checkbox"/> Laparoscopy |
| <input type="checkbox"/> Cervical Cauterization or Cautery Laser Surgery | <input type="checkbox"/> Hysteroscopy |
| <input type="checkbox"/> Fallopian Tube Surgery | <input type="checkbox"/> Dilatation and Curettage |
| <input type="checkbox"/> Post Coital Examination | <input type="checkbox"/> Ultrasound Monitoring of Ovulation |
| <input type="checkbox"/> Urinary LH Testing | <input type="checkbox"/> Endometrial Biopsy |
| <input type="checkbox"/> Medication for Fertility Treatment | <input type="checkbox"/> Insemination with Husband Semen |
| <input type="checkbox"/> Chromosome Studies | <input type="checkbox"/> Insemination with Donor Semen |
| <input type="checkbox"/> Hormonal Testing | |
| <input type="checkbox"/> Previous Attempts with Assisted Reproductive Technology <input type="checkbox"/> GIFT <input type="checkbox"/> IVF <input type="checkbox"/> TET <input type="checkbox"/> ZIFT | |