



Atlantic Assisted Reproductive Therapies  
 Suite 213, 1535 Dresden Row  
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## INFERTILITY QUESTIONNAIRE (FEMALE)

Date: \_\_\_\_\_  
 Day/Month/Year

This is a **confidential document** which will only be used for your treatment. If there are any questions you are unable to answer, leave those blank and we will assist you in the clinic. If there is not enough space for your answers, please add further information at the end.

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Referred by Doctor(s): 1) \_\_\_\_\_ 2) \_\_\_\_\_  
 (Family Doctor) (Specialist)

Date of Birth: \_\_\_\_\_ HCN: \_\_\_\_\_

Occupation: \_\_\_\_\_

Husband/Partner's Name: \_\_\_\_\_

How long have you been married or living with your present partner? \_\_\_ years and \_\_\_ months

How long have you been trying to have a baby? \_\_\_\_\_ years and \_\_\_\_\_ months

Have you ever been pregnant?: Yes / No

If Yes, give dates and details for the outcome of each pregnancy. (e.g., normal delivery, caesarean section, miscarriage, abortion, etc.)

Pregnancy Number	Date: M/Y	Duration (Weeks)	Outcome	Surgery (If any)	Complications	Present Health

**INFERTILITY QUESTIONNAIRE (FEMALE)**

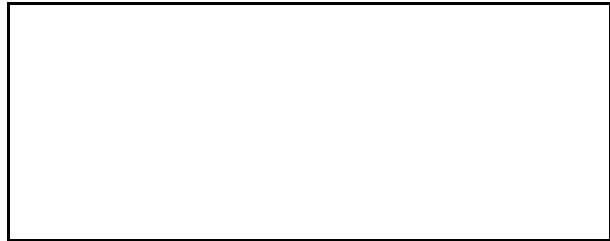
**Menstrual History:**

- A. How old were you when you had your first period? \_\_\_\_\_
- B. How old were you when you started having breast and pubic hair development? \_\_\_\_\_
- C. As a teenager, were your periods regular? \_\_\_\_\_
- D. On what date did your last period start? \_\_\_\_\_
- E. How many days do you usually flow with a period? \_\_\_\_\_
- F. How long are your menstrual cycles? (i.e., how many days from the first day of one period to the first day of your next period) \_\_\_\_\_ days.

Do you notice any of the following either with your period or at certain times of the cycle?

- G. Do you experience cramps with your period? Yes / No If Yes, what, if anything do you take for them? \_\_\_\_\_
- H. Bloating, water retention, or weight gain? Yes / No
- I. Bleeding or spotting between periods? Yes / No  
If Yes, please explain: \_\_\_\_\_
- J. Any increase in vaginal mucous discharge between menstrual periods (around the time of ovulation)? Yes / No
- K. Breast changes? Yes / No
- L. Emotional changes? Yes / No
- M. Any cramping between periods around the expected time of ovulation? Yes / No  
If Yes, please explain: \_\_\_\_\_
- N. Have you had any periods that have been either very light or any periods that you have missed completely? Yes / No  
If Yes, please explain: \_\_\_\_\_

**Contraception:**



What birth control measures have you ever used:

A. The "Pill" Yes / No  
If Yes, from: \_\_\_\_\_ to \_\_\_\_\_  
If Yes, did you have any problems while using the "Pill"?

\_\_\_\_\_

B. An IUD: Yes / No If Yes, from: \_\_\_\_\_ to \_\_\_\_\_  
If Yes, did you have any problems while using the IUD?

\_\_\_\_\_

C. Diaphragm: Yes / No If Yes, from: \_\_\_\_\_ to \_\_\_\_\_

D. Tubal Ligation: Yes / No If Yes, from: \_\_\_\_\_ to \_\_\_\_\_

Where: \_\_\_\_\_ Doctor: \_\_\_\_\_

Have you had the tubal ligation reversed? Yes / No If Yes, when? \_\_\_\_\_

Any other comments in this section: \_\_\_\_\_

\_\_\_\_\_

**Infertility/Sexual History:**

A. Have you had any investigative procedure(s) in regard to your fertility? Yes / No  
If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

B. Approximately how often do you have intercourse per week? \_\_\_\_\_

Do you use any creams or lubricants? Yes / No

Do you experience any discomfort with intercourse? Yes / No

If Yes, please describe: \_\_\_\_\_

C. Have you ever had a pelvic infection (of the tubes or ovaries)? Yes / No If Yes, When?

\_\_\_\_\_

D. Have you ever had a sexually transmitted (venereal) disease? Yes / No If Yes, When?

\_\_\_\_\_

**I**  
**Infertility/Sexual History** (Continued from Page 3)

- E. Do you have many vaginal, kidney, or bladder infections? Yes / No
- F. Do you ever notice any discharge from your breasts? Yes / No
- G. Do you have abnormal hair growth or acne? Yes / No
- H. When was your last cervical (Pap) smear? \_\_\_\_\_ Was it normal? Yes / No
- I. Have you ever had an abnormal Pap smear? Yes / No  
If Yes, was it treated? Yes / No      When: \_\_\_\_\_ Doctor: \_\_\_\_\_

**Medical History:**

- A. Do you have or have you suffered any of the following:

Diabetes	Yes / No
Heart Disease	Yes / No
Chest Disease	Yes / No
Thyroid problems	Yes / No
Rheumatic fever	Yes / No
Tuberculosis	Yes / No

- B. Do you have any other medical conditions you think we should be aware of? Yes / No  
If Yes, please explain: \_\_\_\_\_

- C. Have you ever had surgery?                      Yes / No                      If Yes, please give details:

Date	Hospital	Surgeon	Procedure

- D. What is your height? \_\_\_\_\_ What is your weight? \_\_\_\_\_  
Has your weight been stable over the past 2 years? Yes / No  
If No, please explain: \_\_\_\_\_
- E. Are you on any medications? Yes / No    If yes, please indicate which drug (s) and the frequency with which you take them \_\_\_\_\_

**Medical History:** (Continued from Page 4)

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F. Do you have any allergies? Yes / No  
If Yes, please describe:

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G. Do you smoke? Yes / No      If Yes, how many per day \_\_\_\_\_ per week \_\_\_\_\_

H. Do you drink alcohol? Yes / No      If Yes, how much per day \_\_\_\_\_ per week \_\_\_\_\_

I. Do you use any street drugs? Yes / No

**Family History:**

A.

	<b>Ages(s)</b>	<b>Health Status</b>
Father		
Mother		
Brothers		
Sisters		

B. Do you know if anyone else in your family has had difficulty getting pregnant? Yes / No

If Yes, please explain: \_\_\_\_\_

C. Have any immediate family members suffered from the following?

<b>Disease</b>	<b>Yes / No</b>	<b>Details</b>
Diabetes		
Thyroid Disease		
Heart Disease		
Mental Illness		
High Blood Pressure		
Cancer		
Other		

**Family History** (*Continued from Page 5*)

**D.** Has anyone in your family given birth to an abnormal child?

If yes, please explain: \_\_\_\_\_

Please use this space for any additional information which you feel may help us.

Information completed by: \_\_\_\_\_

Date: \_\_\_\_\_