Kliniek **SINT–JAN**
Clinique **SAINT–JEAN**

Questionnaire fertility

PERSONAL DETAILS PATIENT

Surname ____

First name ____

Date of birth ____

Address ____

Postal code ____

City ____

Country ____

Language ____

Mobile phone ____

e-mail ____

Occupation ____

RRN ____

CONTACT DETAILS REGULAR GYNAECOLOGIST

Surname ____

First name ____

Address ____

Postal code ____

City ____

Country ____

Language ____

Phone number ____

SUMMARY OF THE ASSISTANCE YOU ARE SPECIFICALLY REQUESTING

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PATIENT DETAILS

1. Family history

Anyone in family with?	No	Yes	
Breast cancer	☐	☐	____________
Ovarian cancer	☐	☐	____________
Congenital anomaly	☐	☐	____________
Hereditary illness	☐	☐	____________

Others/ remarks ____________

2. Surgical history

Have you ever had surgery? ☐ no ☐ yes

If yes, what year and what type of surgery? ____________

____

3. Medical history

Have you ever been seriously ill? ☐ no ☐ yes

If yes, what year and which illness? ____________

____

Are you known with a chronic condition? ☐ no ☐ yes

If yes, which condition and do you have regular follow-up consultations with a physician? ____________

____

4. Gynaecological history

At what age did you have your first period? ____________ years old

Have you ever had a gynaecological problem? ☐ no ☐ yes

If yes, which problem and when? ____________

____

Have you ever undergone gynaecological surgery? ☐ no ☐ yes

If yes, what year and type of surgery? ____

____

Are you known with endometriosis? ☐ no ☐ yes

Do you have a regular period? ☐ no ☐ yes

What is the timespan from one bleeding to the next bleeding?

minimum ______________ days/ maximum _____________ days

How long does your menstrual bleeding last? ________________ days

How much blood loss do you have during your period?

☐ not much ☐ normal amount ☐ heavy bleeding

Do you experience abdominal cramps during your period? ☐ no ☐ yes

☐ mild ☐ moderate ☐ severe

Do you experience pain during sexual intercourse? ☐ no ☐ yes

5. Obstetric history

Have you ever been pregnant before? ☐ no ☐ yes

If you've never been pregnant, go to page 6: allergies and risk factors

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How many times (miscarriages and terminations included) have you been pregnant?

Pregnancy	Year	Fertility treatment	Pregnancy evolution
1e		☐ yes ☐ no	☐ life birth ☐ miscarriage ☐ ectopic pregnancy ☐ termination ☐ stillborn
2e		☐ yes ☐ no	☐ life birth ☐ miscarriage ☐ ectopic pregnancy ☐ termination ☐ stillborn
3e		☐ yes ☐ no	☐ life birth ☐ miscarriage ☐ ectopic pregnancy ☐ termination ☐ stillborn
4e		☐ yes ☐ no	☐ life birth ☐ miscarriage ☐ ectopic pregnancy ☐ termination ☐ stillborn
5e		☐ yes ☐ no	☐ life birth ☐ miscarriage ☐ ectopic pregnancy ☐ termination ☐ stillborn

Did you have complications during your pregnancy? ☐ no ☐ yes

If yes, which? ______________________________

____

Did you have problems during the delivery? ☐ no ☐ yes

If yes, which? ______________________________

____

Did you have problems after the delivery of your child? ☐ no ☐ yes

If yes, which? ______________________________

____

Did you breastfeed? ☐ no ☐ yes

If a pregnancy ended in a miscarriage, please complete the following

miscarriage	year	Weeks pregnant	Intra-uterine pregnancy	Cardiac activity	Evolution
1e			☐ yes ☐ no	☐ yes ☐ no	☐ spontaneous ☐ medication ☐ D&C (curettage)
2e			☐ yes ☐ no	☐ yes ☐ no	☐ spontaneous ☐ medication ☐ D&C (curettage)
3e			☐ yes ☐ no	☐ yes ☐ no	☐ spontaneous ☐ medication ☐ D&C (curettage)
4e			☐ yes ☐ no	☐ yes ☐ no	☐ spontaneous ☐ medication ☐ D&C (curettage)
5e			☐ yes ☐ no	☐ yes ☐ no	☐ spontaneous ☐ medication ☐ D&C (curettage)

6. Allergies and risk factors

Current weight: ______________ kg Length: ______________ cm

Do you smoke? ☐ yes ☐ no If yes, number of cigarettes/day ______________

Do you drink alcohol? ☐ yes ☐ no If yes, number of units/day ______________

Do you use drugs? ☐ yes ☐ no If yes, which? ______________

Do you have allergies? ☐ no ☐ yes

If yes, which? ______________________________

Do you use medication? ☐ no ☐ yes

If yes, which? ____

____

Do you take folic acid? ☐ no ☐ yes

7. <u>Previous fertility treatments</u>

Have you undergone any fertility treatment? ☐ no ☐ yes

If yes, which?

- ☐ ovulation – induction — If yes, number of cycles ______________
- ☐ intra-uterine inseminations — If yes, number of cycles ______________
- ☐ IVF/ ICSI treatment — If yes, number of cycles ______________
- ☐ cryopreservation oocytes — If yes, number of cycles ______________