



Questionnaire fertility

PERSONAL DETAILS PATIENT

Surname _____

First name _____

Date of birth _____

Address _____

Postal code _____

City _____

Country _____

Language _____

Mobile phone _____

e-mail _____

Occupation _____

RRN _____

PERSONAL DETAILS PARTNER

Surname _____

Firstname _____

Date of birth _____

Address _____

Postal code _____

City _____

Country _____

Language _____

Mobile phone _____

e-mail _____

Occupation _____

RRN _____



CONTACT DETAILS CURRENT GYNAECOLOGIST

Surname _____

First name _____

Address _____

Postal code _____

City _____

Country _____

Language _____

Phone number _____

SUMMARY OF THE ASSISTANCE YOU ARE SPECIFICALLY REQUESTING

COUPLE DETAILS

Civil state: married since _____ living together _____

Duration relationship? _____

Childwish since? _____



DETAILS FEMALE

1. Family history

Anyone in family with?	No	Yes	
Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ovarian cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Congenital anomaly	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hereditary illness	<input type="checkbox"/>	<input type="checkbox"/>	_____

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



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

Pregnancy	Year	Fertility treatment	Pregnancy evolution	Partner
1 ^e		<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> life birth <input type="checkbox"/> miscarriage <input type="checkbox"/> ectopic pregnancy <input type="checkbox"/> termination <input type="checkbox"/> stillborn	<input type="checkbox"/> current partner <input type="checkbox"/> previous partner
2 ^e		<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> life birth <input type="checkbox"/> miscarriage <input type="checkbox"/> ectopic pregnancy <input type="checkbox"/> termination <input type="checkbox"/> stillborn	<input type="checkbox"/> current partner <input type="checkbox"/> previous partner
3 ^e		<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> life birth <input type="checkbox"/> miscarriage <input type="checkbox"/> ectopic pregnancy <input type="checkbox"/> termination <input type="checkbox"/> stillborn	<input type="checkbox"/> current partner <input type="checkbox"/> previous partner
4 ^e		<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> life birth <input type="checkbox"/> miscarriage <input type="checkbox"/> ectopic pregnancy <input type="checkbox"/> termination <input type="checkbox"/> stillborn	<input type="checkbox"/> current partner <input type="checkbox"/> previous partner
5 ^e		<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> life birth <input type="checkbox"/> miscarriage <input type="checkbox"/> ectopic pregnancy <input type="checkbox"/> termination <input type="checkbox"/> stillborn	<input type="checkbox"/> current partner <input type="checkbox"/> previous partner

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
1 ^e			<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> spontaneous <input type="checkbox"/> medication <input type="checkbox"/> D&C (curettage)
2 ^e			<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> spontaneous <input type="checkbox"/> medication <input type="checkbox"/> D&C (curettage)
3 ^e			<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> spontaneous <input type="checkbox"/> medication <input type="checkbox"/> D&C (curettage)
4 ^e			<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> spontaneous <input type="checkbox"/> medication <input type="checkbox"/> D&C (curettage)
5 ^e			<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> spontaneous <input type="checkbox"/> medication <input type="checkbox"/> 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. Previous fertility treatments

Have you undergone any fertility treatment? no yes

If yes, which?

- | | |
|--|--------------------------------|
| <input type="checkbox"/> ovulation – induction | If yes, number of cycles _____ |
| <input type="checkbox"/> intra-uterine inseminations | If yes, number of cycles _____ |
| <input type="checkbox"/> IVF/ ICSI treatment | If yes, number of cycles _____ |
| <input type="checkbox"/> cryopreservation oocytes | If yes, number of cycles _____ |



DETAILS MALE

1. Family history

People in the family with?	No	Yes	
Congenital anomaly	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hereditary illness	<input type="checkbox"/>	<input type="checkbox"/>	_____
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. Andrological history

Have you ever undergone surgery on the penis or testicles? no yes

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

Do you have erectile dysfunction or ejaculation problems? no yes

