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 ______________________________

PERSONAL DETAILS PARTNER

Surname ______________________________

First name ______________________________

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

DETAILS COUPLE

Civil state: ☐ married since ______________ ☐ living together ______________

Duration relationship ? ______________________________

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

DETAILS PATIENT

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. <u>Obstetric history</u>

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
1e		☐ yes ☐ no	☐ life birth ☐ miscarriage ☐ ectopic pregnancy ☐ termination ☐ stillborn	☐ current partner ☐ previous partner
2e		☐ yes ☐ no	☐ life birth ☐ miscarriage ☐ ectopic pregnancy ☐ termination ☐ stillborn	☐ current partner ☐ previous partner
3e		☐ yes ☐ no	☐ life birth ☐ miscarriage ☐ ectopic pregnancy ☐ termination ☐ stillborn	☐ current partner ☐ previous partner
4e		☐ yes ☐ no	☐ life birth ☐ miscarriage ☐ ectopic pregnancy ☐ termination ☐ stillborn	☐ current partner ☐ previous partner
5e		☐ yes ☐ no	☐ life birth ☐ miscarriage ☐ ectopic pregnancy ☐ termination ☐ stillborn	☐ current partner ☐ 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
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. Previous fertility treatments

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 ____________

DETAILS PARTNER

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? ______________________________

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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? ______________________________

5. Obstetric history

Have you ever been pregnant before? ☐ no ☐ yes

If yes, how many children do you have? ____________________

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? ____________________

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☐	cryopreservation oocytes	If yes, number of cycles __________