



FERTILITY / ENDOMETRIOSIS QUESTIONNAIRE

Please fill in this questionnaire and send it back to us as soon as possible.

If not applicable, please skip the questions on fertility.

FEMALE PATIENTS PERSONAL DETAILS

Surname:

First name:

Date of birth:

Address:

Postcode:

City:

Country:

Language:

Tel.:

Mobile phone:

Email:

Occupation:

PARTNERS PERSONAL DETAILS

Surname:

First name:

Date of birth:

Address:

Postcode:

City:

Country:

Language:

Tel.:

Mobile phone:

Email:

Occupation:





COUPLES DETAILS

Marital status: married since living together since

Length of your relationship:

Trying to have children since:

FEMALE PATIENTS DATA

Blood group: (Your blood group card will be requested at the consultation.)

FAMILY HISTORY

Do you have any brothers and/or sisters? no yes, brothers and/or..... sisters

Is there anyone in your family of origin with:	No	Yes	If yes, specify:
Breast cancer	<input type="radio"/>	<input type="radio"/>
Colon cancer	<input type="radio"/>	<input type="radio"/>
Lung cancer	<input type="radio"/>	<input type="radio"/>
Skin cancer	<input type="radio"/>	<input type="radio"/>
Ovarian cancer	<input type="radio"/>	<input type="radio"/>
Prostate cancer	<input type="radio"/>	<input type="radio"/>
Uterine cancer	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>
Thrombosis (blood clot in a major blood vessel)	<input type="radio"/>	<input type="radio"/>
Endometriosis	<input type="radio"/>	<input type="radio"/>
Double uterus or uterine septum	<input type="radio"/>	<input type="radio"/>
Menopause before the age of 46	<input type="radio"/>	<input type="radio"/>

MEDICAL HISTORY - FEMALE

Have you ever been seriously ill? no yes

If yes, give the name of the disease and state whether you are still being monitored by a physician:

.....



Do you suffer from one or more of the following conditions?

	No	Yes
Asthma	<input type="radio"/>	<input type="radio"/>
Chronic fatigue syndrome	<input type="radio"/>	<input type="radio"/>
Deafness or impaired hearing in one or both ears	<input type="radio"/>	<input type="radio"/>
Depression	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>
Eczema	<input type="radio"/>	<input type="radio"/>
Fibromyalgia	<input type="radio"/>	<input type="radio"/>
Glandular fever	<input type="radio"/>	<input type="radio"/>
Thyroiditis (Hashimoto disease)	<input type="radio"/>	<input type="radio"/>
Migraine	<input type="radio"/>	<input type="radio"/>
Multiple sclerosis	<input type="radio"/>	<input type="radio"/>
Pyloric stenosis	<input type="radio"/>	<input type="radio"/>
Rheumatoid arthritis	<input type="radio"/>	<input type="radio"/>
Scoliosis (sideways curvature of the spinal column)	<input type="radio"/>	<input type="radio"/>
Other back problems	<input type="radio"/>	<input type="radio"/>
Chronic inflammation of tear ducts & salivary glands (Sjörger's syndrome)	<input type="radio"/>	<input type="radio"/>
Thyroid problems	<input type="radio"/>	<input type="radio"/>
Heart conditions; if yes, please specify:	<input type="radio"/>	<input type="radio"/>
Lupus erythematoses	<input type="radio"/>	<input type="radio"/>
Crohn's disease	<input type="radio"/>	<input type="radio"/>
Inflammation of the colon (ulcerative colitis)	<input type="radio"/>	<input type="radio"/>
Irritable bowel syndrome	<input type="radio"/>	<input type="radio"/>
Other (specify):		

.....

Are you allergic to any medication (e.g. antibiotics), latex or disinfectants?

no yes - specify:

Have you ever had gynaecological problems?

no yes - specify:

Do you have (or have you ever had) cancer?

no yes - specify:

GYNAECOLOGICAL HISTORY

At what age was your first period? years

Do you have any abnormalities of the uterus or cervix? no yes

If yes, have you ever had surgery for this problem? no yes

Do you have endometriosis? no yes

If yes, have you ever had surgery for this problem? no yes





SURGICAL HISTORY

Have you ever had surgery? no yes

If yes, state the year and name of the operation:

Have you ever had a gynaecological surgery? no yes

If yes, state the year, the nature of the operation and the name of the gynaecologist who performed it:

.....

FERTILITY HISTORY

Are you currently taking folic acid? no yes

Have you been trying to get pregnant for more than one year? no yes

Have you ever undergone tests to ascertain the cause of decreased fertility?

no yes

LIFESTYLE

Have you smoked more than 100 cigarettes during your life? no yes

If yes, at what age did you start smoking? years

If yes, are you currently smoking? no yes





OBSTETRIC HISTORY

If you don't have an obstetric history, please go to the section 'Details of previous fertility treatments'.

How many pregnancies (including miscarriages or terminations) have you already had?

Pregnancy	When (year)	Infertility treatment needed for this pregnancy?	Time taken to get pregnant	Outcome of pregnancy	Weight at birth
1 st		<input type="radio"/> no <input type="radio"/> yes		<input type="radio"/> live birth <input type="radio"/> miscarriage <input type="radio"/> ectopic pregnancy <input type="radio"/> termination <input type="radio"/> still born	
2 nd		<input type="radio"/> no <input type="radio"/> yes		<input type="radio"/> live birth <input type="radio"/> miscarriage <input type="radio"/> ectopic pregnancy <input type="radio"/> termination <input type="radio"/> still born	
3 rd		<input type="radio"/> no <input type="radio"/> yes		<input type="radio"/> live birth <input type="radio"/> miscarriage <input type="radio"/> ectopic pregnancy <input type="radio"/> termination <input type="radio"/> still born	
4 th		<input type="radio"/> no <input type="radio"/> yes		<input type="radio"/> live birth <input type="radio"/> miscarriage <input type="radio"/> ectopic pregnancy <input type="radio"/> termination <input type="radio"/> still born	
5 th		<input type="radio"/> no <input type="radio"/> yes		<input type="radio"/> live birth <input type="radio"/> miscarriage <input type="radio"/> ectopic pregnancy <input type="radio"/> termination <input type="radio"/> still born	

Did you have any problems during your pregnancy/pregnancies? no yes

If yes, specify the problems and during which pregnancy

Did you have any problems after giving birth? no yes

If yes, specify:

Did your child/children have any problems after birth? no yes

If yes, specify:





Did you breastfeed? no yes

If a pregnancy ended in a miscarriage, please fill in the table below.

<i>Pregnancy</i>	<i>Year</i>	<i>Number of weeks</i>	<i>Presence of amniotic sac</i>	<i>Presence of fetal heartbeat</i>
1 st miscarriage			<input type="radio"/> no <input type="radio"/> yes	<input type="radio"/> no <input type="radio"/> yes
2 nd miscarriage			<input type="radio"/> no <input type="radio"/> yes	<input type="radio"/> no <input type="radio"/> yes
3 rd miscarriage			<input type="radio"/> no <input type="radio"/> yes	<input type="radio"/> no <input type="radio"/> yes
4 th miscarriage			<input type="radio"/> no <input type="radio"/> yes	<input type="radio"/> no <input type="radio"/> yes
5 th miscarriage			<input type="radio"/> no <input type="radio"/> yes	<input type="radio"/> no <input type="radio"/> yes

DETAILS OF PREVIOUS FERTILITY TREATMENTS

Have you ever been treated for decreased fertility? no yes

If so, who was your doctor?

Have you ever had a treatment to induce ovulation? no yes

If yes, please provide more information below and fill in the table.

How many cycles?

<i>Cycle</i>	<i>Medication (*)</i>	<i>Dose (**)</i>	<i>Ovulation</i>	<i>Result (***)</i>
1 st			<input type="radio"/> no <input type="radio"/> yes	
2 nd			<input type="radio"/> no <input type="radio"/> yes	
3 rd			<input type="radio"/> no <input type="radio"/> yes	
4 th			<input type="radio"/> no <input type="radio"/> yes	
5 th			<input type="radio"/> no <input type="radio"/> yes	
6 th			<input type="radio"/> no <input type="radio"/> yes	

(*) (**) (***) see options on next page



(*) Medication: Gonal-F, Puregon, Menopur, Clomid, Pergotime, Pregnyl, other (specify)

(**) Dose: state number of tablets/ampoules per day

(***) Choose one of the following options:

- 1= not pregnant
- 2= pregnancy hormone increased in blood or urine, but followed by very early miscarriage
- 3= miscarriage
- 4= ectopic pregnancy
- 5= pregnancy & birth

Have you ever had artificial insemination?

no yes

If yes, please provide more information below and fill in the table.

How many cycles?

Cycle	Medication (*)	Dose (**)	Insemination	Sperm	Result (***)
1 st			<input type="radio"/> no <input type="radio"/> yes	<input type="radio"/> partner <input type="radio"/> donor	
2 nd			<input type="radio"/> no <input type="radio"/> yes	<input type="radio"/> partner <input type="radio"/> donor	
3 rd			<input type="radio"/> no <input type="radio"/> yes	<input type="radio"/> partner <input type="radio"/> donor	
4 th			<input type="radio"/> no <input type="radio"/> yes	<input type="radio"/> partner <input type="radio"/> donor	
5 th			<input type="radio"/> no <input type="radio"/> yes	<input type="radio"/> partner <input type="radio"/> donor	
6 th			<input type="radio"/> no <input type="radio"/> yes	<input type="radio"/> partner <input type="radio"/> donor	

(*) Medication: Gonal-F, Puregon, Menopur, Clomid, Pergotime, Pregnyl, other (specify)

(**) Dose: state number of tablets/ampoules per day

(***) Choose one of the following options:

- 1= not pregnant
- 2= pregnancy hormone increased in blood or urine, but followed by very early miscarriage
- 3= miscarriage
- 4= ectopic pregnancy
- 5= pregnancy & birth



Have you ever had an attempt at IVF or ICSI?

no

yes

If yes, please provide more information below and fill in the table.

When?

Where?

How many fresh cycles (=cycles with egg aspiration)?

How many thaw cycles (=cycles where frozen embryos are used)?

<i>Cycle</i>	<i>Medication (*)</i>	<i>Initial medication dose (Menopur, Gonal-F or Puregon) (**)</i>	<i>Number of eggs at aspiration</i>	<i>IVF/ICSI</i>	<i>Number of fertilised eggs</i>	<i>Day of embryo transfer (after aspiration)</i>	<i>Number of embryos transferred</i>	<i>Number of embryos frozen</i>	<i>Result (***)</i>
1 st				<input type="radio"/> IVF <input type="radio"/> ICSI					
2 nd				<input type="radio"/> IVF <input type="radio"/> ICSI					
3 rd				<input type="radio"/> IVF <input type="radio"/> ICSI					
4 th				<input type="radio"/> IVF <input type="radio"/> ICSI					
5 th				<input type="radio"/> IVF <input type="radio"/> ICSI					
6 th				<input type="radio"/> IVF <input type="radio"/> ICSI					

(*) (**) (***) see options on next page



(*) Medication: Suprefect, Decapeptyl, Cetrotide, Orgalutran, Gonal-F, Puregon, Menopur, Pregnyl, other (specify)

(**) Dose: state number of units per day

(***) Choose one of the following options:

- 1= not pregnant
- 2= pregnancy hormone increased in blood or urine, but followed by very early miscarriage
- 3= miscarriage
- 4= ectopic pregnancy
- 5= pregnancy & birth

CURRENT PERSONAL SITUATION

Are you taking medication? no yes

If yes, specify the medication and dose:

Do you drink alcohol? no occasionally yes

If yes, how many glasses a day?

Do you use or have you used soft or hard drugs? no yes

If yes, specify:

Are you exposed to toxic substances? no yes

If yes, specify:

Do you work in unusual conditions? no yes

How much do you weigh?..... kg

How tall are you? cm

CYCLE INFORMATION

When was your last period?/...../.....

Are your periods regular? no yes

What is the time span (in days) from one bleeding to the next?

Minimumdays /maximumdays

How long does your menstrual bleeding (= number of days of bright red blood loss) last?

How much blood do you lose during your period?

not much normal amount a lot, with clots a very large quantity, with clots



- Do you experience abdominal cramps during your period?** no yes
- If yes, are these cramps: mild moderate severe very severe
- How many times a week do you have intercourse?** no yes
- Do you take into account your fertile period?** no yes
- Do you experience any difficulties during intercourse?** no yes
- Do you experience pain during intercourse?** no yes
- Do you sometimes have blood loss in between periods?** no yes
- Do you experience abdominal cramps other than during your period?** no yes
- Do you have painful bowel movements during your period?** no yes
- Do you sometimes have blood in your stool?** no yes
- Do you suffer from constipation?** no yes
- Do you suffer from diarrhoea?** no yes
- Do you find it painful urinating during menstrual bleeding?** no yes
- Do you sometimes have blood in your urine?** no yes
- Do you suffer from abnormal vaginal secretion?** no yes
- Do you suffer from vaginal itching?** no yes
- Do you suffer from excessive hair growth on your legs, arms or face?** no yes
- Do you suffer from hot flushes or night sweats?** no yes
- Do you suffer from abdominal pain constantly (almost daily, including outside your period)?**
 no yes
- Do you suffer from fatigue?** no yes



MALE PARTNERS DETAILS (IF APPLICABLE)

Blood group type: (Your blood group card will be requested at the consultation.)

FAMILY HISTORY

Is there anyone in your family with:	No	Yes	If yes, specify:
Congenital abnormalities	<input type="radio"/>	<input type="radio"/>
Known hereditary disorders	<input type="radio"/>	<input type="radio"/>
Fertility problems	<input type="radio"/>	<input type="radio"/>
Psychological problems (depression, schizophrenia, etc.)	<input type="radio"/>	<input type="radio"/>
Other problems not mentioned above	<input type="radio"/>	<input type="radio"/>

MEDICAL HISTORY

Have you ever been seriously ill? no yes

If yes, give the name of the disease and state whether you are still being monitored by a doctor for it:

.....

Have you ever had depression or taken antidepressants? no yes

If yes, specify when, and whether you are still being monitored by a doctor for this:

.....

Are you allergic to medication (e.g. antibiotics), latex or disinfectants?

no yes - specify:

Have you ever had problems in your testicles or penis?

no yes - specify:

Have you ever had problems with getting or maintaining an erection? no yes

Have you ever had problems with ejaculation? no yes

Have you ever had surgery? no yes

If yes, state the year and name of the operation:

Have you ever had an operation on your testicles or penis? no yes

If yes, state the year, the nature of the operation and the name of the doctor who performed it:

.....



Are you taking medication? no yes

If yes, state the medication you take and the dose:

Do you have children from your current relationship? no yes

If yes, how many?

Do you have children from a previous relationship? no yes

If yes, how many?

LIFESTYLE

Are you currently an active smoker? no yes

If yes, how many per day?

Do you drink alcohol? no occasionally yes

If yes, how many glasses a day?

Do you use or have you used soft or hard drugs? no yes

If yes, specify:

Do you use or have you recently used any dietary supplements obtained via the Internet or through gyms/shops?

no yes - specify:

Are you exposed to toxic substances? no yes

If yes, specify:

Do you work in unusual conditions? no yes

How much do you weigh?..... kg

How tall are you? cm

