Dr.Myran Ponnam-Palam FERTILITY SPECIALIST
MBBS BSc (Med) Hons DRACOG FRANZCOG MM
Female and Male Infertility

Confidential Fertility Patient Medical Questionnaire – Female.

Answering the below questions accurately as possible will help us understand any issues that may be impacting your fertility. Please take your time answering all questions and return to reception.

Surname: ________________________________ First/Middle Name:__________________________

Date of Birth: _____/______/______ Weight (kg):______________ Height (cm):______________________

(Please circle)

Do you smoke? Yes / No How many cigarettes per day?_____________________

Do you drink alcohol? Regularly / Rarely / Never

Do you use recreational drugs? Yes / No If yes, please specify: ____________________________

Have you lost or gained a lot of weight recently? Yes / No

How would you rate your workplace stress level? Extreme / Moderate / Low

Have you ever received infertility treatment? Yes / No

If yes, please specify:____

Have you ever used contraception? Yes / No

If yes, please specify: Contraceptive Pill / Condoms / Intrauterine device / other: ________________________

How long is your cycle? 25-27 days / 28-30 days / 31-35 days / 36+ days / irregular.

How many days does your period last? ___________ At what age did you first get your period?___________

Is your period painful? Yes / No Do you feel the amount of blood loss is abnormal? Yes / No

Do you have a lot of symptoms prior to your period? Yes / No

Do you ever have spotting in between periods? Yes / No

Have you ever been pregnant? Yes / No If yes, when was your last pregnancy?_______________

If yes, please specify how many pregnancies you have had below:

	Current Partner	Previous Partner (s)
Miscarriages		
Terminations of pregnancy		
Ectopic Pregnancies		
Live births		

If no, for how many months have you been trying to get pregnant?______________________________

Is intercourse painful? Yes / No Do you sometimes use lubricant? Yes / No

How often do you have intercourse per month? More than 9 / 4-9 / 1-4 / Rarely

Please turn page over →

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Confidential Fertility Patient Medical Questionnaire – Female continued.

When did you have your last Pap smear?___________ Have you had an abnormal Pap smear? Yes / No

If yes, how were you treated? ____

(Please tick)
Do you have a known history of any of the following?

- ☐ Fibroids
- ☐ Polyps
- ☐ Ovarian Cysts
- ☐ Endometriosis

If so, please specify if these have been treated? ____

Have you ever had an operation?

	Year		Year
☐ Laparoscopy	________.	☐ Tubal ligation	________.
☐ Hysteroscopy	________.	☐ Myomectomy	________.
☐ Hysterectomy	________.	☐ Removal of ovarian cyst	________.
☐ D&C	________.	☐ Bladder repair	________.

☐ Other: ____

Have you been treated for the following?

- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Tuberculosis

Have you recently had any of the following?

- ☐ Hair growth
- ☐ Hair loss
- ☐ Breast discharge
- ☐ Change in urinary function
- ☐ Hot flushes / flashing
- ☐ Night sweats
- ☐ Acne

(Please circle)
Have you ever been hospitalized for an illness? Yes / No If yes, please specify:______________________

____

Are you currently under any form of treatment? Yes / No If yes, please specify:______________________

____

Do you have any diseases that run in the family? Yes / No If yes, please specify:______________________

____

Are you currently on any medications? Yes / No If yes, please specify:______________________

____

Do you have any allergies? Yes / No If yes, please specify:______________________

____

Personal Remarks: ____

____

I declare the above information to be complete and correct

Signature:____ Date: ______/______/______