

Confidential Fertility Patient Medical Questionnaire – Female PAGE 1

*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: ____ / ____ / ____ Height (CM): _____ Weight (KG): _____

(Please tick)

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 pregnancies		
Ectopic pregnancies		
Live births		

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

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

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

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

Have you ever had an operation? Yes No

If yes, please specify:

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
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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 tick)

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: ____ / ____ / ____