Fertility Questionnaire

Date:......................

All information provided in this document is treated in strictest confidence and will not be divulged to any other practitioner, without your permission.

Female Partner

Name ....

Address...

....

....

....

Tel...

Email...

Age............... DOB........./......./.......

Occupation ....
Female Partner cont....

Height..

Weight..

Male Partner

Name ....

Address...

....

....

....

Tel...

Email...

Age................. DOB........../......./.......

Occupation ....
Male Partner cont....

Height..

Weight..

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Fertility Questionnaire

GP

Name……………………………………………………………………

Address…………………………………………………………………

……………………………………………………………………………

……………………………………………………………………………

Tel No…………………………………………………………………

GP

Name……………………………………………………………………

Address…………………………………………………………………

……………………………………………………………………………

……………………………………………………………………………

Tel No…………………………………………………………………

Fertility Clinic and Consultant (if Applicable)

……

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Fertility Difficulties Y/N………………… No. Of Years …………………

Female ………………………… Male……………………………

Previous Fertility Treatments **IUI Y/N** **IVF Y/N** **ICSI Y/N**

Fertility Questionnaire

Female Gynaecological History

Do you or have you suffered from any of the following?
(Please tick any that apply either currently or previously)

Amenhorrhoea (no periods)	Irregular Periods
Anovulation	Low Back pain
Malformed Womb	Ovulation Pain
Cystitis	Ovarian Cysts
Endometriosis	Andometriosis
Fallopian Tube Issues	Pain on Intercourse
Painful Periods	PMS
Thrush	Fibroids
Genital Ulcers	Water Retention
Vaginal Discharge/Burning/Irritation	

Male Fertility Status

Have you had a semen analysis? Y/N

Dates: ....

Count (in millions) ....

Percentage Normally Formed Sperm..................................

Percentage Motile Sperm ....

Have you had any of the following?
(Please tick any that apply)

Mumps	Testicular Cancer
Non-specific urethritis	Varicocele
Rubella	Vasectomy Reversal

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Fertility Questionnaire

Have you been checked or previously treated for?
(Please tick any that apply)

AIDS
Gonorrhoea
B. Strep
Herpes
Candida
Cervical Erosion
Chlamydia
Genital Warts
Syphilis
Trichomonas

Have you been checked or previously treated for?
(Please tick any that apply)

AIDS
Gonorrhoea
B Strep
Herpes
Candida
Chlamydia
Syphilis
Genital Warts
Trichomonas

Any further information about present/past fertility issues?

....

....

....

Any further information about present/past fertility issues?

....

....

....

Fertility Questionnaire

Contraception

How long? .... Dates:...................................

Coil	OCP
Diaphragm	Condom
Female Condom	Sponge
Natural family Planning	None
Persona	

Current Medical Treatment
(Please tick any that apply)

Antidepressants	Painkillers
Diuretics	Sleeping Tablets
Steroids	Laxatives
Tranquillizers	

Other Medication/Supplements

....

....

....

Current Medical Treatment
(Please tick any that apply)

Antidepressants	Painkillers
Diuretics	Sleeping Tablets
Steroids	Laxatives
Tranquillizers	

Other Medication/Supplements

....

....

....

Fertility Questionnaire

Do you use any of the following?

Do you smoke? Y/N How many per week? ....

Do you drink? Y/N How many units per week? ....

Do you use drugs? Y/N Please provide further info....... .

....

Do you use any of the following?

Do you smoke? Y/N How many per week?.......................

Do you drink? Y/N How many units per week? ....

Do you use drugs? Y/N Please provide further info ....

....

Thank you for providing this information, please be reassured that it will be treated with the greatest confidence, and will only be used in helping you to achieve your goal of conception and parenthood.

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