

Brian C. Su, M.D.

Infertility Questionnaire

Menstrual History:

How old were you when you started your first period? _____

Do you have regular periods? Yes _____, No _____

How many days does your period last? _____

Do you have heavy periods? _____

Do you have menstrual cramps? _____

Do you have spotting or bleeding in between periods? Yes _____, No _____

Fertility History:

Did you ever get pregnant in the past? Yes _____, No _____

Abortion _____, Miscarriage _____, Full term pregnancy _____, Premature Delivery _____,

Others _____

Did you ever use any type of birth control pills or IUD in the past? Yes _____, No _____, What type? _____

Do you have pain with intercourse? Yes _____, No _____

How long have you tried to get pregnant? _____

Past Medical and Surgical History:

When did you have your last Pap smear done? _____ Results? Normal _____, Abnormal _____

When did you have your last mammogram done? _____

Are you taking any medication at the present time? _____

Do you have any allergies? Yes _____, No _____, Type _____

Do you drink or smoke? Yes _____, No _____, How much _____

Do you drink coffee or tea? Yes _____, No _____, How much per day? _____

Do you use any recreational drugs? Yes _____, No _____, What type? _____

Do you have diabetes? Yes _____, No _____

Do you have high blood pressure? Yes _____, No _____

Do you have any heart condition? Yes _____, No _____

Do you have problems with your lungs? Yes _____, No _____

Do you have problems with your liver such as Jaundice or hepatitis? Yes _____, No _____

Do you have Epilepsy? Yes _____, No _____

Do you have any bleeding problems? Yes _____, No _____

Did you ever receive blood transfusion? Yes _____, No _____

Do you have any discharge from your nipples? Yes _____, No _____

Did you have any operations in the past? Yes _____, No _____

Do you have problems with your thyroid? Yes _____, No _____

Did you ever have an infection in your pelvic area? Yes _____, No _____

Did your mother take any hormones when she was pregnant of you? Yes _____, No _____

Do you have any other medical problems? Please State _____

Male Partner Medical History:

Did you ever receive infertility treatment in the past? Yes _____, No _____, What Type? _____

Do you have Diabetes? Yes _____, No _____

Do you have chronic lung problems? Yes _____, No _____

Do you have tuberculosis? Yes _____, No _____

Do you have Cystic fibrosis? Yes _____, No _____

Do you have any medical problems? Yes _____, No _____, what type? _____

Are you taking any medicine at the present time? Yes _____, No _____, What type? _____

Did you have any operations in the past? Yes _____, No _____, What type? _____

Did you ever have an infection in your genital area? Yes _____, No _____

Did you ever have trauma in your genital area? Yes _____, No _____

Do you smoke or drink? Yes _____, No _____

Do you use recreational drugs? Yes _____, No _____

What type of work do you do? _____

Family History for Both Partners:

Down syndrome? Yes ____, No ____

Sickle Cell Disease or trait? Yes ____, No ____

Hemophilia or other bleeding disorders? Yes ____, No ____

Mental retardation? Yes ____, No ____

Cystic Fibrosis? Yes ____, No ____

Spinal cord problems? Yes ____, No ____

Fluid in the brain? Yes ____, No ____

Stillbirth? Yes ____, No ____

More than two miscarriages? Yes ____, No ____

Anemia? Yes ____, No ____

Tay Sacks Disease? Yes ____, No ____

Muscular Dystrophy? Yes ____, No ____

Cancer of the breast, colon, or ovary? Yes ____, No ____

Other genetic problems? Yes ____, No ____