LIGHTHOUSE MISSION HOSPITAL AND FERTILITY CENTER

FEMALE FERTILITY QUESTIONNAIRE

Name…….. Marital status……..

Date of Birth…….. Phone number.……..

Address…….. E-mail…….

Education level…….

Occupation…….

Partner's name……

Partner's Date of Birth……..

SECTION A: GYNECOLOGICAL HISTORY;

How old were you when started having you periods? ……..

Date of your last period …….

Are your periods regular? Yes/No

If yes, how many days between periods (start until start) ……..

If no, how many periods per year do you have?(1-12) ……..

How many days do your periods last? ……

Do you have cramps with your periods? Yes/No

If yes, are they ☐ Mild ☐ Moderate ☐ Severe?

Have you ever missed work or school due to menstrual pains? Yes/No

Do you have pain with intercourse? Yes/No

Were ever diagnosed with endometriosis? Yes/No/I don't know

What type of contraception have you used in the past?(Tick all that apply)

☐ Birth control Pill ☐ IUD ☐ Depo (birth control Injections) ☐ **Condoms**

☐ Diaphragm ☐ Foam Tablets ☐ Withdrawal ☐ Rhythm method

☐ Tubal ligation Norplant (rods under the skin of the arm)

Have you had any Contraceptive complications? Yes/No

When did you last use contraception? ……..

Have you ever had a Pap smear? Yes/No

When was your last Pap smear? ……

Have you ever had any of the following (Tick all that apply)

☐ Gonorrhea ☐ Veneral Warts ☐ Syphilis

☐ Chlamydia ☐ Genital Herpes ☐ Pelvic Inflammatory Disease (PID)

Have you ever had an abnormal mammogram? Yes/No

If so, when? ……

What was done about it? ……

When was your last mammogram? ……

SECTION B: MEDICAL HISTORY

Do you have or have you ever had (Tick all that apply)

☐ Anemia ☐ Diabetes ☐ Ovarian cysts

☐ Appendicitis ☐ Gallbladder Problems ☐ Arthritis

☐ Heart Disease ☐ Blood Transfusions ☐ Hepatitis

☐ Breast discharge-white ☐ Breast pain ☐ Hirsutism (Excess facial hair)

☐ High Blood pressure ☐ Seizures ☐ Chicken Pox or Vaccination

☐ Kidney infections ☐ Thyroid Problems ☐ Liver Problems

☐ Tuberculosis (TB) ☐ Chronic Headaches ☐ Migraine Headaches

☐ Ulcers ☐ Vision Problems

Current medications you are taking? (please include herbal medications)

……

……

……

Are you allergic to any medications? Yes/No

What? ……

Have you had surgery before? Yes/No

Date/Type ……

SECTION C:PREGNANCY HISTORY

How many pregnancies (including abortions and miscarriages) have you had? .....

	When? (Year)	How long To conceive? (months)	Fertility therapy used? (Yes/No)	Is current partner father?	Duration of pregnancy (months)	*Outcome	Complications
1st Pregnancy							
2nd Pregnancy							
3rd Pregnancy							
4th Pregnancy							
5th Pregnancy							

*Outcomes: Vaginal Delivery=VD; Cesarean section=CS; Abortion=AB; Miscarriage=MS; Ectopic=EP

SECTION D: FERTILITY HISTORY

How long have you and your partner been trying to conceive? .....

If so, how long? …….

Have you ever been infertile with a past partner? Yes/No

Have you had any of the following tests performed on you? Tick all that apply and the results.

	Date	Result
☐ Basal Body Temperature	……	……
☐ Urinary LH (Ovulation) Predictor kits	……	……
☐ Hormone Test	……	……
☐ Endometrial Biopsy	……	……
☐ Hysterosalpingogram (HSG)	……	……
☐ Ultrasound	……	……
☐ Laparoscopy	……	……
☐ Gonorrhea/ Chlamydia Cultures	……	……
☐ Hepatitis B or C	……	……
☐ HIV	……	……
☐ RPR (Syphilis)	……	……

☐ Blood Type and Rh …….. ……..

What type of fertility therapy have you received in the past?

Drug/Treatment	Dose	How long or how many cycles	When?
Clomiphene citrate (Clomid)			
Gonadotropins (Pergonal, Repronex, Humegon, Metrodin, Fertinex, Gonal-F, Follistim)			
HCG (Profasi, Pregnyl)			
GnRH Agonists (Lupron, Zoladex, Synarel)			
Progesterone			
Prednisone or Dexamethasone			
Bromcriptine (Parlodel, Dostinex) Artificial Insemination			
Donor Insemination			
In Vitro Fertilization=ICSI			

SECTION E: OVULATORY DYSFUNCTION HISTORY QUESTIONNAIRE

At what age did you start your menses……

How tall are you? ……feet ……inches

How much do you weigh? ……kg

Are you having trouble getting pregnant? Yes/No

If yes, why do you think you are having trouble? ……

……

Has anyone told you that you have polycystic ovarian syndrome? Yes/No

Has a doctor ever told you that you have a problem with ovulating? Yes/No

Do you have diabetes? Yes/No/Don't know

Do you have insulin resistance? Yes/No/Don't Know

Have you ever taken any medication to help you get pregnant? Yes/No

If yes, tick the medicine that you were given

(You may tick more than one)

I. ☐ Clomiphene citrate (CLOMID)

II. ☐ Glucophage (Metformin)

III ☐ Gonadotropins (FSH)

IV ☐ Other (Pls list) ……

Approximately how many menstrual cycles do you have per year when you **ARE NOT** on any medication?

……

Are your menstrual cycles regular and predictable? Yes/No

a. If yes, approximately how often do your menstrual cycles come?

   (Tick the box that best describes most of your menstrual cycles)

   i. ☐ More frequently than every 27 days

   ii. ☐ Every 27-29 days

   iii. ☐ Every 30 -32 days

   iv. ☐ Every 33- 35 days

   v. ☐ Less frequently than every 35 days

b. If your periods are not regular and predictable, what is the shortest and longest interval that you have had between periods

   Longest …….. days

   Shortest ……days

c. If your periods are not regular and predictable, at what age did this begin……. years old.

Have you ever taken medicine to regulate your menstrual cycle? Yes/No

If yes, tick all the medicines that you were given?

I. ☐ Birth control pills

II. ☐ Povera

III. ☐ Other (please name if you remember)…….

If yes, when was the last time? …….

Do you think that you have more hair than most women on some areas of your body? Yes/No

Have you ever removed hair from one of these areas of your body Yes/No

If yes, what area did you remove hair from? …….

As an adult have you had acne? Yes/No

If yes, do you have now? ` Yes/No

Do you have any problem with hair loss on your head? Yes/No

SECTION F: SOCIAL HISTORY

Current or Recent Employer/Position ……

Do you drink alcohol? Yes/No

Number of drinks per week ……

Do you smoke? Yes/No

Number of cigarettes per day …….. Number of years smoking ……

Do you now, or have you ever used illicit drugs (marijuana, cocaine, etc)? Yes/No

If yes, Specify……

Do you have special exercise program? Yes/No

Type …… Number of hours per week ……..

Are you on a special diet? Yes/No

Type ……..

SECTION G: REVIEW OF SYSTEMS

Have you had more than a 10 kilogram weight gain or loss in the past 12 months?Yes/No

Do you have problems with your vision (besides usual glasses), hearing, swallowing, sinuses, or throat? Yes/No

If yes, specify: ……..

Do you have heart problems, chest pain, and irregular heartbeats? Yes/No

If yes, specify: ……

Do you have asthma, wheezing, shortness of breath or trouble breathing? Yes/No

If yes, specify: ……..

Do you have breast pain, breast discharge, or a lump in your breast? Yes/No

If yes, specify: ……..

Do you have urinary burning, incontinence, kidney stones or blood in your urine? Yes/No

If yes, specify: ……..

Do you have chronic joint or muscle pain or swelling? Yes/No

If yes, specify: ……

Do you have chronic skin rashes or moles that have changed in size and appearance? Yes/No

If yes, specify: ……

Do you changes in cold or hot tolerances, changes in skin tone or color, changes in your nails or body hair growth? Yes/No

If yes, specify: ……..

Do you history of seizures, recurrent headaches or numbness in your extremities? Yes/No

If yes, specify: ……..

Do you have any symptoms of depression such as sadness, frequent crying or anger, emotional liability? Yes/No

If yes, specify: ……..

SECTION H: FAMILY HISTORY

Do any of family members have significant health problems or inherited diseases? Yes/No

Tick all that apply:

- ☐ Birth Defects
- ☐ Brain/ Spinal Defects
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Sickle Cell Disease
- ☐ Thyroid Disease

Who? ……

……

PLEASE ATTEMPT TO ANSWER **ALL** THE QUESTIONS. FOR HELP IN ANSWERING ANY QUESTIONS DO SPEAK WITH OUR FERTILITY COUNSELLOR**, Mrs. Doris Nyarko – 026 549 1116**

PLEASE BRING THIS FORM WITH YOU TO YOUR FIRST APPOINTMENT.

ENSURE THAT ALL MEDICAL RECORDS AND LAB TESTS FROM CURRENT OR PAST DOCTORS ARE ALSO BROUGHT FOR YOUR APPOINTMENT.

WE LOOK FORWARD TO SEEING YOU.