

SERVY INSTITUTE FOR REPRODUCTIVE ENDOCRINOLOGY

812 CHAFEE AVENUE ~ AUGUSTA, GEORGIA 30904

PHONE 706-724-0228 ~ FAX 706-722-2387

Infertility Questionnaire for Women

Name _____ Date _____

Occupation _____

Ethnic background _____

Height _____ Weight _____ Eye color _____ Hair color _____

Highest education _____

Do you smoke? _____ Packs per day _____

Do you drink alcohol? _____ Number per week _____

Husband's name _____ Marriage Date _____

Number of previous marriages _____ How ended _____

How long have you not used contraception? _____

How long have you tried to conceive? _____

Age of first period _____ First day of your last period _____

Shortest number of days from the start of one period to the next _____

Longest number of days from the start of one period to the next _____

Length of menses _____ Is the flow heavy? _____

Do you have any bleeding or spotting between menses? _____

Are your periods painful? _____ How bad (1-10) _____

Do you know when you ovulate? _____ How? _____

Have you noticed any clear cervical secretions before ovulation? _____

Do you have any abnormal discharge between menses? _____

Describe _____

Are your breast sore before your menses? _____

Have you noticed any milk secretions from your breast? _____

Have you taken birth control pills _____ how long _____

When did you stop _____ Were menses regular after stopping _____

Were menses regular before you started the pill? _____

Have you used an IUD _____ Diaphragm _____ Condom _____ Foam _____

Do you have children? _____ Ages _____

How long did it take you to conceive? _____

Miscarriages _____ Children _____

Premature deliveries _____ Vaginal deliveries _____

Elected abortions _____ C-Sections _____

Complications during pregnancy or delivery _____

Please indicate if you have had any of the following testing. Please include the date and the results.

Testing	Yes	No	Date	Result
Temperature charts	_____	_____	_____	_____
Hysterosalpingogram (HSG)	_____	_____	_____	_____
Hysteroscopy	_____	_____	_____	_____
Endometrial biopsy	_____	_____	_____	_____
Post-coital test	_____	_____	_____	_____
Laparoscopy	_____	_____	_____	_____
Hormone tests	_____	_____	_____	_____
Chromosome studies	_____	_____	_____	_____
Thyroid tests	_____	_____	_____	_____
Diabetes tests	_____	_____	_____	_____
Sickle cell screening	_____	_____	_____	_____
Tuberculosis test	_____	_____	_____	_____

Have you had any procedures on your cervix? _____

Laser surgery _____ Biopsy _____

Cone _____ Cauterization _____

Cryosurgery _____ Cerclage _____

Have you had any other procedures? _____

When and why _____

Have you been treated for pelvic inflammatory disease? _____

Have you been treated for endometriosis? _____

Have you ever taken clomid? _____ How many cycles? _____

Have you ever taken injections to stimulate ovulation? _____

Has anyone ever suggested insemination? _____

Was insemination performed? _____

Do you ever use douches? _____ how frequently _____

How often do you have sexual intercourse per week? _____

Do you use a lubricant? _____ What kind _____

Is intercourse painful to you? _____ to your partner? _____

Is your sex drive normal or depressed? _____

Please indicate if you have ever had any of the following and when.

	Yes	No	Date and or comment
Mumps	_____	_____	_____
Measles	_____	_____	_____
Chicken pox	_____	_____	_____
Rubella	_____	_____	_____
Rheumatic fever	_____	_____	_____
Elevated blood pressure	_____	_____	_____
Heart disease	_____	_____	_____
Diabetes	_____	_____	_____
Lung Disease	_____	_____	_____
Liver or gallbladder disease	_____	_____	_____
Jaundice	_____	_____	_____
Kidney infections	_____	_____	_____
Gout	_____	_____	_____
Urinary tract infections	_____	_____	_____
Thyroid disease	_____	_____	_____
Arthritis	_____	_____	_____
Autoimmune diseases	_____	_____	_____
Other	_____	_____	_____

Did your mother take any medications while pregnant with you? _____

Are you allergic to any medication? _____

Do you have a history of any sexually transmitted disease? _____

Do you have a history of Herpes outbreaks? _____

Have you ever had treatment with x-rays or anti-cancer drugs? _____

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Infertility Questionnaire for Men

Name _____ Date _____

Occupation _____

Ethnic background _____

Height _____ Weight _____ Eye color _____ Hair color _____

Highest education _____

Do you smoke? _____ Packs per day _____

Do you drink alcohol? _____ Number per week _____

Wife's name _____ Marriage Date _____

Number of previous marriages _____

How long have you not used contraception? _____

How long have you tried to conceive? _____

Have you ever fathered a child _____ Dates of birth _____

Have you ever been told you are infertile? _____

By whom and when _____

Are you circumcised? _____ If no, does the foreskin retract easily? _____

Has there been any change in your sex drive? _____

Do you have difficulty maintaining an erection? _____

Do you ejaculate into the vagina without difficulty? _____

Do you have pain or burning with urination or ejaculation? _____

Do you have a discharge from your penis? _____

Number of ejaculations per week _____

Has a semen analysis ever been performed? _____

What were the results? _____

Has insemination ever been suggested? _____

If yes, with your sperm or with donor sperm? _____

Do you have a history of undescended testes? _____

Do you have a history of injury to your testes _____

Do you have a varicocele? _____ What type _____

Have you had a hernia repair? _____ where and when _____

Have you undergone treatment to improve fertility? _____

Please explain _____

Please indicate if you have had any of the following testing. Please include the date and the results.

Testing	Yes	No	Date	Result
Post-coital test	_____	_____	_____	_____
Semen analysis	_____	_____	_____	_____
Hormone tests	_____	_____	_____	_____
Chromosome studies	_____	_____	_____	_____
Thyroid tests	_____	_____	_____	_____
Diabetes tests	_____	_____	_____	_____
Sickle cell screening	_____	_____	_____	_____
Tuberculosis test	_____	_____	_____	_____

Please indicate if you have ever had any of the following and when.

	Yes	No	Date and or comment
Mumps	_____	_____	_____
Measles	_____	_____	_____
Chicken pox	_____	_____	_____
Rubella	_____	_____	_____
Rheumatic fever	_____	_____	_____
Elevated blood pressure	_____	_____	_____
Heart disease	_____	_____	_____
Diabetes	_____	_____	_____
Lung Disease	_____	_____	_____
Liver or gallbladder disease	_____	_____	_____
Jaundice	_____	_____	_____
Gout	_____	_____	_____
Urinary tract infections	_____	_____	_____
Thyroid disease	_____	_____	_____
Arthritis	_____	_____	_____
Autoimmune diseases	_____	_____	_____

Did your mother take any medications while pregnant with you? _____

Are you allergic to any medication? _____

Do you have a history of any sexually transmitted disease? _____

Do you have a history of Herpes outbreaks? _____

Have you ever had treatment with x-rays or anti-cancer drugs? _____

When and why _____

Have you had any surgeries? _____

What and when _____

Please list any medication you are taking _____

Have you ever been employed in an occupation with sustained high temperatures? __

When and where _____

Have you been exposed to toxic chemicals or radiation? _____

Do you use hot tubs, saunas or ice baths? _____