FEMALE QUESTIONNAIRE

DATE:

(All information disclosed herein is confidential and will not be shared with other parties unless consent is given by the client named below)

NAME:

PARTNER'S NAME:

D.O.B:

D.O.B:

ADDRESS:

ADDRESS:

CONTACT NUMBERS:

CONTACT NUMBERS:

Who referred you to us? *(Please give name where appropriate)*
(Please circle)
Consultant / G.P. / Self referred

How long have you and your partner been together?

When did you first start trying for a baby?
(i.e.: when did you stop using any form of contraception)

PREVIOUS PREGNANCIES

Have you ever been pregnant?
(If with a previous partner please indicate)

YEAR AND OUTCOME OF ANY PREGNANCIES

Year	Outcome (live birth, miscarriage, ectopic, termination)*	Mode of Delivery (normal/caesarean section)	Type of Conception (Natural / IVF / Donor)

* Please state any complications which occurred during or after pregnancy.

POUNDBURY FERTILITY

MENSTRUAL HISTORY

How old were you when your period started? ....

Do you have regular periods? YES / NO

How many days do you bleed for? ....

How many days are there in your cycle ....

If your periods are not regular, what were the shortest and shortest ....

longest times between periods in the last 12 months? longest ....

What was the first day of your last period? / /

Do you have painful periods? YES / NO
If "yes" does this stop you working or doing other activities YES / NO

Do you have regular sexual intercourse? YES / NO

Over the last 4 weeks how many times did you have sexual intercourse ....

Do you bleed during or after sexual intercourse? YES / NO
If "yes" much.

Do you experience pain during intercourse? YES / NO

Do your breasts ever secrete fluid? YES / NO

Do you have a problem with body hair? YES / NO
Please indicate where. ....

Have you started your menopause? YES / NO
If so, when? ....

Do you take hormone replacement therapy? YES / NO
If so, when started? ....

What form of HRT do you take?

PREVIOUS CONTRACEPTION: (please tick)

			years (from/to)	any problems
The pill	(brand)	( )		
IUCD	(coil)	( )		
Barrier	(condom/cap)	( )		
Intra-muscular injection		( )		

PREVIOUS MEDICAL HISTORY

(please tick if you have had any of the following)

( ) Rheumatic Fever

( ) Tuberculosis (TB)

( ) Diabetes

( ) Jaundice

( ) Raised blood pressure (hypertension)

( ) Stroke (CVA)

( ) Liver problems/gall stones

( ) Porphyria

( ) Radiotherapy

( ) Chemotherapy

( ) Thyroid disorders

( ) Asthma

( ) Heart Attack (myocardial infarction)

( ) Epilepsy

( ) Systemic Lupus Erythematosus (SLE)

( ) Cancer of the womb

Do you or anyone in your family have any inherited conditions? YES / NO
If yes, please give details

Do you know if you are immune to rubella? YES / NO

Do you have any relatives from either the Mediterranean region, Middle East or from Asia? YES / NO

Are you aware of any family history or do you have?

Sickle cell anaemia or trait YES / NO

Thalassaemia YES / NO

......

Have you had a recent blood pressure check If "yes" please give date	YES / NO ....
Have you ever had a cardiac/circulator problem	YES / NO
Do you suffer from migraine	YES / NO
Do you have a history of blood clotting disorders? (Pulmonary embolus (PE) or Deep Venous Thrombosis (DVT)	YES / NO
Are you on any long-term medication? If yes, please give details	YES / NO
Are you taking Folic Acid? What preparation are you taking?	YES / NO ....
Do you have any allergies? If yes, please give details	YES / NO
Do you suffer from stress?	YES / NO

If "yes" please expand as to what causes stress and how do help to reduce it. How does stress affect your lifestyle?

How often do you exercise? *(please circle)* regularly / infrequently / never

What exercise do you do and please record what you have done in the last 7 days ....

Have you had any operations? YES/NO
If yes, please give details and date

GYNAECOLOGICAL HISTORY

Have you ever been referred to a gynaecologist? YES / NO
If yes, please give details

Have you ever had any surgery following referral? YES / NO
(please indicate procedure and year it took place)

When was your last cervical smear? / /

Have you ever had an abnormal smear? YES / NO
If yes, please give details (repeat smear, colposcopy only, cone biopsy, laser treatment)

Have you ever had pelvic inflammatory disease YES / NO
If so, when ....

***Any vaginal discharge requiring treatment by a doctor (excluding thrush) YES / NO

***STD (eg Chlamydia, Syphilis, Gonorrhoea, genital herpes or genital warts YES / NO
*** If "yes" please expand and give dates and treatment (if known)

PREVIOUS INVESTIGATIONS *Please indicate if you have ever had any of the following*

	Carried out	Year	Place
Laparoscopy	( )		
Hysteroscopy	( )		
Hysterosalpingogram	( )		
HyCosy (tube test)	( )		
Scan	( )		

*Please could you contact your doctor and bring the results with you to your consultation.

Blood Tests (Please bring along any bloods already taken)

Hormonal assays	( )

PREVIOUS FERTILITY TREATMENT *Please indicate if you have ever had any of the following*

Ovulation induction YES / NO

IVF YES / NO

Other YES / NO

Have you had any fertility treatment with your current partner or a previous partners YES / NO
If yes, please give details

Location of fertility treatment ....
(Please bring along to your consultation any information that may be beneficial)

GENERAL HEALTH

What is your occupation?

Do you travel away alot? YES / NO

How tall are you?

What is your weight?

Is your weight steady / increasing / decreasing?

Do you smoke? YES / NO

If yes, how many cigarettes a day ....

Do you drink alcohol? YES / NO
If yes, how many units a week ....

Do you take any recreational drugs? YES / NO
If "yes" what do you use?

POUNDBURY FERTILITY

Is there a family history of breast or gynaecological cancer on your mother's side of the family?
If yes, please give details

Have you had any hospital admissions for any other illnesses? YES / NO
If yes, please give details

Have you had any problems with anaesthetic in the past? YES / NO
If "yes" please indicate reason.

COMPLEMENTARY MEDICINE

Have you ever used any form of complementary therapy? YES / NO
If yes, what and when?

If yes, please give names and addresses of practitioners

If yes, consent to contact practitioners? YES / NO

Please make a list below of any questions you would like answered at your consultation below

Thank you for taking the time to complete this form