****

**PregnaClinic Pregnancy & Fertility Medical Questionnaire Form**

**(FEMALE)**

**Section 1 - GENERAL INFORMATION**

**1.1 ALL ABOUT YOURSELFEF**

 FULL NAME: DATE OF BRITH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 MARTIAL STATUS:

 Partner Name: Partner DOB:

 Height: Weight: Race:

 Occupation:

**1.2 CONTACT DETAILS** ADDRESS

 Phone (day):

 Phone (night):

 E-mail:

1.3 Are you pregnant? Yes No I don’t know

 If yes, how many weeks are you?

**SECTION 2 - PREGNANCY History**

 2.1 How many Pregnancies (including abortions) have you had?

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|   | When? (year)  | How long To conceive? (months)  | Fertility therapy used? Y/N  | Is current partner father? Y/N  | Duration of Pregnancy (months)  | Outcome\*  | Complications  |
| 1st Pregnancy  |   |   |   |   |   |   |   |
| 2nd pregnancy  |   |   |   |   |   |   |   |
| 3rd pregnancy  |   |   |   |   |   |   |   |
| 4th pregnancy  |   |   |   |   |   |   |   |
| 5th pregnancy  |   |   |   |   |   |   |   |

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

 2.2 Any additional information you believe is important regarding your pregnancies, please tell us.

2.3 Please tell us of any family history of complicated pregnancy or miscarriages, blighted ovum etc.

**SECTION 3 - Fertility History**

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

 3.2 Have you ever been infertile with a past partner? If so, How long?

 3.3 Have you had more than a 10-pound weight gain or loss in the past 12 months?

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

|  |
| --- |
| Test Date Results |
|  Basal Body Temperature  |
| Urinary LH (Ovulation) Predictor Kits  |
| Postcoital Test   |
| Hormone Tests  |
| Endometrial Biopsy  |
| Hysterosalpingogram (HSG)  |
| Sonohysterogram  |
| Ultrasound  |
| Antisperm Antibodies  |
| Laparoscopy  |
| Hysteroscopy  |
| Gonorrhea/Chlamydia Cultures  |
| Rubella (German Measles)  |
| Hepatitis B or C  |
|  HIV  |
| Syphilis  |
| Blood Type and Rh  |
|  Antibody Screen  |

 3.5 Have you received any fertility treatment? Yes No

If so, what types of fertility therapy have you received in the past and give brief details on its outcome below

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  * 1. Has anyone ever told you that you have polycystic ovarian syndrome? Yes No
	2. Has a doctor ever told you that you have a problem ovulating? Yes No

 * 1. Do you have diabetes? Yes No I don’t know
	2. Do you have insulin resistance? Yes No I don’t know
	3. Have you taken any medications to help you get pregnant? Yes No

  If yes, specify  3.11 Have you ever had surgery that may have affected your reproductive organs? Yes No   If yes, please briefly explain  3.12 How often do you have unprotected sex during the fertile time of your monthly cycle?  At least every other day  Every few days  Once or twice  I don't know when I am fertile**SECTION 4 - Gynecological & BACKGROUND Medical History**

|  |  |
| --- | --- |
|  4.1 How old were you when you started having periods ?  Date your last period started?  |  |

 4.2 Are your periods regular?  If yes, how many days between periods (start until start)?  If no, how many periods per year do you have?  How many days do your periods last?   4.3 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   4.4 Have you ever taken medicine to regulate your menstrual cycles? Yes No  If yes, when was the last time?  If yes, what medicines were given?  4.5 Do you have cramps with your periods?

|  |  |
| --- | --- |
|  If yes, are they: Mild Moderate  | Severe  |
|  |   |
|  4.6 Do you have pain with intercourse?  |   |

  4.7 Where you ever diagnosed with endometriosis?   4.8 What type of contraception have you used in the past?   4.9 Any Contraceptive Complications:     4.10 When did you last use contraception?  |  |
|  |    |

 4.11 Please tell us of any medical conditions you had or currently suffering from and brief description of

 Medication taken

4.12 Do any family members have significant health problems or inherited diseases, including pregnancy and

 Fertility related

 If so, who and briefly explain

 **Section 5 - Social History**

 5.1 Current or Recent Employer/Position

 Occupation

 5.2 Do you drink alcohol?

 If yes, please specify number of drinks per week

5.3 Do you smoke?

 If yes, please specify number of cigarettes per day

 please specify number of years smoking

 5.4 Do you now, or have you ever, used illicit drugs (marijuana, cocaine, etc.)?

 If yes, please specify

5.5 Do you have a special exercise program?

Number of hours per week

 5.6 Are you on a special diet?

Type