BRATTLEBORO OBSTETRICS AND GYNECOLOGY
Infertility Questionnaire

NAME________________________________ DOB______________ DATE ______________

Occupation: ____________________________ AGE________

Partner's Name __________________________ DOB _________ Occupation ______________

How long have you been trying to conceive? ___________________
Have you ever been evaluated for infertility? ___ yes ___ no
If so what tests were performed? ____
Have you undergone any treatment for infertility? ___ yes ___ no
If so, what treatment(s) were performed? ____________________________________

GYNECOLOGIC HISTORY:
Age at first period _____ Date of last menstrual period _____ Was it normal? ___ yes ___ no
Menses (periods) occur every _____ days and last for _____ days
Check if you have any of the following:
_____ Painful periods requiring more than Motrin or Tylenol
_____ Heavy bleeding _____ Irregular periods or bleeding _____ Bleeding > 7 days
_____ Spotting in between periods _____ Bleeding after intercourse
_____ Change in menstrual bleeding patterns ____________________________________

What types of birth control, if any have you used in the past:
_____ Birth control pill _____ Withdrawal _____ None
_____ Condom _____ Foam or jelly _____ Diaphragm or cervical cap
_____ IUD _____ Depo-Provera _____ Norplant
_____ Tubal ligation _____ Vasectomy _____Natural Family Planning

Do you have or have you ever had any of the following problems or concerns?
_____ Unusual vaginal odor or discharge _____ DES exposure
_____ Have you ever had an abnormal Pap smear? ___ yes ___no
If so, how was it treated? ____
_____ Painful intercourse _____ other concerns about sexual activity
_____ Concerns about the presence of a sexually transmitted disease
_____ History of sexual or physical abuse. Have you talked with someone about this? _____
_____ Chlamydia _____ Gonorrhea _____ Herpes _____ Venereal Warts _____ PID
_____ Leaking of fluid from the breasts _____ Heat or cold intolerance
_____ Increased facial hair growth _____ Acne
_____ Unexplained weight loss/or gain _____ Fatigue or weakness

Family History: (check if you have blood relatives with....
_____High blood pressure _____ Heart attacks _____ High cholesterol
_____ Diabetes _____ Thyroid disease _____ Bleeding problems
_____ Birth defects _____ Down's Syndrome _____ Sickle cell disease
_____ Breast Cancer _____ Ovarian cancer _____ Colon cancer
_____ Hepatitis _____ Recurrent pregnancy loss

OBSTETRICAL HISTORY: Number of pregnancies _____ Number of births _____

Please list all pregnancies in order (include pregnancy losses, abortions and preterm births)

MO/YR	HOSPITAL	WKS/MO	WT	SEX	COMPLICATIONS

PAST MEDICAL HISTORY:

Do you have any medical problems for which you must seek regular medical attention?

____

____

____

Current Medications: _______________

____

____

____

Allergies: _______________

____

____

____

Please list all operations and hospitalizations for reasons other than childbirth:

DATE	HOSPITAL	OPERATION/REASON FOR ADMISSION

Do you have financial concerns in reference to today's visit? _____ yes __ no

Do you have any other questions or concerns that you would like to address today?

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