Fertility Center of Dallas
J. Michael Putman, M.D., PA
Lilly Zhang, Ph.D.

Reproductive Endocrinology and Infertility
Advanced Gynecologic Endoscopy

Baylor Medical Pavilion
3900 Junius St., Ste. 610
Dallas, TX 75246
(214) 823-2692 (O)
(214) 887-8244 (F)

FERTILITY QUESTIONNAIRE - PATIENT

Name:__________________________Date:___________Date of Birth:___________Age: _______

A. GENERAL INFORMATION

1) Height: ___________ Weight: ___________
2) How long have you been married? _________
3) How long have you been seeking a pregnancy? _________
4) Is this your first marriage? _________
5) Do you have children from this marriage? _________
   If yes, how many children? Adopted_____Biological______
6) Do you have children from a previous marriage(s) or relationship?
   If yes, how many children? Adopted_____Biological______

B. MENSTRUAL CYCLE

1) What age were you when menses started? _________
2) Are your menses regular? _____ Number of days in your cycle? _____
3) How many days of flow do you have in an average period? _________
4) What was the date of your last menstrual period? _________
5) How do you decide that ovulation is occurring? _________
6) Do you have pain when ovulating? _________
7) Do you have bleeding near ovulation? _________
8) What is your frequency of intercourse near ovulation? _________
9) Do you have mid-cycle bleeding? _________
10) Do you have pain with your menstrual flow? _________

11) Do you have spotting prior to the onset of a brisk menstrual flow? __________

12) Have you taken your basal body temperature during a menstrual cycle? __________

C. INTERCOURSE

1) How frequently do you have intercourse? __________
2) Do you use lubricants with intercourse? __________
3) Do you use douches near Intercourse? __________
4) Do you have pain with intercourse? __________

D. PREVIOUS PREGNANCIES

1) How many times have you been pregnant? ______ Dates:
2) What was the outcome?

____ live birth ____therapeutic abortion
____ ectopic pregnancy ____spontaneous abortion
____ stillborn ____miscarriage

3) How long did it take to conceive in previous attempts at pregnancy?

E. CONTRACEPTION

1) Have you previously used contraception?
2) If yes, what form(s) of contraception?

____ contraceptive pill ____ intrauterine device
____ diaphragm ____other
____ condom

F. MEDICAL/SURGICAL

1) Have you ever had surgery?
If yes, Procedure(s): Date(s): Place(s):
2) Have you recently lost or gained over 20 pounds?

3) Do you exercise regularly? If yes, how often and what type?

4) Do you follow any special dietary regimen?

5) Are you allergic to any medications? If yes, please list:

6) Do you take any herbal supplements or alternative medications?

If so, please list:

7) Do you use or have you used:

____ Prescription drugs or medications? If yes, please list:

____ Non-prescription drugs or medications? If yes, please list:

____ Marijuana or other drugs? What? How much?

____ Tobacco products? What? How much?

____ Alcoholic beverages? What? How much?

8) Do you or have you ever:

_____Anemia
_____Appendicitis
_____Arthritis
_____Headache
_____Heart Disease
_____Hepatitis
_____Bronchitis
_____Excess Body/ Facial Hair
_____High Blood Pressure
_____Immunizations
_____Intolerance to Heat/Cold
_____Liver Problems
_____Visual Problems

_____Gall Bladder Problem
_____Gonorrhea
_____Ovarian Cysts
_____Pelvic Infection
_____Herpes
_____Hirsutism
_____Rheumatic Fever
_____Syphilis
_____Thyroid Problems
_____Ulcers
_____Urinary Tract Infection
_____Vaginitis

_____Measles-Regular or German
_____Blood Product Transfusions
_____Breast Discharge
_____Poor Sense of Smell
_____Cancer
_____Chlamydia
_____Colitis
_____Color Blindness
_____Diabetes
_____Dizziness
_____Endometriosis
_____Epilepsy Seizure

G. PREVIOUS FERTILITY EVALUATION AND TREATMENT

1) Have you had:

_____Hysterosalpingogram
_____Cervical Cauterization Laser Surgery
_____Fallopian Tube Surgery
_____Post Coital Examination
_____Urinary LH Testing
_____Medication for Fertility Treatment
_____Chromosome Studies

_____Hormonal Testing
_____Laparoscopy
_____Hysteroscopy
_____Dilatation and Curettage
_____Ultrasound Monitoring of Ovulation
_____Endometrial Biopsy
_____Insemination with Husband Semen
_____Insemination with Donor Semen

____ Previous Attempts with Assisted Reproductive Technology:

____ GIFT______IVF______TET______ZIFT