

THE MUASHER CENTER FOR FERTILITY AND IVF  
FERTILITY QUESTIONNAIRE

NAME: \_\_\_\_\_

To understand your situation fully, it is very important that I am familiar with all pertinent facts. Please take time to answer these questions honestly. Seemingly unimportant facts may prove helpful. If for any reason you have a personal objection to answering any specific portion of this questionnaire, leave it blank and speak to me in private. This questionnaire will be held in strictest confidence.

Suheil J. Muasher, MD, FACOG  
Medical Director

**What problem(s) do you want help with?**

How long have you been trying to get pregnant? \_\_\_\_\_ years

What tests have been done to check your fertility?

TEST	DATE OF TEST	FINDINGS/RESULTS
Temperature charting		
Semen Analysis		
Hysterosalpingogram (HSG)		
Post-Coital Test		
Endometrial Biopsy		
Laparoscopy		

Other Test Results: \_\_\_\_\_

What, if any, treatments have you had to correct your problem? \_\_\_\_\_

Have you ever been pregnant? Yes  No

How many times have you been pregnant? \_\_\_\_\_

What was the outcome of all the pregnancies you have had? \_\_\_\_\_

Were previous pregnancies by your present husband (partner)? Yes  No

Have you adopted children? Yes  No

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**Gynecological History**

How old were you when your periods began? \_\_\_\_\_ Years

How long do your periods last? \_\_\_\_\_ Days

Are they regular? Yes  No

What was the longest time between periods during the past year? \_\_\_\_\_ days

What was the shortest time between periods during the past year? \_\_\_\_\_ days

When do your cramps occur in relation to your period? \_\_\_\_\_

When was your last period? Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Can you tell when you ovulate? Yes  No

Do you ever bleed between periods? Yes  No

Do you ever feel moody, depressed, or bloated before your period starts? Yes  No

Most troubling symptoms: \_\_\_\_\_

Have you ever used birth control? Yes  No

Check all that apply:

Pills  IUD  Condoms  Spermicide  Shots  Implants

Have you ever had any pelvic infections; Infected tubes or ovaries? Yes  No   
If yes, where was the infection, what type of treatment and by whom?

When was your last pap smear? Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Has it ever been abnormal? Yes  No

Have you ever had surgery on your cervix? Yes  No

Have you ever had a mammogram? Yes  No

Has it ever been abnormal? Yes  No

Do you have breast implants? Yes  No

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**General Medical History**

Current Height \_\_\_\_\_ Weight \_\_\_\_\_

Have you had any recent loss or gain? Yes  No

If yes, how many pounds? \_\_\_\_\_

Do you feel like you are in good general overall health? Yes  No

Do you currently smoke? Yes  No

If yes, how many packs per day? \_\_\_\_\_

How long have you been smoking? \_\_\_\_\_ Number of years

Have you ever smoked? Yes  No

If yes, when did you quit? \_\_\_\_\_ Year

Do you drink alcoholic beverages? Yes  No

If yes, what type of alcohol? Beer  Wine  Liquor

How many drinks per day or week do you consume? \_\_\_\_\_

Do you exercise regularly? Yes  No

If yes what type of exercise do you do? \_\_\_\_\_

How many hours/day? \_\_\_\_\_ How many days/week? \_\_\_\_\_

List all medications you currently take.

Prescription: \_\_\_\_\_

Over the counter: \_\_\_\_\_

Vitamins & Herbal Supplements: \_\_\_\_\_

Do you have any allergies? Yes  No

If yes list them and the reactions they cause.

Medications: \_\_\_\_\_

Foods: \_\_\_\_\_

Environmental: \_\_\_\_\_

Other: \_\_\_\_\_

Have you been vaccinated for or had any of the following illnesses?

Measles/Mumps/Rubella Vaccine  Illness

Chicken Pox Vaccine  Illness

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**Family History**

How many brothers and sisters do you have? \_\_\_\_\_

Do any of your siblings or relatives have infertility problems? Yes  No

Describe: \_\_\_\_\_

Did your mother take any prescription drugs when she was pregnant with you? yes  No

Have any of your relatives had any significant health problems? Yes  No   
Describe in detail including any cancers:

**Social History**

How long have you been with your current partner? \_\_\_\_\_ Years

How old is he? \_\_\_\_\_ Years

Is he in good health? Yes  No

Is he a smoker? Yes  No   
If yes, how many packs per day? \_\_\_\_\_ Packs/day

Has he ever smoked? Yes  No   
If yes, when did he quit? \_\_\_\_\_ Year

List all medications he takes, include prescription, over-the-counter, herbal supplements and vitamins:

Has he ever had hernia surgery or any surgery of his genital organs? Yes  No

What type of under shorts does he wear? Boxers  Briefs

Has he had any children in a prior relationship? Yes  No

How often do you have intercourse? \_\_\_\_\_

Do you douche? Yes  No   
What product? \_\_\_\_\_ How often do you douche? \_\_\_\_\_

Do you ever find intercourse painful? Yes  No   
If so, describe (when in cycle; deep or external; at the beginning, during or after):

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**Review of Specific Conditions:**

Have you ever had: (If yes, give dates, where treated and by whom)

- |                         |                              |                             |       |
|-------------------------|------------------------------|-----------------------------|-------|
| Venereal diseases       | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Pneumonia               | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| High Blood Pressure     | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Diabetes                | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Cancer                  | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Kidney Problems         | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Anemia                  | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Hepatitis               | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Phlebitis               | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Nervous breakdown       | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Severe depression       | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Epilepsy/seizures       | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Migraine headaches      | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Bleeding tendencies     | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Thyroid disease         | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Heart disease           | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Radiation therapy       | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Breast secretions       | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Anorexia or bulimia     | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Other serious illnesses | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |

**Other issues / Comments / Concerns:**