UZ LEUVEN | GYNAECOLOGIE EN VERLOSKUNDE
Leuvens universitair fertiliteitscentrum

FERTILITY / ENDOMETRIOSIS QUESTIONNAIRE

Please fill in this questionnaire and bring it with you to the first consultation.

If not applicable, please skip the questions on fertility.

FEMALE PATIENTS PERSONAL DETAILS

Surname: ....

First name: ....

Date of birth: ....

Address: ....

Postcode: ....

City: ....

Country: ....

Language: ....

Tel.: ....

Mobile phone: ....

Email: ....

Occupation: ....

PARTNERS PERSONAL DETAILS

Surname: ....

First name: ....

Date of birth: ....

Address: ....

Postcode: ....

City: ....

Country: ....

Language: ....

Tel.: ....

Mobile phone: ....

Email: ....

Occupation: ....

YOUR REGULAR GYNAECOLOGISTS CONTACT DETAILS

Surname: ....
First name: ....
Address: ....
Postcode: ....
City: ....
Country: ....
Language: ....
Tel.: ....
Mobile phone: ....
Fax: ....
Email: ....

SUMMARY OF THE ASSISTANCE YOU ARE SPECIFICALLY REQUESTING FROM THE LUFC

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COUPLES DETAILS

Marital status: O married since ………………… O living together since …………………

Length of your relationship: ………………………………………………………………………………………………

Trying to have children since: ………………………………………………………………………………………………

FEMALE PATIENTS DATA

Blood group: ……….. (Your blood group card will be requested at the consultation.)

FAMILY HISTORY

Do you have any brothers and/or sisters? O no O yes, …… brothers and/or…… sisters

Is there anyone in your family of origin with:	**No**	**Yes**	**If yes, specify:**
Breast cancer	O	O	…………………………………………
Colon cancer	O	O	…………………………………………
Lung cancer	O	O	…………………………………………
Skin cancer	O	O	…………………………………………
Ovarian cancer	O	O	…………………………………………
Prostate cancer	O	O	…………………………………………
Uterine cancer	O	O	…………………………………………
Asthma	O	O	…………………………………………
Diabetes	O	O	…………………………………………
Thrombosis (blood clot in a major blood vessel)	O	O	…………………………………………
Endometriosis	O	O	…………………………………………
Double uterus or uterine septum	O	O	…………………………………………
Menopause before the age of 46	O	O	…………………………………………

MEDICAL HISTORY - FEMALE

Have you ever been seriously ill? O no O yes

If yes, give the name of the disease and state whether you are still being monitored by a physician:

………

Do you suffer from one or more of the following conditions?	No	Yes
Asthma	O	O
Chronic fatigue syndrome	O	O
Deafness or impaired hearing in one or both ears	O	O
Depression	O	O
Diabetes	O	O
Eczema	O	O
Fibromyalgia	O	O
Glandular fever	O	O
Thyroiditis (Hashimoto disease)	O	O
Migraine	O	O
Multiple sclerosis	O	O
Pyloric stenosis	O	O
Rheumatoid arthritis	O	O
Scoliosis (sideways curvature of the spinal column)	O	O
Other back problems	O	O
Chronic inflammation of tear ducts & salivary glands (Sjörgen's syndrome)	O	O
Thyroid problems	O	O
Heart conditions; if yes, please specify:	O	O
Lupus erythematodes	O	O
Crohn's disease	O	O
Inflammation of the colon (ulcerative colitis)	O	O
Irritable bowel syndrome	O	O
Other (specify):		

....

Are you allergic to any medication (e.g. antibiotics), latex or disinfectants?

O no O yes - specify: ....

Have you ever had gynaecological problems?

O no O yes - specify: ....

Do you have (or have you ever had) cancer?

O no O yes - specify: ....

GYNAECOLOGICAL HISTORY

At what age was your first period? .... years

Do you have any abnormalities of the uterus or cervix? O no O yes

If yes, have you ever had surgery for this problem? O no O yes

Do you have endometriosis? O no O yes

If yes, have you ever had surgery for this problem? O no O yes

SURGICAL HISTORY

Have you ever had surgery? O no O yes

If yes, state the year and name of the operation: ....

Have you ever had a gynaecological surgery? O no O yes

If yes, state the year, the nature of the operation and the name of the gynaecologist who performed it:

....

FERTILITY HISTORY

Are you currently taking folic acid? O no O yes

Have you been trying to get pregnant for more than one year? O no O yes

Have you ever undergone tests to ascertain the cause of decreased fertility?

O no O yes

LIFESTYLE

Have you smoked more than 100 cigarettes during your life? O no O yes

If yes, at what age did you start smoking? .... years

If yes, are you currently smoking? O no O yes

OBSTETRIC HISTORY

If you don't have an obstetric history, please go to the section 'Details of previous fertility treatments'.

How many pregnancies (including miscarriages or terminations) have you already had?

Pregnancy	*When (year)*	*Infertility treatment needed for this pregnancy?*	*Time taken to get pregnant*	*Outcome of pregnancy*	*Weight at birth*
1st		O no O yes		O live birth O miscarriage O ectopic pregnancy O termination O still born	
2nd		O no O yes		O live birth O miscarriage O ectopic pregnancy O termination O still born	
3rd		O no O yes		O live birth O miscarriage O ectopic pregnancy O termination O still born	
4th		O no O yes		O live birth O miscarriage O ectopic pregnancy O termination O still born	
5th		O no O yes		O live birth O miscarriage O ectopic pregnancy O termination O still born	

Did you have any problems during your pregnancy/pregnancies? O no O yes

If yes, specify the problems and during which pregnancy ....
....

Did you have any problems after giving birth? O no O yes

If yes, specify: ....
....

Did your child/children have any problems after birth? O no O yes

If yes, specify: ....
....

Did you breastfeed? O no O yes

If a pregnancy ended in a miscarriage, please fill in the table below.

Pregnancy	***Year***	***Number of weeks***	***Presence of amniotic sac***	***Presence of fetal heartbeat***
1st miscarriage			O no O yes	O no O yes
2nd miscarriage			O no O yes	O no O yes
3rd miscarriage			O no O yes	O no O yes
4th miscarriage			O no O yes	O no O yes
5th miscarriage			O no O yes	O no O yes

DETAILS OF PREVIOUS FERTILITY TREATMENTS

Have you ever been treated for decreased fertility? O no O yes

If so, who was your doctor? ....

Have you ever had a treatment to induce ovulation? O no O yes

If yes, please provide more information below and fill in the table.

How many cycles? ....

Cycle	***Medication (*)***	***Dose (**)***	***Ovulation***	***Result (***)***
1st			O no O yes	
2nd			O no O yes	
3rd			O no O yes	
4th			O no O yes	
5th			O no O yes	
6th			O no O yes	

(*) (**) (***) see options on next page

(*) Medication: Gonal-F, Puregon, Menopur, Clomid, Pergotime, Pregnyl, other (specify)

(**) Dose: state number of tablets/ampoules per day

(***) Choose one of the following options:
1= not pregnant
2= pregnancy hormone increased in blood or urine, but followed by very early miscarriage
3= miscarriage
4= ectopic pregnancy
5= pregnancy & birth

Have you ever had artificial insemination? O no O yes

If yes, please provide more information below and fill in the table.

How many cycles? ……………………………………………………………

Cycle	*Medication (*)*	*Dose (**)*	*Insemination*	*Sperm*	*Result (***)*
1st			O no O yes	O partner O donor	
2nd			O no O yes	O partner O donor	
3rd			O no O yes	O partner O donor	
4th			O no O yes	O partner O donor	
5th			O no O yes	O partner O donor	
6th			O no O yes	O partner O donor	

(*) Medication: Gonal-F, Puregon, Menopur, Clomid, Pergotime, Pregnyl, other (specify)

(**) Dose: state number of tablets/ampoules per day

(***) Choose one of the following options:
1= not pregnant
2= pregnancy hormone increased in blood or urine, but followed by very early miscarriage
3= miscarriage
4= ectopic pregnancy
5= pregnancy & birth

Have you ever had an attempt at IVF or ICSI? O no O yes

If yes, please provide more information below and fill in the table.

When? ....

Where? ....

How many fresh cycles (=cycles with egg aspiration)? ....

How many thaw cycles (=cycles where frozen embryos are used)? ....

Cycle	***Medication (*)***	***Initial medication dose (Menopur, Gonal-F or Puregon) (**)***	***Number of eggs at aspiration***	***IVF/ICSI***	***Number of fertilised eggs***	***Day of embryo transfer (after aspiration)***	***Number of embryos transferred***	***Number of embryos frozen***	***Result (***)***
1st				O IVF O ICSI					
2nd				O IVF O ICSI					
3rd				O IVF O ICSI					
4th				O IVF O ICSI					
5th				O IVF O ICSI					
6th				O IVF O ICSI					

(*) (**) (***) see options on next page

(*) Medication: Suprefect, Decapeptyl, Cetrotide, Orgalutran, Gonal-F, Puregon, Menopur, Pregnyl, other (specify)

(**) Dose: state number of units per day

(***) Choose one of the following options:

1= not pregnant
2= pregnancy hormone increased in blood or urine, but followed by very early miscarriage
3= miscarriage
4= ectopic pregnancy
5= pregnancy & birth

CURRENT PERSONAL SITUATION

Are you taking medication? O no O yes

If yes, specify the medication and dose: ....

Do you drink alcohol? O no O occasionally O yes

If yes, how many glasses a day? ....

Do you use or have you used soft or hard drugs? O no O yes

If yes, specify: ....

Are you exposed to toxic substances? O no O yes

If yes, specify: ....

Do you work in unusual conditions? O no O yes

How much do you weigh?............. kg

How tall are you? .... cm

CYCLE INFORMATION

When was your last period? ....../....../.........

Are your periods regular? O no O yes

What is the time span (in days) from one bleeding to the next?

Minimum ......days /maximum ......days

How long does your menstrual bleeding (= number of days of bright red blood loss) last? ....

How much blood do you lose during your period?

O not much O normal amount O a lot, with clots O a very large quantity, with clots

Do you experience abdominal cramps during your period? O no O yes

If yes, are these cramps: O mild O moderate O severe O very severe

How many times a week do you have intercourse?

Do you take into account your fertile period? O no O yes

Do you experience any difficulties during intercourse? O no O yes

Do you experience pain during intercourse? O no O yes

Do you sometimes have bloodlos inbetween periods? O no O yes

Do you experience abdominal cramps other than during your period? O no O yes

Do you have painful bowel movements during your period? O no O yes

Do you sometimes have blood in your stool? O no O yes

Do you suffer from constipation? O no O yes

Do you suffer from diarrhoea? O no O yes

Do you find it painful urinating during menstrual bleeding? O no O yes

Do you sometimes have blood in your urine? O no O yes

Do you suffer from abnormal vaginal secretion? O no O yes

Do you suffer from vaginal itching? O no O yes

Do you suffer from excessive hair growth on your legs, arms or face? O no O yes

Do you suffer from hot flushes or night sweats? O no O yes

Do you suffer from abdominal pain constantly (almost daily, including outside your period)?

O no O yes

Do you suffer from fatigue? O no O yes

MALE PARTNERS DETAILS (IF APPLICABLE)

Blood group type: .... (Your blood group card will be requested at the consultation.)

FAMILY HISTORY

Is there anyone in your family with:	No	Yes	If yes, specify:
Congenital abnormalities	O	O	....
Known hereditary disorders	O	O	....
Fertility problems	O	O	....
Psychological problems (depression, schizophrenia, etc.)	O	O	....
Other problems not mentioned above	O	O	....

MEDICAL HISTORY

Have you ever been seriously ill? O no O yes

If yes, give the name of the disease and state whether you are still being monitored by a doctor for it:

....

Have you ever had depression or taken antidepressants? O no O yes

If yes, specify when, and whether you are still being monitored by a doctor for this:

....

Are you allergic to medication (e.g. antibiotics), latex or disinfectants?

O no O yes - specify: ....

Have you ever had problems in your testicles or penis?

O no O yes - specify: ....

Have you ever had problems with getting or maintaining an erection? O no O yes

Have you ever had problems with ejaculation? O no O yes

Have you ever had surgery? O no O yes

If yes, state the year and name of the operation: ....

Have you ever had an operation on your testicles or penis? O no O yes

If yes, state the year, the nature of the operation and the name of the doctor who performed it: ....

....

Are you taking medication? O no O yes

If yes, state the medication you take and the dose: ....

....

Do you have children from your current relationship? O no O yes

If yes, how many? ....

Do you have children from a previous relationship? O no O yes

If yes, how many? ....

LIFESTYLE

Are you currently an active smoker? O no O yes

If yes, how many per day? ....

Do you drink alcohol? O no O occasionally O yes

If yes, how many glasses a day? ....

Do you use or have you used soft or hard drugs? O no O yes

If yes, specify: ....

Do you use or have you recently used any dietary supplements obtained via the Internet or through gyms/shops?

O no O yes - specify: ....

Are you exposed to toxic substances? O no O yes

If yes, specify: ....

Do you work in unusual conditions? O no O yes

How much do you weigh?............. kg

How tall are you? .... cm