Fertility Consultation Questionnaire

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

How were you referred to FMCC? _____

Are you using Creighton Model Fertility Care menstrual charting (circle): **YES / NO**

Have you used any method to avoid pregnancy in the past? If so, what method/methods (pills, IUD, condoms, NFP, etc.): _____

_____

Menstrual History

How often do your menstrual periods occur (example 28-30 days)?_____

Total number of bleeding days: _____. Of this total number of days, how many days are heavy? _____.

Do you have significant pain with your menses? (circle) **YES / NO** If so, do you use medication for the pain? (circle) **YES / NO** If you use medication, what medication? _____

_____

Are you able to identify ovulation? (circle): **YES / NO** What method?_____

Any history of (circle all that apply): pelvic pain, abdominal pain, bloody stool, nipple discharge, vaginal discharge, or none

Male Factor

What is your spouse's name? _____ His date of birth: _____

Has he fathered children in the past? (circle) **YES / NO**

Does he have any history of (circle all that apply): varicocele, substance abuse, hypospadias, inguinal hernia surgery, genital surgery, genital trauma, testicular torsion, diabetes, spinal cord injury, kidney disorders, regular hot tub use

Does he have any sexual dysfunction concerns (e.g. erectile dysfunction, ejaculation problems, libido problems): _____

His occupation/work environment: _____

Has he had a semen analysis performed? (circle) **YES / NO** If so, when and what were the results? Date: _____ Results: _____

_____

Obstetrical History

Do you have a history of (circle): previous C-section, pregnancy loss/miscarriage, placental abruption, preterm labor or birth, still birth, pre-eclampsia, postpartum hemorrhage

Other

When was your last well-woman/annual exam? _____

When was your last pap smear performed? _____

Do you have pain with intercourse? (circle) YES / NO If yes, describe (circle all that apply): deep, central, insertional, position dependent, position independent, prevents intercourse on a regular basis, intermittent, constant-every time, or other (explain): _____

_____

Have you been evaluated for infertility in the past? (circle) **YES / NO** If so, what diagnosis, if any, were you given? _____

Have you had recent laboratory evaluation of your hormones? (circle) **YES/ NO** If so, what were the results? Date: _____ Results: _____

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