

Petoskey Gynecology and Infertility

INFERTILITY QUESTIONNAIRE

Your Name _____

Please circle or fill in the answers for the following questions if you are seeing Dr.Heidtke to discuss fertility issues. This will help use your office visit time more efficiently. She will also review any information that your other doctors have sent or that you bring with you.

1. How long have you been "trying" to have a baby? <1yr. 1-2 yrs. 3-4 yrs. 5-6 yrs. 7-10 yrs. >10yrs.
2. Were you on hormonal birth control before that? Yes No
If yes, was it: birth control pills DepoProvera Other _____
3. Have you had any pregnancies? Yes No
If yes, please fill in: Year
_____ miscarriage normal pregnancy vaginal birth C-Section
_____ miscarriage normal pregnancy vaginal birth C-section
_____ miscarriage normal pregnancy vaginal birth C-section
_____ miscarriage normal pregnancy vaginal birth C-section
4. Do you have regular menstrual cycles? Yes No
If yes, how often do they start? <every 26 days every 26-28 days every 28-30 days every 31-34 days
every 35 -38 days > every 38 days
5. If you don't have regular cycles, how many do you have a year? 1-2 3-4 5-6 7-8 9-10 11-12
Have you always had irregular cycles? Yes No
6. How many days do your periods last? 1-2 3-4 5-7 >7
7. Would you call the flow?: light normal heavy
8. Do you have a lot of pain with your menses? Yes No
9. Have you ever been treated for a pelvic infection (ex. PID, STD, chlamydia, gonorrhea)? Yes No
10. Have you ever had an infection in the abdomen or pelvis after surgery? Yes No
11. Have you ever used an IUD? Yes No
12. How long have you been with your current partner? <1yr. 1-2yrs. 3-4yrs. 5-6 yrs. >6yrs.
How old is he? _____
13. Has he had any pregnancies? Yes No
If yes, does he have any children? Yes No What ages?: _____
14. Has your partner had any testing done? Yes No
If yes, was his semen analysis thought to be normal? Yes No
If his test was abnormal, has he seen a urologist for further evaluation? Yes No
15. If he has not had testing done, does he have any medical history or condition which you think might affect his fertility?

(Continue to next page)

Your Name _____

16. Have you had any surgery in the pelvic area (uterus , tubes, ovaries, cervix)? Yes No
If yes, was it: scope surgery how many? 1 2 3
abdominal incision how many? 1 2 3
Was anything removed (i.e. cyst, fallopian tube, ovary) ? Yes No
Were you ever told you had: endometriosis? Yes No
scar tissue or adhesions? Yes No
Have you ever had treatment to your cervix (for an abnormal pap smear and biopsy)?
If yes, do you know what was done? Cryo (freezing) Laser LEEP Conization

17. Have you had an Xray of your uterus and tubes (hysterosalpingogram)? Yes No
If yes, were you told it was normal? Yes No

18. Are you taking prenatal vitamins? Yes No

19. Are there fertility problems in your family? Yes No
If yes, who has had problems? _____

20. Are there fertility problems in your partner's family? Yes No
If yes, who has had problems? _____

21. Is there a history of babies born in either of your families who have genetic problems? Yes No
Please write the name of the problem if you know it _____

22. Have you had any medical treatment yet such as: Clomid? Yes No
Metformin (Glucophage) Yes No

23. If you have not taken any fertility meds, would you consider taking them if I thought they would be helpful?
Yes No Unsure

24. Do you know what IUI (intrauterine insemination) is? Yes No Unsure

25. Do you know what an IVF (In Vitro Fertilization) is? Yes No Unsure

26. If other treatments are unsuccessful, do you think you would ever consider going through IVF?
Yes No Unsure

27. Do you know if you have prescription coverage for fertility meds? Yes No Unsure

Consider writing here any questions or comments you may have concerning your own particular situation, that may have come to mind while answering these questions .
