Patient History Assessment Form
Female Fertility Screening Questionnaire

1. Personal details

Name			
Address			
Date of Birth			
Telephone			
Email			
Height in cm		Weight in Kg	

2. Relationship status

2.1 Are you	☐ Single	☐ In a relationship

If you are in a relationship, please complete below as appropriate

Relationship	Yes (please tick)	Length of relationship in Years and Months	
Heterosexual	☐	Years	Months
Same Sex	☐	Years	Months
Other	☐	Years	Months
Please state your partner's name and their date of birth			
Name			
Date of birth (dd/mm/yy)	/ /		

3. Fertility

3.1 When did you start trying to purposefully get pregnant, i.e. when did you commence having regular, unprotected vaginal intercourse?	Month	Year

4. Menstrual history

4.1 On average how many days is your menstrual cycle, i.e. from the start of one period to the start of the next one?		
4.2 Date of last period		
4.3 Does your period affect your ability to undertake normal daily activities?	☐ Yes	☐ No
4.4 Do you know when you ovulate?	☐ Yes	☐ No
If yes; i) How do you know? i.e. test kit, pain, discharge		
ii) Around what day during your cycle do you ovulate?		

5. Gynaecological history

5.1 Have you ever had any gynaecological issues? *Please tick yes as appropriate.*

	Yes *Provide Details;*	**No**
Ovarian cysts		
Endometriosis		
PCOS (Polycystic ovarian syndrome)		
Pelvic infection		
Polyp		
Fibroids		
Cervical smear that needed treatment, e.g. Lletz, cone biopsy, laser		
Treatment for cancer		
Any other conditions that may be relevant		

6. Previous pregnancies

6.1 Have you ever been pregnant before? *If yes, please provide details below.*	☐ Yes ☐ No

Livebirth	DOB	Number of weeks pregnant at delivery	Type of Delivery (caesarean or vaginal)	Conceived with current partner
1.				☐ Yes ☐ No
2.				☐ Yes ☐ No
3.				☐ Yes ☐ No

Stillbirth				☐ Yes ☐ No

Miscarriage	Month	Year	Number of weeks pregnant	Conceived with current partner
1.				☐ Yes ☐ No
2.				☐ Yes ☐ No
3.				☐ Yes ☐ No

Termination of Pregnancy				☐ Yes ☐ No
Ectopic Pregnancy				☐ Yes ☐ No

6.2 Did you experience any pregnancy related complications? *If yes, please complete as appropriate.*

	Yes	**No**
Gestational diabetes		
Pre-eclampsia		
Post-partum haemorrhage		
Preterm delivery		
Other		

6.3 Do you have any adopted children?	☐ Yes	☐ No
If yes, was your child/children adopted with your current partner?	☐ Yes	☐ No

7. Previous fertility treatment

7.1 Other than your recent visit with your GP who initiated this referral, have you;

Seen a doctor before regarding your fertility?	☐ Yes	☐ No
Had previous fertility investigations?	☐ Yes	☐ No

If you ticked yes to previous fertility investigations, please complete table to the best of your availability?

Investigation	Result	Year	Fertility Service Provider

7.2 Have you ever had fertility treatment involving IUI?	☐ Yes	☐ No
7.3 Have you ever had IVF / ICSI?	☐ Yes	☐ No
7.4 Do you have any stored material remaining, e.g. embryos, eggs or sperm in storage?	☐ Yes	☐ No

Please note that if you have undergone private fertility treatment previously, i.e. IUI and/or IVF/ICSI, you will need to seek a discharge summary of your care from the relevant private provider. This will ensure that the fertility team in the regional service have a complete record of all your previous medical treatment in this area of care. You will need to bring this discharge summary to your first appointment in the regional service.

8. Sexual history

8.1 Have you ever had problems with sexual intercourse or vaginal examinations, e.g. pain, high levels of discomfort, dryness, unable to have vaginal sex	☐ Yes	☐ No

If yes please provide details;

8.2 Have you ever had a sexually transmitted infection (STI)?	☐ Yes	☐ No

If yes; which infection and what treatment did you receive?

9. Current medications

9.1 Please list your current medications (inclusive of non-prescribed medication, e.g. vitamins, folic acid)

10. General medical / surgical history

10.1 Please detail any significant medical conditions,
e.g. asthma, diabetes, inflammatory bowel disease, cancer treatment.

10.2 Please detail any previous general surgery, e.g. appendicitis, bowel surgery. Please provide the surgery dates.

10.3 Have you previously had bloods taken for;				
Hepatitis	☐ Yes	☐ No	If yes please indicate result;	
HIV	☐ Yes	☐ No	If yes please indicate result;	

11. Family history

11.1 Please provide details of any hereditary disorders, birth defects or fertility challenges in your family.

12. General health

12.1 Do you smoke	☐ Yes	☐ No
If yes, how many per day?		
12.2 Do you vape?	☐ Yes	☐ No
12.3 Do you currently use recreational drugs?	☐ Yes	☐ No
12.4 Do you drink alcohol?	☐ Yes	☐ No
If yes, how many standard drinks do you have on average every week? *1 standard drink = ½ pint of beer, 1 small glass of wine or 1 single measure of spirits*		

13. Any other information you think is relevant