FERTILITY QUESTIONAIRE

Both Patients, please omit questions that do not apply to you.

Full Circle
OBSTETRICS & GYNAECOLOGY

Primary Patient

Title:	Mr	Mrs	Ms	Miss	Other:	Date of Birth:	
Surname:						Given Name:	

How long have you been trying to conceive in your current relationship?	Years	Months
Approximately when did you cease using contraception?		
What type of contraception were you and your partner using?		
On average, how many times do you and your partner have intercourse each month?		
Are there any problems with intercourse? Eg. Painful, Dryness, Lack of Desire	Yes	No

Have you previously had any investigations or treatment in relation to fertility? If YES, please complete below:

Please outline or attach documentation if available

Please use this space to jot down any concerns that you would like to discuss:

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FEMALE / PRIMARY PATIENT:
(Part One)

PREGNANCY HISTORY: Number of pregnancies including miscarriages, terminations, ectopic pregnancies, and deliveries.

Year	Gestation (weeks)	Outcome of Pregnancy	Details of Pregnancy – eg Any problems?

MENSTRUAL & GYNAECOLOGICAL HISTORY

At what age did you have your first menstrual period?		Date of first day of your last menstrual period?		
Menstrual cycle eg. 28 days?	Days	Regular		Please tick applicable
How many days is your period?	Days	Irregular		

Do you have any of the following symptoms?					
Bleeding after intercourse:	Yes	No	Painful Period:	Yes	No
Intermenstrual Spotting	Yes	No	Heavy Period	Yes	No

Date of last CST	"Pap Smear"		Screening Result	Abnormal or Normal
Previous Abnormal CST	Yes	No	If yes, what year?	

Have you been diagnosed with any of the following conditions?

Polycystic Ovarian Syndrome (PCOS)	Yes	No
Premature Menopause	Yes	No
Pelvic Inflammatory Disease	Yes	No
Endometriosis	Yes	No
Ectopic Pregnancy	Yes	No
Fibroids	Yes	No
Diabetes?	Yes	No
Thyroid Problems?	Yes	No
Hypertension?	Yes	No
Any other Gynaecological Conditions?	Yes	No
Any other Condition/s, not listed above	Yes	No

If you answered YES to any of the above conditions, please provide further details below:

Have you ever had any of the following procedures?

Laparoscopy	Yes	No	Year
Hysterosalpingogram (HSG)	Yes	No	Year

MEDICATIONS:

Medication	Dose	Frequency	Reason for taking and duration

**Allergies	Describe in detail the reaction

LIFESTYLE:

Do you smoke?	Yes	No	Are you an ex-smoker?	Yes	No
Do you drink alcohol?	Yes	No	If yes, standard drinks	per week	
Do you take recreational or illicit drugs?	Yes	No	If yes, what type?		
Are you taking any Naturopathic or Herbal Medications?	Yes	No	If yes, which ones?		
Do you exercise regularly?	Yes	No	If yes, how many times?	per week	

FAMILY HISTORY: Including genetic disorders, cystic fibrosis, cancers, fertility issues and blood/bleeding disorders:

Family Member	Condition(s) or Disease(s)	Treatment(s)	Outcome

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PATIENT'S PARTNER:
(Part Two) - Patients Partner

Title:	Mr	Mrs	Ms	Miss	Other:	Date of Birth:	
Surname:						Given Name:	

Do you have any children from previous relationships?	Yes	No
Did you require fertility treatment in your previous relationships?	Yes	No
Have you ever had a semen analysis?	Yes	No
If YES, please provide a copy of results, or provide details of when and which pathology lab was used below:		

Have you ever had any of the following? If YES, when was the surgery performed:

Genital Surgery or injury as an adult or child?	Yes	No	Year
Mumps?	Yes	No	Year
Procedures by a urinary tract specialist (Urologist)?	Yes	No	Year
A vasectomy or a vasectomy reversal?	Yes	No	Year

MEDICATIONS:

Medication	Dose	Frequency	Reason for taking and duration

**Allergies	Describe in detail the reaction

Have you ever had any surgical procedures? Please provide details below:

	Year
	Year

LIFESTYLE:

Do you smoke?	Yes	No	Are you an ex-smoker?	Yes	No
Do you drink alcohol?	Yes	No	If yes, standard drinks		per week
Do you take recreational or illicit drugs?	Yes	No	If yes, what type?		
Are you taking any Naturopathic or Herbal Medications?	Yes	No	If yes, which ones?		

Do you exercise regularly?	Yes	No	If yes, how many times?	per week

FAMILY HISTORY: Including genetic disorders, cystic fibrosis, cancers, and blood/bleeding disorders.

Family Member	Condition(s) or Disease(s)	Treatment(s)	Outcome

Remember to forward your completed New Patient Information Form and your completed Questionnaire back to us, to allow Dr Preetam Ganu to review prior to your appointment.
by fax 08 8299 0893 or email flindersobgyn@gmail.com