FERTILITY QUESTIONNAIRE

Necessary to complete and deliver as soon as possible.

If the fertility questions do not apply to you, you may skip them.

PERSONAL DATA OF THE WOMAN WHO WANTS TO BECOME PREGNANT

Name: .....

First name: .....

Date of birth: .....

Address: .....

Postal code: .....

Municipality: .....

Country: .....

Language: .....

Phone number: .....

GSM: .....

E-mail: .....

Profession: .....

PERSONAL DATA OF THE PARTNER

Name: .....

First name: .....

Date of birth: .....

Address: .....

Postal code: .....

Municipality: .....

Country: .....

Language: .....

Phone number: .....

GSM: .....

E-mail: .....

Profession: .....

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CONTACT DETAILS OF YOUR OWN GYNAECOLOGIST

Name: .....

First name: .....

Address: .....

Postal code: .....

Municipality: .....

Country: .....

Language: .....

Phone number: .....

GSM: .....

Fax: .....

E-mail: .....

SUMMARY OF YOUR CONCRETE REQUEST FOR HELP TO LUFC

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PREVIOUS HISTORY OF THE WOMAN WHO WANTS TO BECOME PREGNANT

Wish for children since?.....

Duration of your relationship?.....

Are you ○ married of ○ cohabiting?

Blood type: .....(You will be asked for your blood type card at consultation.)

FAMILY HISTORY

Are there people in your family with:	**No**	**Yes**	**If yes, please specify:**
Congenital anomalies	○	○	.....
Known inherited disorders	○	○	.....
Breast cancer	○	○	.....
Ovarian cancer	○	○	.....
Endometriosis	○	○	.....
Diabetes	○	○	.....
Thyroid problems	○	○	.....
Psychological problems (depression, schizophrenia,…)	○	○	.....
Other things not mentioned above	○	○	.....

MEDICAL HISTORY

Have you ever been seriously ill? ○ no ○ yes

If yes, state the name of the disease and whether you are currently in follow-up with a doctor for this:

.....

Have you ever suffered from depression or taken antidepressants? ○ no ○ yes

If yes, state when and if you are still in follow-up with a doctor for this:

.....

Are you allergic to medication (antibiotics,…), latex or disinfectants? ○ no ○ yes

If yes, please specify:.....

Have you ever had gynaecological problems? ○ no ○ yes

If yes, please specify:.....

Have you ever had surgery? ○ no ○ yes

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

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Have you ever undergone gynaecological surgery? ○ no ○ yes

If yes, mention the year, the type of surgery and the name of the gynaecologist who operated on you:

.....

Are you taking medication? ○ no ○ yes

If yes, please list the medication you are taking and the dose: .....

Are you taking folic acid? ○ no ○ yes

LIFESTYLE

Do you smoke? ○ no ○ yes

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

Do you drink alcohol? ○ no ○ yes

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

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

If yes, please specify:.....

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

How tall are you?: .....cm

GYNAECOLOGICAL HISTORY

At what age did you get your first period?.....

When was your last period (date)?.....

Are your menstrual periods regular? ○ no ○ yes

What is the time span (in days) from one bleeding to the next minimum/maximum ...../.....

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

How much blood loss do you have during your periods?

○ few ○ normal ○ many with lumps ○ very many with lumps

Do you have cramps in the lower abdomen during your periods? ○ no ○ yes

If yes, are the cramps: ○ mild ○ moderate ○ severe

Have you had a gynaecological examination before? ○ no ○ yes

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

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

Do you sometimes have blood loss between your periods? ○ no ○ yes

Do you suffer from abnormal vaginal discharge? ○ no ○ yes

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Do you suffer from itching vaginally?	○ no	○ yes
Do you have painful bowel movements during your period?	○ no	○ yes
Do you sometimes have blood loss in bowel movements?	○ no	○ yes
Do you suffer from constipation?	○ no	○ yes
Do you suffer from diarrhoea?	○ no	○ yes
Do you have pain when urinating during your period?	○ no	○ yes
Do you sometimes have blood loss in urine?	○ no	○ yes
Do you suffer from lower abdominal pain continuously (almost daily and therefore also outside the period)	○ no	○ yes
Are you tired?	○ no	○ yes

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OBSTETRIC HISTORY

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

Pregnancy	***When (year)***	***Infertility treatment needed for this pregnancy?***	***Time taken to arrive at this pregnancy***	***Pregnancy evolution***	***Birth weight***
1e		O no O yes		O child born alive O miscarriage O ectopic pregnancy O abortion O child not born alive	
2e		O no O yes		O child born alive O miscarriage O ectopic pregnancy O abortion O child not born alive	
3e		O no O yes		O child born alive O miscarriage O ectopic pregnancy O abortion O child not born alive	
4e		O no O yes		O child born alive O miscarriage O ectopic pregnancy O abortion O child not born alive	
5e		O no O yes		O child born alive O miscarriage O ectopic pregnancy O abortion O child not born alive	

Have you had any problems during your pregnancy/pregnancies? O no O yes

If yes, state which problems and in which pregnancy: .....

.....

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

If yes, please specify:.....

.....

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Were there any problems with your baby/babies after birth? O no O yes

If yes, please specify:.....

.....

Have you been breastfeeding? .....

.....

If your pregnancy ended in a miscarriage, complete the table below.

Pregnancy	***Year***	**Number of weeks**	***Amniotic sac seen***	***Heart activity***
1e miscarriage			O no O yes	O no O yes
2e miscarriage			O no O yes	O no O yes
3e miscarriage			O no O yes	O no O yes
4e miscarriage			O no O yes	O no O yes
5e miscarriage			O no O yes	O no O yes

DATA PREVIOUS FERTILITY TREATMENTS

Have you ever received treatment for reduced fertility? O no O yes

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

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

If yes, please provide more information below and complete the table below:

Haw many cycles? .....

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Cycle	*Medication*	*Dose Clomid/Menopur(*)*	*Ovulation*	*Result(**)*
1e	O Clomid O Menopur O Ovitrelle		O no O yes	
2e	O Clomid O Menopur O Ovitrelle		O no O yes	
3e	O Clomid O Menopur O Ovitrelle		O no O yes	
4e	O Clomid O Menopur O Ovitrelle		O no O yes	
5e	O Clomid O Menopur O Ovitrelle		O no O yes	
6e	O Clomid O Menopur O Ovitrelle		O no O yes	

(*) Dose:

Clomid: expressed in number of tablets/day
Menopur: expressed in number of ampoules/day

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

1 = not pregnant
2 = only increased pregnancy hormone in blood or urine, but very early miscarriage afterwards
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 complete the table below:

How many cycles?.....

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Cycle	*Medication*	*Dose Clomid/Menopur(*)*	*Insemination*	*Sperm*	*Result(**)*
1e	O Clomid O Menopur O Ovitrelle		O no O yes	O donor	
2e	O Clomid O Menopur O Ovitrelle		O no O yes	O donor	
3e	O Clomid O Menopur O Ovitrelle		O no O yes	O donor	
4e	O Clomid O Menopur O Ovitrelle		O no O yes	O donor	
5e	O Clomid O Menopur O Ovitrelle		O no O yes	O donor	
6e	O Clomid O Menopur O Ovitrelle		O no O yes	O donor	

(*) Dose:

Clomid: expressed in number of tablets/day
Menopur: expressed in number of ampoules/day

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

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

Have you ever participated in an IVF or ICSI attempt? O no O yes

If yes, please provide more information below and complete the table below:

When? .....

Where? .....

How many fresh cycles (= cycles with pick-up)?.....

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

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Cycle	*Medication*	*Dose of medication at start (Menopur, Gonal-F or Puregon)*	*Number of oocytes at pick-up*	*IVF/ICSI*	*Number of fertilised oocytes*	*Day of embryo transfer (after pick-up)*	*Number of embryos transferred*	*Number of frozen embryos*	*Result (**)*
1e	○ Decapeptyl ○ Cetrotide ○ Orgalutran ○ Menopur ○ Gonal-F ○ Puregon			O IVF O ICSI					
2e	○ Decapeptyl ○ Cetrotide ○ Orgalutran ○ Menopur ○ Gonal-F ○ Puregon			O IVF O ICSI					
3e	○ Decapeptyl ○ Cetrotide ○ Orgalutran ○ Menopur ○ Gonal-F ○ Puregon			O IVF O ICSI					

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4e	○ Decapeptyl ○ Cetrotide ○ Orgalutran ○ Menopur ○ Gonal-F ○ Puregon			O IVF O ICSI					
5e	○ Decapeptyl ○ Cetrotide ○ Orgalutran ○ Menopur ○ Gonal-F ○ Puregon			O IVF O ICSI					
6e	○ Decapeptyl ○ Cetrotide ○ Orgalutran ○ Menopur ○ Gonal-F ○ Puregon			O IVF O ICSI					

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

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

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PREVIOUS HISTORY PARTNER

Wish for children since?.....

Duration of your relationship?.....

Are you ○ married of ○ cohabiting?

Blood type:.....(You will be asked for your blood type card at consultation.)

FAMILY HISTORY

Are there people in the family with:	**No**	**Yes**	**If yes, please specify**
Congenital anomalies	○	○	.....
Known inherited disorders	○	○	.....
Breast cancer	○	○	.....
Ovarian cancer	○	○	.....
Endometriosis	○	○	.....
Diabetes	○	○	.....
Thyroid problems	○	○	.....
Psychological problems (depression, schizophrenia,…)	○	○	.....
Other items not mentioned above	○	○	.....

MEDICAL HISTORY PARTNER

Have you ever been seriously ill? ○ no ○ yes

If yes, state the name of the disease and whether you are currently in follow-up with a doctor for this:

.....

Have you ever suffered from depression or take antidepressants? ○ no ○ yes

If yes, state when and if you are still in follow-up with a doctor for this:

.....

Are you allergic to medication (antibiotics,…), latex or disinfectants? ○ no ○ yes

If yes, please specify:.....

Have you ever had gynaecological problems? ○ no ○ yes

If yes, specify:.....

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Have you ever had surgery? ○ no ○ yes

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

Have you ever undergone gynaecological surgery? ○ no ○ yes

If yes, mention the year, the type of surgery and the name of the gynaecologist who operated on you:

.....

Are you taking medication? ○ no ○ yes

If yes, please list the medication you are taking and the dose: .....

Are you taking folic acid? ○ no ○ yes

LIFESTYLE PARTNER

Do you smoke? ○ no ○ yes

Indien ja, hoeveel per dag? .....

Do you drink alcohol? ○ no ○ yes

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

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

If yes, please specify:.....

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

How tall are you?: .....cm

Do you have children? ○ no ○ yes

Have you ever been pregnant? ○ no ○ yes

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1e		O no O yes		O child born alive O miscarriage O ectopic pregnancy O abortion O child not born alive	
2e		O no O yes		O child born alive O miscarriage O ectopic pregnancy O abortion O child not born alive	
3e		O no O yes		O child born alive O miscarriage O ectopic pregnancy O abortion O child not born alive	
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