Female Screening Questionnaire (Fertility)

Forms
Administration AF1.20

Name		DOB (dd/mm/yyyy)	
Address			

When did you start trying to conceive?	

Menstrual History	
How many days is your menstrual cycle *(i.e. from start of one period to the start of next one)*?	
Date of last menstrual period?	
For how many days do you bleed?	
Do you have troublesome pain with your periods?	☐ Yes ☐ No
Do you know when you ovulate? ☐ Yes ☐ No	
If Yes:	
How do you know *(e.g. pain, mucus, ovulation kit)*?	
Approximately what day of your cycle is it?	

Cervical Smear		
Have you ever had an **abnormal** smear?	☐ Yes	☐ No
If yes, did you need treatment?	☐ Yes	☐ No
If yes, please give details:		

Previous Fertility Treatment Details		
Have you ever had fertility treatment elsewhere?	☐ Yes	☐ No
If Yes, please give brief details and bring any paperwork you may have to your consultation		

Previous Pregnancy Details

Body Mass Index			
What is your height (*in cms*)?		What is your current weight (*in kgs*)?	

Medical History	
(Include surgery,/operations, childhood problems, medical conditions e.g. asthma infections)	
Current medications	
Allergies to medications	

Family History
(Include history of serious hereditary disorders, birth defects and/or any multiple births)

Lifestyle			
Cigarettes per day		Average weekly alcohol intake (units) *(I unit = ½ pint beer, 1 small glass wine)*	
Average weekly exercise undertaken			
Do you have any significant stresses in your life? ☐ Yes ☐ No If Yes, please provide details			

Is there any other information you think we should know e.g. Religious/Ethical concerns? ☐ Yes ☐ No If Yes, please provide details

Signed ______________________ Date ______________________