

# FEMALE MEDICAL HISTORY



KINDERWUNSCHZENTRUM  
GOLDENES KREUZ

Name:

Surname:

Date of birth:

Dear patient, filling out this questionnaire correctly and completely is very important, because this allows us to assess your situation faster during the consultation and to choose the best treatment strategy for you. Your assistance is greatly appreciated!

## 1. How long have you been trying to become pregnant with your current partner?

months / years

## 2. Do you have a steady menstrual cycle? (How many days between the first day of one period and the first day of the next?)

☐ Regular menstrual cycle between and days.

☐ Irregular menstrual cycle between and days.

☐ I haven't had my period since . The last period was months/ years ago.

## 3. How many days do you normally have a bleeding during your period?

In average days or between and days.

The intensity is usually: ☐ Light ☐ Mild ☐ Severe

Do you take pain medication during your period?

☐ No ☐ Yes - Which?

## 4. Have you ever been pregnant?

☐ No, never ☐ Yes

Please give information about your pregnancies, if any:

Year	Full term delivery (F) Termination (T) Miscarriage (M) Ectopic (E)	With your present partner?	After an infertility treatment?
	<input type="checkbox"/> F <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> E	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
	<input type="checkbox"/> F <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> E	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
	<input type="checkbox"/> F <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> E	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
	<input type="checkbox"/> F <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> E	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
	<input type="checkbox"/> F <input type="checkbox"/> T <input type="checkbox"/> M <input type="checkbox"/> E	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no

Notes:

## 5. Were there complications during the pregnancies?

☐ No ☐ Yes, namely:

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### 6. Which of the following contraceptives have you used?

☐ Condoms / none    ☐ Birth control pill    ☐ Coil    ☐ Other:

Did any complications arise with the contraceptives?

☐ No    ☐ Yes, namely:

### 7. Have you ever been in treatment resulting from your unfulfilled desire to have children?

☐ No    ☐ Yes,        months /        years

Type of treatment	How often?	Pregnant?
Stimulation of the ovaries with hormones		<input type="checkbox"/> yes <input type="checkbox"/> no
Intrauterine insemination with your partner's semen		<input type="checkbox"/> yes <input type="checkbox"/> no
Intrauterine insemination with donor semen		<input type="checkbox"/> yes <input type="checkbox"/> no
IVF - Classical IVF		<input type="checkbox"/> yes <input type="checkbox"/> no
IVF - ICSI		<input type="checkbox"/> yes <input type="checkbox"/> no
Transfer of cryopreserved embryos		<input type="checkbox"/> yes <input type="checkbox"/> no

Notes:

### 8. Previous IVF / ICSI treatments (important information - should be provided by the IVF facility upon request by the patient):

\* in case you have undergone more than 4 IVF cycles, please give information about the last four only:

Nr	Year	IVF	ICSI	Retrieved ovocytes	Transferred embryos	Number of frozen embryos	Pregnant?	Data from the IVF center is available
1		<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
2		<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
3		<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
4		<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no

Notes:

### 9. Comments on the previous treatments: What sort of stimulation did you receive?

Nr	Year	Medication / Substance (z.B. Menopur, Puregon, Clomiphen)	Dosage / Amount (e.g. 300 / 5 days)	Complications check 10*
1				<input type="checkbox"/> yes <input type="checkbox"/> no
2				<input type="checkbox"/> yes <input type="checkbox"/> no
3				<input type="checkbox"/> yes <input type="checkbox"/> no
4				<input type="checkbox"/> yes <input type="checkbox"/> no
5				<input type="checkbox"/> yes <input type="checkbox"/> no

Notes:

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## 10.\* Did any complications arise due to ovarian stimulation or / and IVF?

- ☐ None
 ☐ Bad response to the stimulation  
☐ Hyper stimulation (OHSS)
 ☐ Fertilization failure  
☐ Difficult or painful transfer
 ☐ Other:

Notes:

## 11. Have you ever had an examination of the Fallopian tubes?

<input type="checkbox"/> No	Yes <input type="checkbox"/> LSK (operation) In (year)	Yes <input type="checkbox"/> HSG (x-ray) In (Year)	Yes <input type="checkbox"/> hydrosalpingography In (year)
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### Results:

Left: ☐ Open ☐ Closed ☐ partially closed or undergone surgical correction  
 Right: ☐ Open ☐ Closed ☐ partially closed or undergone surgical correction

## 12. Gynecological procedures / diseases:

Question	No	Yes	Details
Have you had a tubal surgery? (e.g. because of ectopic pregnancy)	<input type="checkbox"/>	Right <input type="checkbox"/>	<input type="checkbox"/> removed <input type="checkbox"/> sterilization
		Left <input type="checkbox"/>	<input type="checkbox"/> removed <input type="checkbox"/> sterilization
Have your ovaries been completely or partially removed? (e.g. because of a cyst)	<input type="checkbox"/>	Right <input type="checkbox"/>	<input type="checkbox"/> partially removed or cyst
		Left <input type="checkbox"/>	<input type="checkbox"/> partially removed or cyst
Do you have endometriosis? Confirmed / treated by operation?	<input type="checkbox"/>	<input type="checkbox"/>	Laparoscopy: <input type="checkbox"/> Yes, check 13*.
Do you have / have you ever had ovarian cysts?	<input type="checkbox"/>	<input type="checkbox"/>	Laparoscopy: <input type="checkbox"/> Yes, check 13*.
Is there any malformation of your uterus known?	<input type="checkbox"/>	<input type="checkbox"/>	

Notes:

## 13\*. Have you ever had surgery of the abdomen and/or lower abdomen?

☐ No If Yes ☐ please use the following table to give details

Year	Surgeries of abdomen and/or lower abdomen: Appendectomy (A), Ceasarian section (S), Laparoscopic surgery (L), Hysteroscopy (H), Laparotomy (T) Curettage (C), Cone biopsy(K)	Where (hospital) and why?
	<input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> L <input type="checkbox"/> H <input type="checkbox"/> T <input type="checkbox"/> C <input type="checkbox"/> K	
	<input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> L <input type="checkbox"/> H <input type="checkbox"/> T <input type="checkbox"/> C <input type="checkbox"/> K	

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<input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> L <input type="checkbox"/> H <input type="checkbox"/> T <input type="checkbox"/> C <input type="checkbox"/> K	
<input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> L <input type="checkbox"/> H <input type="checkbox"/> T <input type="checkbox"/> C <input type="checkbox"/> K	
<b>Other surgeries?</b>	

Notes:

**14\*. If you take any medication regularly, please give details below:**

Medication name	Dose	Since?	Why?

**15. Do you or have you ever suffered from any of the following diseases?**

(Check all that apply)

Symptom	No	Yes	Details (if known - name of the disease)	Since	Therapy see *14
Allergy against medication	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes*
Thrombosis / blood coagulation disorder	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes*
Cancer / Tumors	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes*
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Since            treated with: Pills <input type="checkbox"/> / Injections (Insulin) <input type="checkbox"/>		<input type="checkbox"/> Yes*
High blood pressure / Hypertonic	<input type="checkbox"/>	<input type="checkbox"/>	>160 <input type="checkbox"/> below 160 <input type="checkbox"/> below 140 <input type="checkbox"/>		<input type="checkbox"/> Yes*
Lung disease (Asthma, Bronchitis)	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes*
Neurological disease (e.g. Epilepsy, Vascular, Trauma, Tumor, Inflammation)	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes*
Kidney / Bladder disease (e.g. Insufficiency, Cysts, Tumors)	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes*
Heart disease (e.g. Infarction, rhythmic disorder, Insufficiency, deformed valves)	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes*
Liver disease (e.g. Hepatitis, Cirrhosis, Cysts)	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes*

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Stomach or Intestines (e.g. Inflammation, Ulcers, Immunological & Chronic diseases)	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes*
Thyroid gland diseases	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes*

Notes:

## 16. Do you have or have you ever had any of the following symptoms?

(Check all that apply)

Symptom	No	Yes	How often?	Due to stress?	Since?	Therapy See *14
Sleeping problems	<input type="checkbox"/>	<input type="checkbox"/>	times/week	<input type="checkbox"/> Yes		<input type="checkbox"/> Yes*
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	times/week	<input type="checkbox"/> Yes		<input type="checkbox"/> Yes*
Frequent or/and strong headaches / Migraines	<input type="checkbox"/>	<input type="checkbox"/>	times/week	<input type="checkbox"/> Yes		<input type="checkbox"/> Yes*
Panic / Depressions	<input type="checkbox"/>	<input type="checkbox"/>	times/week	<input type="checkbox"/> Yes		<input type="checkbox"/> Yes*
Extreme nervousness	<input type="checkbox"/>	<input type="checkbox"/>	times/week	<input type="checkbox"/> Yes		<input type="checkbox"/> Yes*
Hot flashes / extensive sweating	<input type="checkbox"/>	<input type="checkbox"/>	times/week	<input type="checkbox"/> Yes		<input type="checkbox"/> Yes*
Hair loss	<input type="checkbox"/>	<input type="checkbox"/>	Severe <input type="checkbox"/> Head <input type="checkbox"/> Body <input type="checkbox"/>			<input type="checkbox"/> Yes*
Extensive / untypical hairiness	<input type="checkbox"/>	<input type="checkbox"/>	Severe <input type="checkbox"/> Head <input type="checkbox"/> Body <input type="checkbox"/>			<input type="checkbox"/> Yes*
Acne	<input type="checkbox"/>	<input type="checkbox"/>	In the Face <input type="checkbox"/> a/o on the body <input type="checkbox"/>			<input type="checkbox"/> Yes*
Chronic / acute abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	Reason:			<input type="checkbox"/> Yes*
Painful urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Often <input type="checkbox"/> Blood in urine			<input type="checkbox"/> Yes*
Painful defecation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Often <input type="checkbox"/> Blood in feces <input type="checkbox"/> Constipation <input type="checkbox"/> Hemorrhoids			<input type="checkbox"/> Yes*
Painful intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Severe <input type="checkbox"/> Not always			<input type="checkbox"/> Yes*

Notes:

## 17. Have you undergone any of the following examinations?:

**Important:** If you have results from any of the examinations, please send these to us!

Examination	No	Yes	Details (if known)	
Cervical smear test	<input type="checkbox"/>	<input type="checkbox"/>	Last in: (month/year)	
Thyroid gland testing	<input type="checkbox"/>	<input type="checkbox"/> was	<input type="checkbox"/> OK	<input type="checkbox"/> not OK
Blood clotting (Coagulation status)	<input type="checkbox"/>	<input type="checkbox"/> was	<input type="checkbox"/> OK	<input type="checkbox"/> not OK
Immunological status	<input type="checkbox"/>	<input type="checkbox"/> was	<input type="checkbox"/> OK	<input type="checkbox"/> not OK
Chromosome mapping / Caryotyping	<input type="checkbox"/>	<input type="checkbox"/> was	<input type="checkbox"/> OK	<input type="checkbox"/> not OK
Cystic fibrosis (CFTR gene test)	<input type="checkbox"/>	<input type="checkbox"/> was	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive

Notes:

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### 18. How often do you have sexual intercourse with your partner?

Usually          times/week          times/month

### 19. Your weight and height please:          kg          cm

Did you lose or gain more than 5kg in the last 12 months?

☐ No          Yes I gained          kg          kg / lost

### 20. Do you smoke or have you ever smoked?

☐ No, never          ☐ I quit smoking          months          years ago.  
☐ Yes, I smoke          cigarettes/day.

### 21. Do you drink alcohol?

☐ Never          ☐ Rarely          ☐ Occasionally          ☐ Regularly

### 22. Do you or have you ever consumed any street drugs?

☐ No          ☐ Yes, in the past          ☐ Yes, now          Which?

### 23. Did or do any of your relatives suffer from the following?

☐ Genetic diseases\*          ☐ Cancer (>2 close relatives)\*  
☐ Infertility\*          ☐ Other:          \*

\* Details (who is affected and how severe):

### 24. What is your profession?

I am working as:

Are you exposed to any severe physical stress or chemical substances at your workplace?

☐ No          ☐ Yes, I am exposed to: