FEMALE MEDICAL HISTORY

Виена Ин Витро Център
Vienna In Vitro Center

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?
	☐ F ☐ T ☐ M ☐ E	☐ yes ☐ no	☐ yes ☐ no
	☐ F ☐ T ☐ M ☐ E	☐ yes ☐ no	☐ yes ☐ no
	☐ F ☐ T ☐ M ☐ E	☐ yes ☐ no	☐ yes ☐ no
	☐ F ☐ T ☐ M ☐ E	☐ yes ☐ no	☐ yes ☐ no
	☐ F ☐ T ☐ M ☐ E	☐ yes ☐ no	☐ yes ☐ 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		☐ yes ☐ no
Intrauterine insemination with your partner's semen		☐ yes ☐ no
Intrauterine insemination with donor semen		☐ yes ☐ no
IVF – Classical IVF		☐ yes ☐ no
IVF - ICSI		☐ yes ☐ no
Transfer of cyropreserved embryos		☐ yes ☐ 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		☐	☐				☐ yes ☐ no	☐ yes ☐ no
2		☐	☐				☐ yes ☐ no	☐ yes ☐ no
3		☐	☐				☐ yes ☐ no	☐ yes ☐ no
4		☐	☐				☐ yes ☐ no	☐ yes ☐ 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				☐ yes ☐ no
2				☐ yes ☐ no
3				☐ yes ☐ no
4				☐ yes ☐ no
5				☐ yes ☐ no

Notes:

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

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

Notes:

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

☐ No	Yes ☐ LSK (operation) In (year)	Yes ☐ HSG (x-ray) In (Year)	Yes ☐ hydrosonography In (year)

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)	☐	Right ☐	☐ removed	☐ sterilization
		Left ☐	☐ removed	☐ sterilization
Have your ovaries been completely or partially removed? (e.g. because of a cyst)	☐	Right ☐	☐ partially removed or cyst	
		Left ☐	☐ partially removed or cyst	
Do you have endometriosis? Confirmed / treated by operation?	☐	☐	Laparoscopy: ☐ Yes, check 13*.	
Do you have / have you ever had ovarian cysts?	☐	☐	Laparoscopy: ☐ Yes, check 13*.	
Is there any malformation of your uterus known?	☐	☐		

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?**
	☐ A ☐ S ☐ L ☐ H ☐ T ☐ C ☐ K	
	☐ A ☐ S ☐ L ☐ H ☐ T ☐ C ☐ K	

	☐ A ☐ S ☐ L ☐ H ☐ T ☐ C ☐ K	
	☐ A ☐ S ☐ L ☐ H ☐ T ☐ C ☐ K	
	Other surgeries?	

Notes:

14*. If you take any medication regularaly, 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	☐	☐			☐ Yes*
Thrombosis / blood coagulation disorder	☐	☐			☐ Yes*
Cancer / Tumors	☐	☐			☐ Yes*
Diabetes	☐	☐	Since treated with: Pills ☐ / Injections (Insulin) ☐		☐ Yes*
High blood pressure / Hypertonic	☐	☐	>160 ☐ below 160 ☐ below 140 ☐		☐ Yes*
Lung disease (Asthma, Bronchitis)	☐	☐			☐ Yes*
Neurological disease (e.g. Epilepsy, Vascular, Trauma, Tumor, Inflammation)	☐	☐			☐ Yes*
Kidney / Bladder disease (e.g. Insufficiency, Cysts, Tumors)	☐	☐			☐ Yes*
Heart disease (e.g. Infarction, rhythmic disorder, Insufficiency, deformed valves)	☐	☐			☐ Yes*
Liver disease (e.g. Hepatitis, Cirrhosis, Cysts)	☐	☐			☐ Yes*

Stomach or Intestines (e.g. Inflammation, Ulcers, Immunological & Chronic diseases)	☐	☐			☐ Yes*
Thyroid gland diseases	☐	☐			☐ 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	☐	☐	times/week	☐ Yes		☐ Yes*
Weakness	☐	☐	times/week	☐ Yes		☐ Yes*
Frequent or/and strong headaches / Migraines	☐	☐	times/week	☐ Yes		☐ Yes*
Panic / Depressions	☐	☐	times/week	☐ Yes		☐ Yes*
Extreme nervousness	☐	☐	times/week	☐ Yes		☐ Yes*
Hot flashes / extensive sweating	☐	☐	times/week	☐ Yes		☐ Yes*
Hair loss	☐	☐	Severe ☐ Head ☐ Body ☐			☐ Yes*
Extensive / untypical hairiness	☐	☐	Severe ☐ Head ☐ Body ☐			☐ Yes*
Acne	☐	☐	In the Face ☐ a/o on the body ☐			☐ Yes*
Chronic / acute abdominal pain	☐	☐	Reason:			☐ Yes*
Painful urination	☐	☐	☐ Often ☐ Blood in urine			☐ Yes*
Painful defecation	☐	☐	☐ Often ☐ Blood in feces ☐ Constipation ☐ Hemorrhoids			☐ Yes*
Painful intercourse	☐	☐	☐ Severe ☐ Not always			☐ 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	☐	☐	Last in: (month/year)	
Thyroid gland testing	☐	☐ was	☐ OK	☐ not OK
Blood clotting (Coagulation status)	☐	☐ was	☐ OK	☐ not OK
Immunological status	☐	☐ was	☐ OK	☐ not OK
Chromosome mapping / Caryotyping	☐	☐ was	☐ OK	☐ not OK
Cystic fibrosis (CFTR gene test)	☐	☐ was	☐ Negative	☐ Positive

Notes:

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: