Gynaecology/Urology Joint Infertility Clinic	Female Questionnaire	NHS Greater Glasgow and Clyde
	Assisted Conception Service	

This questionnaire should be filled in by the female partner. It should be handed in to the clinic nurse when you attend. Please provide as much information as possible. If you are unsure of any details, please do not worry. Make a note of these points in the box provided at the end of the questionnaire and the doctor will be happy to discuss this in the clinic.

Name: Date of birth:

Occupation:

Partner's name: Partner's Date of Birth:

Partner's occupation:

Length of current relationship: .....Years .....Months

Are you married? Yes No

How long have you been trying for a baby? .....Years .....Months

When did you stop using contraception? .....Years .....Months

If you have been sterilised or if your partner had a vasectomy then please specify:

Neither apply I have had a sterilisation My partner had a Vasectomy

<u>Details of previous pregnancies if any:</u>

Have you been pregnant before in this relationship or in a previous relationship?

No Yes. If yes, please provide details below:

.....

.....

Is there a child currently resident with you? No Yes

<u>Details of your menstrual periods:</u>

How are your periods: Regular Irregular I do not have periods

What is the interval between your periods (i.e. the start of one to the start of next period) ..... (e.g. 28 days, 23 -25 days, 32-34 days)

How many days does your menstrual period last usually: ..... (e.g. 3 days, 5 days etc)

Has your GP done tests to check for ovulation: Yes No

If yes, what was the result: Ovulating Not Ovulating Unsure

Gynaecology/Urology Joint Infertility Clinic	Female Questionnaire	NHS Greater Glasgow and Clyde
	Assisted Conception Service	

Have you had a normal smear within the last 3 years: Yes No

If you have had an abnormal smear in the past then please provide details below

.....

.....

Do you suffer from any medical illnesses:

Endometriosis PCOS Asthma Diabetes Epilepsy

Thyroid problems ↑Blood Pressure Deep Vein Thrombosis

Others: please provide details below:.....

.....

.....

Have you had any operations: e.g. Laparoscopy, Appendix, Ectopic pregnancy etc.

Please provide details below

.....

.....

Do you take any regular medications: Please provide details below

.....

.....

Are you taking folic acid: No Yes

Are you allergic to any medication: No Yes

If yes, please provide details:

.....

.....

Do you smoke: No Yes (.....cigs/day)

Do you take alcohol: No Yes (.....units/week)

Are there any serious illnesses that run in your family: No Yes

If yes, please provide details:

.....

Any other information: