Dr Hossam Elzeiny
MBBS FRANZCOG CREI
Reproductive Endocrinologist,
Fertility Specialist,Andrologist,
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FEMALE FERTILITY QUESTIONAIRE

Date of first visit: / /20

Patient Name: Age: Date of Birth: / /19

Weight (kg) : Height (cm):

Occupation:

Partner's Name: Partner's Age: Date Of Birth: / /19

1.	How long have you been actively attempting pregnancy? _____ Years _____ Months		
2.	Have you been pregnant before?	**Yes**	**No**
3.	Previous pregnancies outcome & number : Live Birth X Miscarriage X Ectopic X		
4.	If you have conceived before, how long did it take you to get pregnant? Years months		
5.	If you have conceived before, did you use fertility medications ?	**Yes**	**No**
6.	Has your partner completed a Semen Analysis?	**Yes**	**No**
7.	At what age did you get your first ever menstrual period?		
8.	Do you have regular menstrual periods?	**Yes**	**No**
9.	What is the length of your cycle? (Day 1 of previous cycle to Day 1 of following cycle i.e 28d) ( ) days		
10.	Do you get pain with periods?	**Yes**	**No**
11.	Do you get pain with intercourse?	**Yes**	**No**
12.	Have you been diagnosed with Endometriosis?	**Yes**	**No**
13.	Have you gained or lost any significant weight recently? If yes ,Please encircle gained or lost	**Yes**	**No**
14.	Have you ever been treated for pelvic infection?	**Yes**	**No**
15.	Are you currently taking any medications on a regular basis? If yes, what medications?	**Yes**	**No**
16.	Is your Pap smear up to date and normal?	**Yes**	**No**
17.	Are you allergic to any medications? If yes, what medications?	**Yes**	**No**
18.	Do / did you smoke cigarettes? If yes, how many cigarettes a day?	**Yes**	**No**
19.	Do you drink alcoholic beverages? If yes, how many drinks a week?	**Yes**	**No**
20.	Have you had any operations in the pelvic area i.e laparoscopy ?	**Yes**	**No**
21.	Have you previously had evaluation for infertility?	**Yes**	**No**
22.	Is there any family history of inherited medical conditions?	**Yes**	**No**
23.	Any other relevant information?		

I declare the above information to be complete and correct

Patient Signature: Printed Name: Date: / /20

Please complete this Questionaire and return it to reception or by email, fax or regular post.

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