



Fertility Questionnaire – Women

Please fill out the following fields. If any question is unclear, simply mark it with a question mark. Thank you!

Name _____ Address _____
First Name _____
Date of Birth _____ Phone _____
Occupation _____ Email _____
Who is your gynecologist? _____

Are you married?

☐ No ☐ Yes, since _____ (Year)

Since when have you had the desire to have children?

_____ (Month/Year)

How often do you have sexual intercourse with your partner?

approx. _____ times per week / _____ times per month

Pregnancies

Have you ever been pregnant?

☐ No ☐ Yes

If yes, when and how did the pregnancies progress and what was the outcome?

Month/ Year	Week of pregnancy	Spontaneous birth	Cesarean section	Miscarriage	Abortion	Ectopic pregnancy	with current partner	after fertility treatment

Did any complications occur?

☐ No ☐ Yes, the following: _____

Type of pretreatments

Have you already been treated medically because of your desire to have children?

☐ No ☐ Yes

If yes, which treatment method was applied and did it result in a pregnancy?

Month/Year	Timed intercourse	IUI Intrauterine Insemination	IVF In vitro fertilization	ICSI Intracytoplasmic Sperm Injection	Cryo-transfer of frozen embryos	Pregnancy (yes/no)

Which medications have you received? _____

Previous IVF or ICSI treatments

If you have already had more than four IVF or ICSI treatments, please provide the last four below.

Month/Year	IVF or ICSI	Number of eggs	Number of fertilized eggs	Number of embryos transferred	Number of frozen cells/embryos	Pregnancies (yes/no)

Which medications have you received? _____

Were there any complications with IVF/ICSI treatments?

☐ No ☐ Yes, overstimulation syndrome ☐ Yes, bleeding ☐ Other, the following: _____

Period/Hormones

At what age did you have your first period? At the age of _____ years

Have you used contraception?

☐ No ☐ Yes, pill from _____ (Year) to _____ (Year) ☐ Yes, intrauterine device from _____ (Year) to _____ (Year)

Have you been sterilized?

☐ No ☐ Yes, in _____ (Year)

At what intervals does your period occur (Interval from the first day of your period to the next first day of the period)?

☐ Regularly all _____ to _____ days ☐ Irregularly all _____ to _____ days

☐ Currently no menstrual bleeding since _____

How many days does your period usually last? Between _____ and _____ days

How heavy is your menstrual bleeding?

☐ Light ☐ Medium ☐ Strong

Do you have intermenstrual bleeding?

☐ No ☐ Yes If yes, when? _____

Do you have pain before or during your period?

☐ No ☐ Light ☐ Medium ☐ Strong

Do you experience any of the following symptoms?

☐ Acne ☐ Increased hair loss ☐ Increase in body hair ☐ Nipple discharge

Gynecological history

Has your fallopian tube function already been checked?

☐ No ☐ Yes If yes, when? _____ (Year)

By which method?

☐ Hysterosalpingo-contrast sonography (HyCoSy) ☐ Laparoscopy

With what result?

Left fallopian tube: ☐ clear ☐ closed Right fallopian tube: ☐ clear ☐ closed

Do you have or have you ever had a fallopian tube infection or sexually transmitted diseases (e.g., chlamydia)?

☐ No ☐ Yes, the following: _____

When was your last gynecological cancer screening? _____ (Year)

When was your last mammogram? _____ (Year)

General Background

Do you have or have you had one or more of the following diseases or conditions?

☐ Thyroid diseases	since _____ (Year)	☐ Kidney diseases	since _____ (Year)
☐ Diabetes	since _____ (Year)	☐ Liver diseases	since _____ (Year)
☐ Cardiovascular diseases	since _____ (Year)	☐ Cancer	Type? _____ since _____ (Year)
☐ Thrombosis/Embolism	since _____ (Year)	☐ Mental illnesses	since _____ (Year)
☐ Blood clotting disorders	since _____ (Year)	☐ Headaches/Migraines	since _____ (Year)
☐ Epilepsy	since _____ (Year)	☐ Genetic disorders	since _____ (Year)
☐ Asthma/Chronic bronchitis	since _____ (Year)	☐ Other	Which? _____ since _____ (Year)
☐ Gastrointestinal diseases	since _____ (Year)		_____ since _____ (Year)

Are you taking any medication?

☐ No ☐ Yes, the following: _____

How much do you weigh and how tall are you?

Weight (kg) _____ Height (cm) _____ BMI _____

Have you already undergone surgery?

☐ No ☐ Yes, the following: _____ in _____ (Year)

_____ in _____ (Year)

_____ in _____ (Year)

Do you have any allergies (e.g., to medications, antibiotics)?

☐ No ☐ Yes, the following: _____

Do you drink alcohol?

☐ Never ☐ Rarely ☐ Occasionally ☐ Regularly

Do you smoke?

☐ No ☐ Yes, _____ cigarettes/day

Do you consume other substances (drugs or doping)?

☐ No ☐ Yes, the following: _____

Are there any serious illnesses in your family (e.g., hereditary diseases, cancer, involuntary infertility)?

☐ No ☐ Yes, the following: _____

Have you had an inpatient hospital stay of more than 3 days in the last 12 months?

☐ No ☐ Yes, due to: _____

Do you have or have you ever had chronic bacterial colonization (e.g., MRSA)?

☐ No ☐ Yes

Additional Information
