

FEMALE REPRODUCTIVE HEALTH HISTORY QUESTIONNAIRE

Please fill this as comprehensively as you can – it will help me to build up a picture of your individual circumstances and needs. All the information you provide is completely confidential.

Name _____ Date of birth _____

At what age did you begin menstruating? _____

Have you ever experienced problems? If so, please state what (eg PMS, irregular cycles, fibroids, endometriosis) _____

What contraception are you currently using? _____

Have you ever taken the Pill or used other contraceptive aids other than condoms? _____

If yes, give details _____

Do you have any children? _____

If yes, how many and when were they born? _____

Did you experience any problems/complications conceiving or during pregnancy or birth?

Have you ever had a miscarriage or abortion? If yes, give details _____

PTO

Have you ever had any medical treatment related to your reproductive health (eg a D&C, investigative operations, scans etc) _____

Have you ever had any sexually-transmitted diseases? If so, give details _____

Are you seeing or have you seen a doctor or specialist for fertility treatment? If so, give details

Please give details of your partner – his age, reproductive history and current state of health

Is there any other information which you feel is relevant to your pre-conceptual care programme?
