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INFERTILITY QUESTIONNAIRE

Please complete this form and return it to the rooms prior to, or at the time of your consultation.

Name & Contact Details:

Name _____ Date of Birth _____
Partners name _____ Partners date of birth _____

Your History:

How long have you been trying to conceive? _____

Have you ever been pregnant, _____

- was there any difficulty conceiving with previous pregnancies _____
- what was the outcome of any previous pregnancies _____

Are your periods usually regular _____

What is the length of your cycle – i.e. from the first day of one period to the first day of the next period _____

Have you ever been diagnosed with any of the following _____

- Polycystic Ovarian Syndrome Endometriosis Ovarian cysts Pelvic Inflammatory Disease or Pelvic Infection
 Adhesions Ectopic pregnancy Reversal of tubal ligation Fibroids

What methods of contraception have you used in the past? _____

Do you smoke? _____

How much alcohol would you drink per week on average? _____

Are you taking folic acid supplements? _____

Your Partners History:

Does your partner have any children from previous relationships? _____

If so was there any difficulty with conception? _____

Does your partner smoke? _____

How much alcohol would your partner drink per week on average? _____

Does your partner have any history of the following? Yes/No _____

- undescended testes testicular infection varicocele vasectomy reversal

Does your partner have any major medical illnesses? _____

Have you or your partner had any previous investigations or treatment for infertility? Yes/No _____

Have you or your partner had any of the following investigations or treatment? _____

- laparoscopy +/- dye studies hysterosalpingogram (HSG) pelvic ultrasound semen analysis
 clomiphene tubal surgery in-vitro fertilization (IVF) intracytoplasmic sperm injection (ICSI)