FERTILITY QUESTIONNAIRE Name: …….. Date: _ _ / _ _ / 20 _ _

For how long have you been trying to fall pregnant? ___ (months/years)

	Tick if describes you
Acne, oily skin, or dandruff	
Amenorrhea (no period)	
Anxiety	
Bladder problems	
Constipation	
Cysts on ovaries	
Dark-coloured patches of thick skin on neck, groin, underarms or skin folds	
Depression	
Diarrhoea	
Endometriosis	
Excess facial and body hair growth	
Family history of infertility	
Fatigue	
Heavy bleeding	
High blood pressure	
History of physical, sexual or emotional abuse	
Hot flashes and night sweats	
Hyperglycaemia or Diabetes	
Increased levels of male hormone, like testosterone	
Increased premenstrual symptoms	
Infrequent periods	
Irregular bleeding	
Irritability	
IVF treatment (If so how many attempts? ___)	
Lipid abnormalities (high or low cholesterol, high triglycerides)	
Long term stress	
Loss of sex drive	
Lower back pain	
Male-pattern baldness or thinning hair	
Overweight	
Pain during or after sex	
Pain during ovulation	
Painful bowel movements or urination during period	
Painful periods	
Pelvic pain or pressure	
Previous miscarriage (If so how many? ___)	
Previous successful pregnancy (If so how many? ___)	
Severe grief or trauma	
Skin tags in the armpits or neck	
Sleep problems	
Spinal, low back or pelvic injury	
Stomach bloating	
Underweight	
Vaginal dryness	
Total number of boxes ticked =	

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