

## 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) \_\_\_\_\_

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

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

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

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

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