Gynaecology Practice
Centre for Reproductive Medicine

Dr. med. R. Behrens
Dr. med. A. Hammel

Questionnnaire for the woman

Surname: …… First name: …… Date of birth: ……..

Address: ……

Telephone Nr. Private: …… Mobile: …… Business: ……...

Medical Insurance …… Occupation: ……

Gynaecologist ……... Email address: ……

Are you married with your partner? □ yes □ no

Appointed day …… **Appointed time** ……..

□ Dr. Behrens □ Dr. Hammel

□ Dr.Treutlein □ Dr. Wiedmann □ PD Dr. Freis

1. When did you have your first period? at approx ..... years of age

2. When did your breasts start to develop? at approx ..... years of age

3. When did hair start growing under the arms and in the pubic area?

at approx ..... years of age

4. Have you ever had regular periods without taking hormone supplements (e.g. the Pill) ?

□ yes □ no

5. Are your periods regular and how many days are there from day 1 of a period till day 1 of the next cycle without taking medication?

□ regular between ……..and ……. days
□ irregular between ……....and …….
days/weeks/months
□ I haven't had a period for …….
weeks/months/years

6. How many days on average does your period last? ……days

Have you had bleeding between your periods (intermenstrual bleeding)?

□ no □ yes

If yes, when does the intermenstrual bleeding take place □ early in the cycle
□ later in the cycle

7. How strong is your usual menstrual flow? □ weak □ average □ heavy

8. Do you have pain in the lower abdomen? □ no
□ before or during your period
□ during sexual intercourse
□ independent of the period

9. When did your last period begin? ……..

If you are not sure, give month or year ……..

10. Does your weight remain constant or does it tend to fluctuate (more than 4 kg or ½ stone)?

□ remains constant □ tends to fluctuates Your height ……cm

□ mostly increases □ mostly decreases Your weight ……kg

11. Have you had any problems with your breasts? □ no □ yes

If yes, what type? ..... treatment ……..

12. Have you notices any secretion from the breasts, excluding during pregnancy, and breast feeding?

□ no

□ yes, ……

13. Have you been pregnant before? □ no □ yes

Birth, year and month	1. …….. year 2. …….. year 3. …….. year
Miscarriage / spontaneous abortion	1. …….. year, which month? …… 2. …….. year, which month? …… 3. …….. year, which month? ……
Abortion	1. …….. year, which month? ..... 2. …….. year, which month? .....
Ectopic pregnancy	1. ……year, □ left □ right 2. ……year, □ left □ right

Treatment……..

14. Have you experienced problems in previous pregnancies □ no

□ Problems with the development of the placenta

□ Fever/ inflammation after the birth/ abortion or miscarriage

15. How long have you been trying to fall pregnant? ……years

16. Do you experience problems having sexual intercourse {e.g. physical separation, discomfort or pain during intercourse, physical difficulties or differences in attitude with your partner} which you think could be a reason for your childlessness?

□ no □ yes.……

17. Did you or do you have any pelvic disorders? □ no □ if yes

□ Ovarian cysts

□ Endometriosis

□ Fibroids (Myomata)

□ Pelvic infection (Salpingitis)

□ Blocked tubes (Hydrosalpingx)

□ appendicitis

In which year ……..

How were you treated

(medication/operation)?.....

18. Have you had an examination of the uterus and tubes? □ no

if yes,	when	where
□ Laparoscopy with tube examination	……	
□ Hystersalpingogram (X-ray of the tubes using contrast fluid) ……		
□ Hysteroscopy /scope of the uterus ……		

result:……

19. Have you noticed an increase in body hair? □ no □ yes

if yes, since when?.....

where? □ face □ breasts □ stomach □ back □ thighs

Can you assess the growth as □ weak □ middle □ strong?

20. Do you suffer from heavy loss of hair on your head? □ no □ yes

if yes, since when?.....

Can you asses the loss of hair as □ weak □ middle □ strong ?

21. Do you suffer from acne? □ no □ yes

if yes, since when?.....

where? □ face □ breasts □ back

Can you assess the severity of the acne as □ weak □ middle □ strong?

22. Last Pap smear (cervical test for cancer)……/…… Result: □ normal □ abnormal

23. Have you taken hormone supplements e.g. the Pill?

□ yes □ no if yes,

Medication	from	to	Medication	from	to
1……			2……		
3……					

24. Have you ever had an intrauterine device (e.g. IUD, coil) inserted?

□ no □ yes, from……. to……

25. What fertility treatment have you received so far? □ none

	how often	place	from – to
□ Tablets to improve ovulation……			
□ Hormone injection……			
□ Insemination……			
□ IVF……			
□ ICSI……			

26. Have you suffered from any of the following? none

□ Thyroid disorder	□ Diabetes	□ Adrenal gland disease
□ Thrombosis/Embolism	□ Migraine	□ Kidney disease
□ Cardiovascular disease/Hypertension	□ Epileptic fits	□ Liver disease
□ Varicose veins	□ Cancer/ Tumours	□ Mental disorders
□ Asthma/ Chronic bronchitis	□ Gastro-intestinal illness	□ Infectious diseases

□ Other……..

27. Do you regularly take any medication? □ no

If yes, name ……. ... …… for what?……

…… for what?……

28. Are you allergic to any medication or substances? □ no

yes, to……

29. Were you or are you exposed to any of the following (at work or at home)?

□ Noise
□ Solvents
□ Lead or mercury compounds
□ Dust, Gas or other air pollutants
□ Pesticides, Insecticides
□ Preservatives for leather, wood or textile

30. Do you smoke? □ no □ 1-5 Cig/day □ 5-15 Cig/day □ more, approx….day

31. Do you drink alcohol? □ never □ occasionally □ regularly

32. Do you play sport? if yes, what types

33. Have any of the following conditions been diagnosed in a blood relative in your family? □ no

□ Thrombosis .....Unwanted childlessness Cancer

□ Inherited diseases (eg cystic fibrosis, Muscular dystrophy

□ Other……..

34. Are you inoculated against hepatitis B? □ no if yes, when last?.....

35. Have you been vaccinated 2x against rubella (German measles)?

□ no

□ yes (please bring eather your vaccination certificate or a report)

If your blood has been examinated to prove German measels protection, please bring a report with you

36. How did you become aware of our practice?

□ On recommendation/ Referral from Doctor (Name:……

□ On recommendation of a friend

□ Information from the telephone book

□ Information from the internet

Other……

Comments:……..……

……..

……..