AUGMENT QUESTIONNAIRE

Today's Date: _____

Your name: _____

Street Address: _____

_____

City, Province/State and Postal/Zip Code _____

Contact Phone Number: _____

Email address: _____

Date of Birth: _____(dd/mm/yy) Age: _____(years)

Height: _____(cm/inches) Weight: _____(kg/lbs)

Fertility Diagnosis: _____ (example, endometriosis)

Duration of Infertility: _____(years)

Menstrual History

Last Menstrual Period Date: _____

Do you have regular periods and if not, number of days of your cycle?: _____

How old were you when you first had your period: _____ years old

Menstrual Flow: ☐ Normal ☐ Light ☐ Heavy

Do you ever pass clots? ☐ Yes ☐ No

Do you experience pain with your periods? ☐ None ☐ Mild ☐ Moderate ☐ Severe

Do you take medication for the pain? ☐ Yes ☐ No

If yes, what medication? _____

Before your periods, do you have (please circle):

☐ Cramps ☐ Breast tenderness ☐ Bloating ☐ Mood Changes

Gynecological History:
Do you have any history of sexually transmitted diseases (STDs)? ☐ Yes ☐ No
If Yes, explain: _____

When was your last PAP? _____(mm/dd/yy) Was it normal? ☐ Yes ☐ No

Did you have any treatment on the cervix? ☐ Yes ☐ No

If yes, explain: _____

Have you ever used any birth control of contraception in the past? ☐ Yes ☐ No

If yes, explain: _____

If applicable, do you have pain with intercourse? ☐ Yes ☐ No

If yes, is it : ☐ Initial ☐ Deep

Previous Fertility Investigations/Treatment:
What was your most recent FSH level? (level and date): _____(include unit of measure)

What is your most recent AMH level? (level and date): _____(include unit of measure)

What is your most recent antral follicle count? (# of follicles and date): _____

How many cycles of IVF have you done? _____

In your last IVF cycle, how many eggs were retrieved? _____

Do you have any frozen eggs? If so, how many? _____

Obstetric History:
Have you been pregnant before this period of infertility?: ☐ Yes ☐ No

If so, what was the outcome (date of birth/ vaginal or C-section/at term/ complications/sex):

_____

_____

If you experienced miscarriages, please provide details of your miscarriages:

_____

_____

If you ever had an elective abortion, please provide details:

_____

_____

Past Medical History

Have you had abdominal surgery before? ☐ Yes ☐ No

Do you have fibroids? ☐ Yes ☐ No

Do any genetic diseases run in your family? ☐ Yes ☐ No

Do you have any other health issues of concern?

☐ Heart disease ☐ Hypercholesterolemia ☐ Hypertension ☐ Diabetes

☐ Cancer of any kind ☐ Asthma ☐ Hepatitis B or C Carrier)

Other:_____

_____

Are you current taking folic acid of a prenatal vitamin? ☐ Yes ☐ No

Please list any medications you are currently taking on a regular basis:

_____

Social History

Do you smoke? ☐ Yes ☐ No If yes, how many per day? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how many per day? _____

Do you use recreational drugs? ☐ Yes ☐ No If yes, please explain: _____

If applicable, are you and your partner related by blood? ☐ Yes ☐ No

What is your ethnic background? _____

Once complete, please send to First Steps Fertility:
Email: f.weisberg@firststepsfertilityclinic.com
Fax: 416-924-7099
Mailing address: Suite 215 - 4025 Yonge St., Toronto ON, CANADA M2P 2E3