Fertility Clinic New Patient Questionnaire

Patient Information

Full Name

Date of Birth

Phone Number

Email Address

Address

City

State/Province

ZIP/Postal Code

Partner Information

Partner Name

Partner Date of Birth

Partner Phone

Medical History

Medical conditions (including fertility issues)

Surgeries

Allergies

Current Medications

Menstrual & Obstetric History

Age at first period

Cycle length (days)

Are cycles regular?

Number of pregnancies

Number of births

Number of miscarriages

Date of last period

Fertility History

How long have you been trying to conceive?

Previous fertility treatments

Prior investigations (tests, labs, imaging)

Lifestyle

Do you smoke?

Do you use alcohol?

Caffeine intake (cups/day)

Recreational drug use

Exercise frequency

Family History

Family history of fertility problems or genetic disorders

Anything else you would like us to know?