Please fill out the following questionnaire as completely as possible. This enables your Fertility Specialist to design a safe and appropriate treatment plan for you.

Please note, if not applicable, please write N/A

## Female

Age: _____ no of children: _____ (current partner, previous partner)

General health:

Chronic diseases:

Chronic Drugs intake:

Drug allergy: Smoking: ____/ day

Previous operation:

Previous pregnancies:

- Normal deliveries:
- Cesarean sections:
- Induced abortions:

Current infertility problem:

- Ovulation problem:
- Sperm problem
- Mechanical problem (blocked tubes, adhesions)

Tests for mechanical problem:

Hysterosalpingogram

Hysteroscopy

Laparoscopy

Previous infertility treatments:

- Hormones
- Insemination
- IVF

Partner

Age: no of children: (current partner, previous partner)

General health:

Chronic diseases:

Chronic drugs intake:

Drug allergy: Smoking: ____/ day

Previous operation:

Semen analysis result:

Other remarks:

_____

_____