



**INFERTILITY Questionnaire (continued)**

**INVESTIGATIONS**

Please obtain copies of results and bring them with you.

Tick appropriate box to indicate whether test has been completed or not.

FEMALE		MALE	
Rubella	yes <input type="checkbox"/> no <input type="checkbox"/>	Semen analysis	yes <input type="checkbox"/> no <input type="checkbox"/>
HIV (AIDS)	yes <input type="checkbox"/> no <input type="checkbox"/>	HIV (AIDS)	yes <input type="checkbox"/> no <input type="checkbox"/>
Hepatitis C	yes <input type="checkbox"/> no <input type="checkbox"/>	Hepatitis C	yes <input type="checkbox"/> no <input type="checkbox"/>
Hepatitis B	yes <input type="checkbox"/> no <input type="checkbox"/>	Hepatitis B	yes <input type="checkbox"/> no <input type="checkbox"/>
Sperm Antibodies	yes <input type="checkbox"/> no <input type="checkbox"/>		
Full Blood Examination (FBE)	yes <input type="checkbox"/> no <input type="checkbox"/>		
Blood Group	yes <input type="checkbox"/> no <input type="checkbox"/>		
Ultrasound	yes <input type="checkbox"/> no <input type="checkbox"/>		
Hormone Tests	yes <input type="checkbox"/> no <input type="checkbox"/>		
When was your last smear test?	.....		
Are you taking Folic Acid?	yes <input type="checkbox"/> no <input type="checkbox"/>		

**FEMALE ONLY**

Have you had:		Have you been told that you have:	
Laparoscopy	yes <input type="checkbox"/> no <input type="checkbox"/>	Polycystic ovaries (PCO)	yes <input type="checkbox"/> no <input type="checkbox"/>
Hysteroscopy	yes <input type="checkbox"/> no <input type="checkbox"/>	Endometriosis	yes <input type="checkbox"/> no <input type="checkbox"/>
Curette (D & C)	yes <input type="checkbox"/> no <input type="checkbox"/>	Problems with tubes	yes <input type="checkbox"/> no <input type="checkbox"/>
Other surgery	yes <input type="checkbox"/> no <input type="checkbox"/>	Fibroids	yes <input type="checkbox"/> no <input type="checkbox"/>

Previous treatment:

ovulation induction (clomiphene or injections)	yes <input type="checkbox"/> no <input type="checkbox"/>	Artificial insemination with Husband/Partner sperm (OI/AIH)	yes <input type="checkbox"/> no <input type="checkbox"/>
IVF	yes <input type="checkbox"/> no <input type="checkbox"/>	GIFT	yes <input type="checkbox"/> no <input type="checkbox"/>

Other Treatment – please specify .....