nij barrahûs
centrum voor vruchtbaarheid

Questionnaire for the female partner
for the purpose of treatment of Fertility

Would you please answer the following questions? On your visit you can always give an explanation and complementary comments.

Name .....

Date of birth..... BSN.....

Insurance company..... Insurance Number.....

Address .....

Postcode..... City.....

Direct phone number..... Mobile.....

Email.....

GP ..... Address..... City.....

In case of a relationship:

Name partner..... Date of birth partner.....

Mobile Phone.....

What is the reason of your visit? .....

Have you previously been treated for fertility? ❑ Yes ❑ No

If so:

Type of treatment / research: .....

Hospital : .....

Date : .....

NOTE: it saves time when you bring copies of correspondence with your GP / specialist concerning previous examinations and / or treatments.

Menstrual pattern, hormonal factors and fertility

At what age was your first period? .....years

What was the date of your last period? .....

How long is your average cycle? .....days

Shortest cycle..... days / longest cycle .....days

How long does your period usually last? .....days

Do you feel your period arrive in the days preceding it? ❑ Yes ❑ No

Have you ever interim blood loss? ❑ Yes ❑ No

Have you ever gone through a period in which the menstruation was not

or very irregularly occurring? ❑ Yes ❑ No

If so, when? .....

Is the menstruation very painful? ❑ Yes ❑ No

If so, only the first day? ❑ Yes ❑ No

Do you use painkillers then? ❑ Yes ❑ No

Do you suffer from too much hair growth on face, breasts or stomach? ❑ Yes ❑ No

Have you ever spontaneously moisture loss from the nipples? ❑ Yes ❑ No

Do you suffer from acne? ❑ Yes ❑ No

Have you ever used contraception? ❑ Yes ❑ No

If so, which ones? .....

How long? ..... years. Until when? .....

How long have you been with your current partner? Since.....

How long have you been trying to conceive? From.....

Have you ever been pregnant (including miscarriages) ? ❑ Yes ❑ No

If so, when and how was the end of pregnancy(ies)?

.....

Occupation and education

What is your nationality? .....

Do you understand Dutch? ❑ Yes ❑ No

If not, what language do you speak.....

What is the highest level of education you have followed? .....

What is your occupation? .....

How many hours per week do you work? .....

Do you work irregular hours or are you often away from home? ❑ Yes ❑ No

Do you come by profession or hobby into contact with toxic substances? ❑ Yes ❑ No

If so, which ones? .....

Are you exposed to serious stress within your job? ❑ Yes ❑ No

Health

Do you smoke? ❑ Yes ❑ No If so, how many? .....

Do you use alcohol? ❑ Yes ❑ No If so, how many? ..... glasses / week

Have you ever used drugs? ❑ Yes ❑ No If so, what..... to when.....

Are you allergic to anything? ❑ Yes ❑ No If so, what kind of allergy? .....

Do you use folic acid? ❑ Yes ❑ No

Are you vaccinated against rubella? ❑ Yes ❑ No

Are you or have you been under specialist treatment ? ❑ Yes ❑ No

If so, by whom, when and why? .....

Have you ever had an inflammation in the stomach? ❑ Yes ❑ No

Have you ever had abdominal surgery? ❑ Yes ❑ No

If yes, what year and what kind of surgery? In ....., Reason.....

Have you ever had an STD? (Chlamydia, gonorrhea or other) ❑ Yes ❑ No

If yes, what kind of disease? .....

Do you suffer from excessive vaginal fluid? ❑ Yes ❑ No

Do you often have itching of the vagina? ❑ Yes ❑ No

Do you often lose blood during or after intercourse? ❑ Yes ❑ No

When was the last smear of the cervix made? ..... ❑ Never

If so, what was the outcome? .....

What is your height? .....cm

What is your weight? .....kg

Do you follow a special diet? ❑ Yes ❑ No

If so, which? .....

Do you suffer of high blood pressure? ❑ Yes ❑ No

Do you use medication? ❑ Yes ❑ No

If yes, which medication: .....

Family

Are there in your immediate family, one or more of the following diseases concerning:

• Hereditary diseases? ❑ Yes ❑ No

If yes, which ones? .....

• Congenital anomalies? ❑ Yes ❑ No

If yes, which ones? .....

• Heart disease? ❑ Yes ❑ No

If yes, which ones? .....

• Diabetes? ❑ Yes ❑ No

• Unwanted childlessness? ❑ Yes ❑ No

If yes, with whom? .....

Do you know at what age your mother had her menopause? ❑ Yes ❑ No

If yes, at what age? .....

Date:. .....

We would appreciate it if you can send this form before your first visit.

There are two different ways:

Scan and email to: info@nijbarrahus.nl

Or

By mail to: Nij Barrahûs, Heerenveenseweg 99b, 8471 ZA Wolvega

In advance thank you!

nij barrahûs
centrum voor vruchtbaarheid

Questionnaire for male partner

for the purpose of treatment of Fertility

Would you please answer the following questions? On your visit you can always give an explanation and complementary comments.

Name .....

Date of birth..... BSN.....

Insurance company..... Insurance Number.....

Address .....

Postcode..... City.....

Direct phone number..... Mobile.....

Email.....

GP ..... Address..... City.....

Name partner..... Date of birth partner.....

Have you previously been treated for fertility? ❑ Yes ❑ No

Type of treatment / research: .....

Hospital: .....

Date: .....

NOTE: it saves time when you bring copies of correspondence with your GP / specialist concerning previous examinations and / or treatments.

Occupation and education

Do you understand Dutch? ❑ Yes ❑ No

What is the highest level of education you have followed? .....

What is your occupation? .....

How many hours per week do you work? .....

Do you work irregular hours or are you often away from home? ❑ Yes ❑ No

Do you by profession or hobby come into contact with toxic substances? ❑ Yes ❑ No

If so, which ones? .....

Are you exposed to serious stress within your job? ❑ Yes ❑ No

History and medication

How long have you been with your current partner? Since .....

Did you ever conceived a pregnancy in this or previous relationship? ❑ Yes ❑ No

Are you or have you been under specialist treatment ? ❑ Yes ❑ No

If so, by whom, when and why? .....

Do you use any medication? ❑ Yes ❑ No

If yes, which medication and what dose ? .....

Are you allergic to anything? ❑ Yes ❑ No

If so, what kind of allergy? .....

Family

Are there in your immediate family, one or more of the following diseases concerning:

• Hereditary diseases? ❑ Yes ❑ No

If yes, which ones? .....

• Congenital anomalies? ❑ Yes ❑ No

If yes, which ones? .....

• Heart disease? ❑ Yes ❑ No

If yes, which ones? .....

• Diabetes? ❑ Yes ❑ No

• Unwanted childlessness? ❑ Yes ❑ No If yes, with whom? .....

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Hormonal factors and fertility

Have the testes, as far as you know, always been in the scrotum? ❑ Yes ❑ No

Have you ever been treated for non-descended testicles? ❑ Yes ❑ No

Have you ever had hormone injections? ❑ Yes ❑ No

Have you had the mumps after puberty? ❑ Yes ❑ No

Have you ever had an inguinal hernia? ❑ Yes ❑ No

Have you ever had an injury or bruising to the genitals? ❑ Yes ❑ No

Have you ever had a testicle or epididymis inflammation? ❑ Yes ❑ No

Have you ever had a STD? (chlamydia, gonorrhoea or other) ? ❑ Yes ❑ No

How old were you when you got pubic hair? .....years

How old were you when you had your first sexual contact? .....years

How often (on average) do you have intercourse with your partner? ..... times per week

Are there or have there ever been problems during intercourse? ❑ Yes ❑ No

If so, did this concerned:

- No sexual interest ❑ Yes ❑ No
- Erection problems ❑ Yes ❑ No
- No orgasm ❑ Yes ❑ No
- Penetration of the penis does not succeed ❑ Yes ❑ No
- Premature ejaculation ❑ Yes ❑ No
- Other problems ❑ Yes ❑ No

If so what kind of problems?.....

Health

Do you smoke? ❑ Yes ❑ No If so, how many? .....

Do you use alcohol? ❑ Yes ❑ No If so, how many? ..... glasses / week

Have you ever used drugs? ❑ Yes ❑ No If so, what kind ..... until when.....

Do you often take hot baths or go to the sauna? ❑ Yes ❑ No

What is your height? .....cm

What is your weight? .....kg

Date:. .....

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In advance thank you!