

Pathways to Parenthood

Dr. Joel Bernstein

M.B.,Ch.B.(Rand)B.Sc.,(Wits) F.R.C.O.G., F.R.A.N.Z.C.O.G.

Provider No: 049624DL



MEDICAL DIRECTOR
FERTILITY EAST

Suite 502, Harley Place
251 Oxford Street,
Bondi Junction, NSW 2022

Appointments & Enquiries
Phone: 9386 1315 Fax: 9389 7442
Emergency: 99 633 536

FERTILITY QUESTIONNAIRE

Dear Patient/s

I have provided this questionnaire for you to fill in prior to your first visit. I strongly recommend you to do so as it achieves a number of valuable objectives:

1. Time to remember and collate your valuable medical history
2. Time to obtain any past blood reports, medical files, investigative reports such as Xrays, HyCoSy, semen analyses, genetic tests and operative reports.
3. Providing comprehensive and detailed information greatly assists me with the diagnosis and management decisions needed for your case.
4. Once this information is received it is covered by the Privacy Act and dealt with by the same confidential process.
5. The privacy act allows all patients to obtain copies of their records from any doctor or hospital.

Please complete this questionnaire and either bring it to your first visit or fax it (ONLY the questionnaire) to 02 93897442.

DO NOT FAX results or other information but rather, please bring all other test results, Xrays and films with you to the consultation.

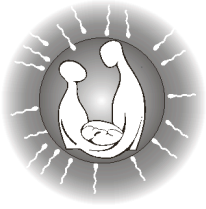
Certain questions may not be applicable, where indicated mark n/a

GENERAL PATIENT INFORMATION

Name : _____ Age: _____ Date of Birth: _____

Tel. Home: _____ Work: _____ Mobile: _____

Partner's Name: _____ Partner's date of birth: _____



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FEMALE INFERTILITY

GYNECOLOGICAL HISTORY

How old were you when your periods started _____ years

Are you still having periods? Yes No

If No when did they stop? _____ Months/years

If Yes:

How frequently do you have periods? Every _____ days

Average length of menstrual cycles? _____ days.

*From the 1st day of proper bleeding to the next first day of proper bleeding
Average means checking last few cycles 28,30, 29. Average = 29 days.*

When did your last period start? _____ Day 1

Day 1 is referred to as the date of the 1st day of proper bleeding.

Do you experience cramping with your periods? Yes No

If Yes, when during your cycles do you have pain (*check all that apply*):

Before During After

How would you describe the cramps? Mild Moderate Severe

Mild: Still able to go about your daily routine, no medication

Moderate: Able to go about daily routine, but requires medication

Severe: Unable to go about daily routine, requires or requires bed rest of medication.

Do you take pain medication for the cramps? Yes No

If yes, specify

Medication: _____

Do you bleed or spot between periods? Yes No

If yes please describe:

Have you ever had an abnormal Pap smear? Yes No

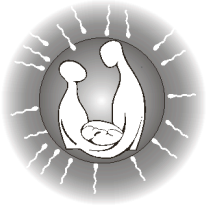
If yes, what treatment was required:

Cryotherapy (freezing of cervix) Laser therapy Cone biopsy , Letz loop/ LEEP

N/a Other: _____

Have you been diagnosed with ovarian failure or premature menopause?

Yes No



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SEXUALLY TRANSMITTED DISEASE

Have you ever had any of the following infections involving any part of the reproductive tract (vagina, cervix, uterus, ovaries)?

Check all that apply:

Chlamydia Trichomonas Gonorrhoea Herpes Genital warts/HPV

Syphilis

Pelvic Inflammatory Disease

Pelvic inflammatory disease is an infection of the uterus tubes and ovaries, being a serious infection and requiring antibiotic treatment and occasionally a stay in hospital. It does not refer to a simple vaginal discharge.

Have you ever had peritonitis? Yes No .

Peritonitis is an inflammation of the lining of the abdominal cavity and an extremely serious condition. It would normally only be treated in hospital.

What treatment did you receive? _____ Year: _____

INTERCOURSE

Do you have pain with intercourse? Never sometimes frequently always

If yes, is the pain? Superficial , deep : *Check all that apply*

How often do you have intercourse? _____ per week/Month (*circle*)

How frequently do you and your partner have intercourse around ovulation? _____ times per month.

Do you usually use lubrication during intercourse? Yes No .

If yes, please specify: _____

Have you experienced any difficulties with intercourse that may be contributing to infertility?

Yes No

If yes please describe: _____

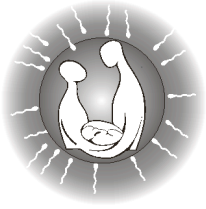
CONTRACEPTION

Have you ever used contraception? Yes No

If yes, please *check all that apply*:

Contraceptive pills Condoms IUD Injectable Hormones/Implants Foam/Sponge

Rhythm Withdrawal Other _____



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FERTILITY EVALUATION

How long have you been trying to conceive? _____ Months/Years

Have used temperature charts? Yes No

Have you used urine ovulation kits? Yes No

Have you ever tried to conceive with a different partner? Yes No

Have you ever conceived with a different partner? Yes No

Has your male partner ever gotten someone else pregnant? Yes No N/a

Have you been treated for infertility previously? Yes No

If yes, where/when: _____

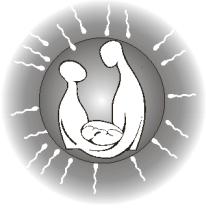
What were the causes of infertility?

Which of the following fertility tests have already been performed?

Female

| Test/Treatment | Date | Doctor/Clinic | Result |
|-------------------|------|---------------|--------|
| Hormone tests | | | |
| Genetic tests | | | |
| Infection screen | | | |
| Xray uterus / HSG | | | |
| Pelvic ultrasound | | | |
| HyCoSy | | | |
| Hysteroscopy | | | |
| Laparoscopy | | | |
| Clomid/serophene | | | |
| Puregon/Gonal F | | | |
| Other medication | | | |

IT IS ESSENTIAL THAT YOU OBTAIN AND BRING ALL RESULTS INCLUDING ULTRASOUND PICTURES OR XRAY PLATES, OPERATION REPORTS WITH YOU TO YOUR CONSULTATION.



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FERTILITY TREATMENTS

Have you ever had Intrauterine inseminations (IUI)? Yes No

If yes, how many cycles? _____ cycles

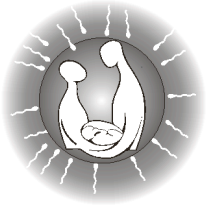
If yes, sperm was provided by: Partner Donor *Check all that apply*

Have you ever attempted in vitro fertilization? Yes No

If yes please fill in the following table, and you can add in any relevant information below.

| Cycle | Mo/Yr | Clinic | Dose of FSH | Number of eggs | ICSI | Number embryo transferred | Outcome |
|--------|-------|--------|-------------|----------------|---------------|---------------------------|---------|
| IVF #1 | | | | | * Yes * No | | |
| IVF #2 | | | | | * Yes * No | | |
| IVF #3 | | | | | * Yes * No | | |
| IVF #4 | | | | | * Yes * No | | |
| IVF #5 | | | | | * Yes * No | | |

IT IS ESSENTIAL THAT YOU OBTAIN AND BRING ALL RESULTS OF TREATMENT CYCLES.



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OBSTETRICAL HISTORY Have you ever been pregnant (including positive pregnancy test, elective terminations, miscarriages, births? Yes No

| Pregnancy | 1st | 2nd | 3rd | 4th |
|--------------------------------|--|--|--|--|
| Mo/Yr conception | | | | |
| Outcome | <input type="checkbox"/> Live born <input type="checkbox"/> Miscarriage <input type="checkbox"/> Ectopic <input type="checkbox"/> Termination | <input type="checkbox"/> Live born <input type="checkbox"/> Miscarriage <input type="checkbox"/> Ectopic <input type="checkbox"/> Termination | <input type="checkbox"/> Live born <input type="checkbox"/> Miscarriage <input type="checkbox"/> Ectopic <input type="checkbox"/> Termination | <input type="checkbox"/> Live born <input type="checkbox"/> Miscarriage <input type="checkbox"/> Ectopic <input type="checkbox"/> Termination |
| Pregnancy with current partner | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

PAST MEDICAL HISTORY

Do you have or ever had any of the following (*check all that apply*):

Anaemia Gallbladder disease Arthritis

Heat/cold intolerance Hair loss Seizures High blood pressure

Hirsutism (excess hair growth) Hot flushes Visual problems Cystic Fibrosis

Diabetes Breast (Nipple discharge) Colitis Acne Chronic headaches

Kidney /Liver problems German Measles Neurological problems

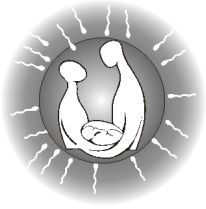
Autoimmune disease (e.g. Lupus)

Immunizations: Tetanus Hepatitis B German Measles Varicella (chickenpox)

PAST SURGICAL HISTORY

Have you ever suffered from endometriosis ovarian cysts/tumours fibroids adhesions in or out of the uterus

Have you ever had any type of operation or surgical procedure from the time you were born up till the present time? Yes No



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If yes:

| Date | Type of Operation |
|------|-------------------|
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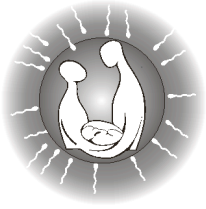
I have included a list some of the relevant operations, which include:

- Curettage (D&C) operation performed through the vagina and cervix to remove the lining of the uterus.*
- Laparoscopy keyhole surgery using operating telescope inserted into the abdominal cavity usually via the umbilicus and allows the operator to see inside the abdominal cavity, and pelvis*
- Hysteroscopy surgery where a telescope is passed via the vagina into the uterus to check the cavity of the uterus. For this procedure no cuts are made.*
- Sterilisation procedure either performed through laparoscopy or laparotomy in which the Fallopian tubes are blocked or cut to prevent conception.*
- Laparotomy an operation in the abdominal or pelvic cavity performed through a cut in the abdominal wall*
- Oophorectomy removal of an ovary*
- Ovarian cyst removal or drainage of an ovarian cyst*
- Salpingectomy removal of a Fallopian tube*
- Adhesiolysis freeing of adhesions in the pelvic cavity especially those affecting the uterus, tubes and ovaries*
- Surgery for endometriosis either by laparoscopy or laparotomy to remove endometriosis of the reproductive tract*
- Appendicectomy removal of the appendix*
- Operation on the bladder or ureters*
- Cancer surgery for cancer, anywhere in the body.*
- Operations anywhere on the body even those not related to fertility*

Where you told after your last surgery whether the following organs are normal?

- Uterus normal? Yes No Don't know
- Right ovary? Yes No Don't know
- Right tube open? Yes No Don't know
- Left ovary? Yes No Don't know
- Left tube open? Yes No Don't know

PLEASE PROVIDE A COPY OF THE SURGICAL REPORT AND PATHOLOGY WHERE POSSIBLE, ESPECIALLY FOR SURGERY IN THE LAST 3 YEARS.



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FAMILY HISTORY

Have any of these problems occurred in your family? Check all that apply and indicate relationship to you:

High blood pressure _____ Ovarian cancer _____ Infertility _____
 _____ DES exposure in utero _____ early menopause _____
 _____ Heart disease _____ colon/breast CA _____
 diabetes _____
 Thyroid disease _____

Have any of your children had birth defects?
(congenital abnormalities)

Yes No

| Male | Female | Type of Birth Defect |
|------|--------|----------------------|
| | | |
| | | |

Has anyone in your family had children with birth defects?
or a child who has died in the first few weeks of life.

Yes No

If yes please supply details including their relationship with you,
example, brother, sister or cousin.

| Relationship | Birth Defect |
|--------------|--------------|
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Does anyone in the family have a genetic /inherited condition?

Yes No

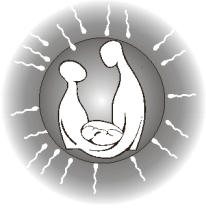
Has anyone in the family had multiple miscarriages?

Yes No

This means 3 or more consecutive miscarriages

Have any members of your family on both your mother
and/or father's side had cancer of the ovary or breast ?

Yes No



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Have any members of your family on your mother or father's side had Polycystic Ovarian Syndrome (PCO)?

Yes No

Have any members of your family suffered with Non insulin dependent diabetes, (Type 2 diabetes, or late onset/adult onset diabetes)?

Yes No

Have any members of your family suffered with infertility?

Yes No

What are their relationships with you? (Brothers, Sisters):

| Brother | Sister | Cause of infertility if it is Known |
|---------|--------|-------------------------------------|
| | | |
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REVIEW OF SYSTEMS

MEDICAL HISTORY

Illnesses:

Do you suffer from any disease of the heart, lungs, Intestinal tract, kidneys, bladder, immune system, nervous system or other any other system?

Yes No

Do you suffer from any type of endocrine disease?
(Diseases affecting the thyroid, parathyroid, adrenal or pituitary glands including diabetes?)

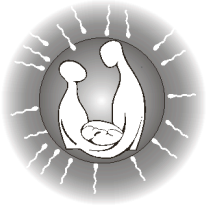
Yes No

Have you suffered from any tropical diseases eg malaria?

Yes No

Have you suffered from TB (tuberculosis)?

Yes No



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Please fill in the name/nature of any of these diseases / illness (s)?

| | Type/nature of Illness | Treatment | |
|---|------------------------|-----------|----|
| | | Yes | No |
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |

Allergies:

Are you allergic to any form of medication?

Yes No

Please list the medication(s) and its generic name if possible:

Use the generic names where possible ie the actual drug name rather than the trade name.

| |
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Birth Defects:

Were you born with any birth defects or abnormalities?

Yes No

Please describe below:

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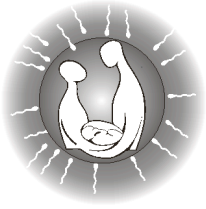
CURRENT MEDICATION

Are you taking any form of medication at present?

Yes No

Please fill in the name(s) of the medication you take. Use the generic names where possible ie the actual drug name rather than the trade name.

| |
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Are you taking any form of herbal medicine or vitamins? Yes No

Please fill in the name(s) of the medication you take. Use the generic names where possible ie the actual drug name rather than the trade name.

| |
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| |

Have you noted any significant: Heat/Cold intolerance recently? Yes No

If yes, please explain: _____

Unusual hair distribution changes or breast nipple discharge? Yes No

If yes, please explain: _____

Significant weight change in the last year? If so, please describe how many Kgs and over what time: _____

HABITS

Do you smoke? Yes No

If yes, how many packs per day? _____

Do you take hot baths? Yes No

Do you drink alcohol Yes No

If yes, how many alcoholic beverages per week: _____

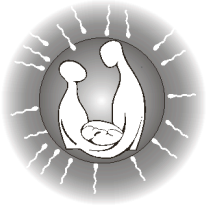
Do you smoke marijuana Yes No

If yes, how much per week: _____

Do you exercise regularly? Yes No

If yes, please indicate type of exercise and estimate hrs per week spent

ADDITIONAL INFORMATION / QUERIES FEMALE



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SECTION FOR MALE PARTNER

GENERAL HISTORY

Illnesses:

Do you suffer from any disease of the heart, lungs, intestinal tract, kidneys, bladder, immune system, nervous system or other any other system? Yes No

Do you suffer from any type of endocrine disease? Yes No
(Diseases affecting the thyroid, parathyroid, adrenal or pituitary glands?)

Have you suffered from any tropical diseases e.g. malaria? Yes No
Have you suffered from TB (tuberculosis)? Yes No

Please fill in the name/nature of the illness (s)?

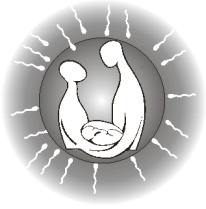
| Type/nature of Illness | Treatment | |
|------------------------|-----------|----|
| | Yes | No |
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | | |

Allergies:

Are you allergic to any form of medication? Yes No

Please list the medication(s):

Please fill in the name(s) of the medication you are allergic to. Use the generic names where possible i.e. the actual drug name rather than the trade name.



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Birth Defects:

Were you born with any birth defects or abnormalities?

Yes No

Please describe below:

Do you have congenital absence of the vas (CAVD)?

Yes No

(The vas deferens is the tube connecting the testis, which runs from the testis to the base of the penis, and transports sperm. In the above condition {CAVD} the vas fails to develop).

CURRENT MEDICATION

Are you taking any form of medication at present?

Yes No

Please fill in the name(s) of the medication you take.

Have you ever taken any of the medications listed below?

Clomiphene (Clomid,Serophene) Testosterone Viagra GnRH agonist
(Lupron,Synarel,Zoladex) Bromocriptine (Parlodel, Dostinex)

Other please list:

Are you taking any form of herbal medicine or vitamins?

Yes No

If yes

Does it contain Gingko, St John's wort or Echinacea?

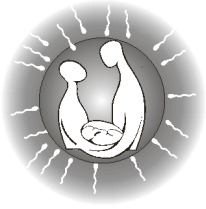
Yes No

SURGICAL HISTORY

Have you ever had any type of operation or surgical procedure from the time you were born up till the present time?

Yes No

If yes:



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| Date | Type of Operation |
|------|-------------------|
| | |
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| | |

I have included a list some of the more relevant operations, which include:

Herniorrhaphy operation performed on weaknesses of the abdominal wall called hernias. These include femoral and inguinal hernias, and may be called direct or indirect hernias.

Orchidopexy / Correction of undescended testes.

The testis normally descend into the scrotum after birth but in some males this fails to happen and requires surgical correction.

Varicocoelectomy / Surgery for a varicocoele

Surgery to correct abnormal or varicose veins around the testis (varicocoele).

Sterilisation or vasectomy a surgical procedure to cut the vas deferens to make the male sterile for permanent contraception/family planning.

Vasectomy reversal

To attempt reversing the effects of vasectomy

Laparotomy an operation in the abdominal or pelvic cavity performed through a cut in the abdominal wall

Appendicectomy removal of the appendix

Orchidectomy surgery to remove a testis.

Prostatectomy surgical removal of some or part of the prostate gland.

Cancer surgery for cancer anywhere on the body.

Removal of a testicular cyst or tumour of the testis

Removal of a testis / orchidectomy

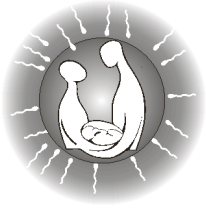
Usually performed to remove damaged testis of for testicular cancer.

FAMILY HISTORY

Have any of your children had birth defects/congenital abnormalities?

Yes No

| Male | Female | Type of Birth Defect |
|------|--------|----------------------|
| | | |
| | | |



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Yes No

Has anyone in your family had children with birth defects congenital abnormalities?

If yes please supply details including their relationship to you, e.g. brother, sister or cousin.

| Relationship | Birth Defect |
|--------------|--------------|
| | |
| | |
| | |

Has anyone had a stillbirth or child who died in the first few weeks after birth?

Yes No

Have any members of your family on both your mother father's side had cancer of the ovary or breast?

Yes No and/or

Have any members of your family suffered with Non insulin dependent diabetes, (NIDDM) (*Type 2 diabetes, or late onset / adult onset diabetes*)?

Yes No

Have any members of your family suffered with infertility?

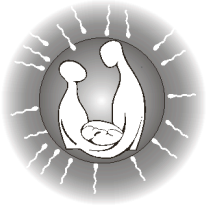
Yes No

What are their relationships with you? (Brothers, Sisters):

| Brother | Sister | Cause of infertility if it is Known |
|---------|--------|-------------------------------------|
| | | |
| | | |
| | | |

GENERAL & SOCIAL HISTORY

What is your occupation?



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Provider No: 049624DL



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Emergency: 99 633 536

Has your occupation brought you into long term contact with toxic chemicals, ionising radiation or microwave irradiation?

Yes No

If yes or you are unsure please describe anyway:

| |
|--|
| |
|--|

Do you smoke tobacco in any form?

Yes No

Do you smoke marijuana?

Yes No

Do you take any habit-forming drugs?

Yes No

Do you drink alcohol?

Yes No

If yes:

| Amount | Per day | Per week |
|--------------|---------|----------|
| Wine glasses | | |
| Beer glasses | | |
| Spirits tots | | |

Do you perform any exercise over and above that required by your daily home or work routines or duties?

Yes No

If yes:

30 Minute Sessions

| | |
|----------------------------|--|
| Less than 3 times per week | |
| 3 times per week | |
| More than 3 times per week | |

FERTILITY

Have you had mumps ?

Yes No

A contagious viral disease usually affecting the salivary glands causing swelling below and behind the ears and sometimes the testicles.

If yes how old were you when you had the mumps?

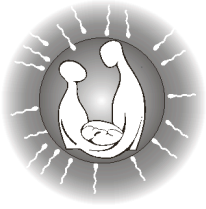
_____ Years

Did it affect your testicles causing pain and swelling?

Yes No

Did you have to have an operation to relieve the swelling?

Yes No



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Have you had any injury to the testicles, which led to severe swelling of the testicles?

Yes No

Did you have an operation to relieve the swelling?

Yes No

Between birth and now have you ever suffered with undescended testis?

Yes No

Testis missing from your scrotum, either permanently or temporarily.

At present are there any abnormal swellings or growths in your scrotum?

Yes No

Do you have a varicocoele?

Yes No

This is an abnormal collection of veins in the scrotum causing a swelling

Feels like a bag of worms.

Has this been treated?

Yes No

Have you ever suffered from a sexually transmitted diseases or infection?

Yes No

If yes:

Yes

No

| | Yes | No |
|------------|-----|----|
| Gonorrhoea | | |
| Syphilis | | |
| Chlamydia | | |
| Herpes | | |
| HIV / AIDS | | |

Have you ever suffered from a discharge from the penis?

Yes No

Have you ever suffered from ongoing pain in the testicles

Yes No

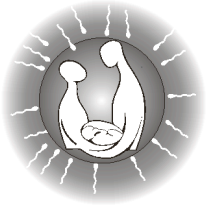
Have you definitely achieved any pregnancies with any partner?

Yes No

SEXUAL INTERCOURSE

How often do you have sex per week on average?

| | |
|-------------|--|
| Less than 1 | |
| 1 to 2 | |
| 2 to 3 | |
| 3 to 4 | |
| More than 4 | |



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- Do you have problems having an erection for sex? Yes No
- Can you have an erection for masturbation? Yes No
- Do you have problems ejaculating? Yes No
- Ejaculation is the release of sperm from the penis.*
- Does this problem occur with sexual intercourse? Yes No
- During sexual intercourse do you ejaculate? Always Yes No
- Occasionally Yes No
- Never Yes No
- Can you ejaculate with masturbation? Yes No
- Have you sought help for these problems? Yes No
- Was the help successful? Yes No
- Have you ever had to freeze your sperm? Yes No
- If yes please give the reason for this:
-
-

FERTILITY AND OTHER TESTS

- BLOOD TESTS

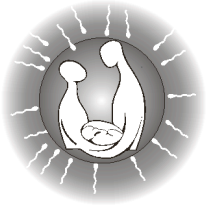
These include hormone levels, full blood count and chemistry, infection screen for Hepatitis A, B & C, HIV and HTLV, Chlamydia, Syphilis, Gonorrhoea, Genetic tests, chromosomes/karyotype, DAZ gene tests, cystic fibrosis, and antisperm antibody tests.

PLEASE ATTACH COPIES OF ALL BLOOD TESTS PERFORMED IN THE LAST YEAR.

- SEMEN ANALYSIS INCLUDING SPERM DNA FRAGMENTATION TESTS

Please include copies of all sperm tests performed in the last 2 years.

- REPORTS OF SURGICAL PROCEDURES AND ASSOCIATED PATHOLOGY TESTS
- ADDITIONAL REPORTS OF ULTRASOUNDS, CT SCANS



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FERTILITY EVALUATION

Which of the following test have already been performed? Semen analysis Chromosome test Ultrasound of testis Antisperm antibody test Testicular biopsy

Have you ever had any of the following procedures done? (check all that apply)_

Varicocele repair hernia repair prostate surgery testicular torsion/repair

testicular biopsy vasectomy reversal other (please specify):

Have you ever had any significant testicular injury? Yes No

If yes please describe

Other information:

Thank you for taking the time to complete this questionnaire.

Please fax it to 0293897442 or bring it with to your consultation with as many results and reports, Xrays and details that you can obtain.