Oocyte cryopreservation questionnaire (social freezing/ medical freezing)

Surname, First name

Date of birth

Street/house No.

Postcode/Town

Land line No.

Mobile phone No.

E-mail address

Profession

Who is your family doctor?

Who is your gynaecologist?

Cycle and hormone analysis

How old were you when your monthly periods started?

How often do your monthly periods currently occur? Approx.

every ____ days ____ weeks ____ months

Have you taken the contraceptive pill?

Yes ☐ No ☐

If yes, when was the last time?

From ____ to ____

Have you noticed any of the following symptoms?

Increase in body hair Yes ☐ No ☐

Increased hair loss Yes ☐ No ☐

Acne Yes ☐ No ☐

Gynaecological history

Have you already been pregnant? Yes ☐ No ☐

If yes, when? Birth/Caesarean section/miscarriage?

Last cancer screening (month/year)

Last mammogram (month/year)

Have you had pelvic inflammatory disease? Yes ☐ No ☐

If yes, when?

What treatment did you have?

Have you already had
abdominal or pelvic surgery? Yes ☐ No ☐

If so, what kind and when?

Further history

Do you have any **pre-existing conditions**? Yes ☐ No ☐

If so, please give details.

Thromboses/pulmonary embolisms Yes ☐ No ☐

High blood pressure Yes ☐ No ☐

High blood lipid levels Yes ☐ No ☐

Cardiovascular system Yes ☐ No ☐

Kidneys/liver/lungs Yes ☐ No ☐

Diabetes Yes ☐ No ☐

Infections (e.g. hepatitis, HIV) Yes ☐ No ☐

Mental health Yes ☐ No ☐

Other/comments:

Have you ever had any **surgery**? Yes ☐ No ☐

If so, what kind / when?

Do you take **medication** regularly? Yes ☐ No ☐

If yes, which?

Weight:

Height:

BMI:

Do you have any **allergies**? Yes ☐ No ☐

If yes, which?

Do you **smoke**? Yes ☐ No ☐

If so, how much? Cigs/day

Do you drink **alcohol**? Yes ☐ No ☐ Occasionally ☐ Regularly ☐

Do you take **drugs**? Yes ☐ No ☐ Never ☐ Rarely ☐ Occasionally ☐ Regularly ☐

If so, which drugs?

Was/is there in your immediate **family**

Thromboses/pulmonary embolisms? Yes ☐ No ☐

High blood pressure? Yes ☐ No ☐

Liver disease? Yes ☐ No ☐

Diabetes? Yes ☐ No ☐

Cancer? Yes ☐ No ☐

Other

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