**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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