Dynacare®
Genetics and Specialty Services

Fertility Questionnaire

This appointment is to discuss genetic testing options available to you based on the fertility workup. Information on your personal and family history is collected to see if there are concerns, **other than the reason you were referred to us**, that should be addressed. If you have additional concerns, it may be necessary to arrange a separate appointment.

Today's date: _____

Partner 1:

Name: _____ DOB: _____ (dd/mm/yyyy)

Your doctor : _____

Current gender identity: ☐ Male ☐ Female ☐ Non-binary ☐ Other ☐ Prefer not to say

Biological Sex Assigned at Birth: ☐ Male ☐ Female ☐ Other (specify) _____
☐ Prefer not to say

What pronouns do you prefer? ☐ He/Him ☐ She/Her ☐ They/Them
☐ Other (specify) _____

Please indicate your preferred language of communication:
☐ English ☐ French ☐ English or French (bilingual) ☐ Mandarin ☐ Other (specify) _____

Partner 2:

Name: _____ DOB: _____ (dd/mm/yyyy)

Your doctor : _____

Current gender identity: ☐ Male ☐ Female ☐ Non-binary ☐ Other ☐ Prefer not to say

Biological Sex Assigned at Birth: ☐ Male ☐ Female ☐ Other (specify) _____
☐ Prefer not to say

What pronouns do you prefer? ☐ He/Him ☐ She/Her ☐ They/Them
☐ Other (specify) _____

Please indicate your preferred language of communication:
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Reproductive History (Please complete as it pertains to you. Print additional copies as needed)

Female at Birth

Have you had any previous pregnancies?
☐ Yes ☐ No

If yes, how many? _____

How many children do you have from:
Current partner? ____ Previous partner(s)? ____

How many miscarriages/losses:
Current partner? ____ Previous partner(s)? ____

Have you ever had a pregnancy in which malformations (physical differences/birth defects) were found in the baby? ☐ Yes ☐ No

If yes, please describe. _____

_____

How long have you and your present partner been trying to conceive? _____

Have you had difficulty conceiving with a past partner? ☐ Yes ☐ No

If yes, for how long? _____

How old were you when you started having periods?

_____

Are they regular? ☐ Yes ☐ No

Has anyone ever told you that you have polycystic ovarian syndrome? ☐ Yes ☐ No

Has anyone ever told you that you have pre-menopause? ☐ Yes ☐ No

If yes, what age did it start? _____

Testing Information

Have you been told that you have a low ovarian reserve for your age? ☐ Yes ☐ No

If yes, please describe _____

_____

Have you received a diagnosis of premature ovarian failure? ☐ Yes ☐ No

Have you ever had a karyotype (chromosome analysis) done? ☐ Yes ☐ No

If yes, was an abnormality found? ☐ Yes ☐ No

If yes, please describe _____

_____

Have you ever had a Fragile X testing done?
☐ Yes ☐ No

If yes, were you a carrier? ☐ Yes ☐ No

Fertility Questionnaire

Male at Birth

Do you have any children from a previous relationship? ☐ Yes ☐ No

If yes, how many? _____

How many children do you have? _____

Did you have any miscarriages/losses with previous partner(s)? ☐ Yes ☐ No

If yes, how many? _____

Have you ever had a pregnancy in which malformations (physical differences/birth defects) were found in the baby? ☐ Yes ☐ No

If yes, please describe _____

_____

Testing Information

Have you had a spermogram done in the past?
☐ Yes ☐ No

If yes, when was the last one done? _____

Were the results abnormal? ☐ Yes ☐ No
If yes, what was found?
☐ Azoospermia (no sperm)
☐ Oligospermia (low sperm count)
☐ Asthenozoospermia (Abnormal motility)
☐ Teratozoospermia (Abnormal shape)
☐ OligoAsthenoTeratozoospermia (OAT)

Have you ever had a karyotype (chromosome analysis) done? ☐ Yes ☐ No

If yes, was an abnormality found?
☐ Yes ☐ No

If yes, please describe _____

_____

Have you ever had a Y microdeletion test done?
☐ Yes ☐ No

If yes, was an abnormality found?
☐ Yes ☐ No

If yes, please describe _____

_____

Have you ever had a diagnosis of congenital bilateral absence of the vas deferens (tubes that carry the sperm out of the testes)? ☐ Yes ☐ No

If yes, did you have genetic testing for Cystic Fibrosis? ☐ Yes ☐ No

Was the result abnormal? ☐ Yes ☐ No

If yes, please describe _____

_____

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Medical History

Do you or your partner have a known medical condition? ☐ Yes ☐ No

If yes, please describe _____

_____

Were you or your partner born with any physical abnormalities (e.g., a hole in the heart)?
☐ Yes ☐ No

If yes, please describe _____

_____

Have you or your partner ever had carrier screening in the past? ☐ Yes ☐ No

If yes, were one or both of you found carrier of a condition? ☐ Yes ☐ No

If yes, please describe _____

_____

Do you or your partner take any medication?
Please list: _____

_____

Are you and your partner related by blood?
☐ Yes ☐ No If yes, how?

☐ first cousins ☐ third cousins
☐ second cousins ☐ other/ I don't know

Family History

Are you or your partner adopted? ☐ Yes ☐ No

If yes, who? _____

Fertility Questionnaire

Please indicate your ancestries (check all that apply):

African	☐ Partner 1	☐ Partner 2
Ashkenazi Jewish	☐ Partner 1	☐ Partner 2
Asian	☐ Partner 1	☐ Partner 2
Arab	☐ Partner 1	☐ Partner 2
Acadian	☐ Partner 1	☐ Partner 2
Caribbean	☐ Partner 1	☐ Partner 2
European	☐ Partner 1	☐ Partner 2
European (Eastern)	☐ Partner 1	☐ Partner 2
French Canadian	☐ Partner 1	☐ Partner 2
Hispanic	☐ Partner 1	☐ Partner 2
Indigenous Canadian	☐ Partner 1	☐ Partner 2
Pacific Islander	☐ Partner 1	☐ Partner 2
Other (Specify):	☐ Partner 1: _____	☐ Partner 2: _____

Do you or your partner have a family history of any of the following?
If yes, please indicate condition and the relationship with the affected individual.

Muscular dystrophy	☐ Yes	☐ No	
Excessive bleeding or bruising	☐ Yes	☐ No	
Neural Tube defect (open spine)	☐ Yes	☐ No	
A child who was very ill or passed away in infancy or early childhood	☐ Yes	☐ No	
Childhood cancer or cancer that occurs at a younger age than usual	☐ Yes	☐ No	
Metabolic conditions (e.g., Gaucher disease, glycogen storage disease)	☐ Yes	☐ No	
Autism	☐ Yes	☐ No	
Learning disabilities or mental handicap	☐ Yes	☐ No	
Malformation at birth (e.g., hole in the heart, cleft lip and/or cleft palate)	☐ Yes	☐ No	
Hearing or vision loss from an early age	☐ Yes	☐ No	
Chromosome differences (e.g., Down syndrome)	☐ Yes	☐ No	

Do you have any other concerns about your family or your partner's family history?

_____

_____