

**WOMAN'S INITIAL QUESTIONNAIRE**  
**Natural Procreative Technology Evaluation for Infertility or Miscarriage**

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(\* To avoid confusion with zero, there is no section O.)

## **Introduction and Purpose of the Woman's Initial Questionnaire**

### **Why you are receiving this questionnaire**

You are being given this Woman's Questionnaire because you have scheduled an initial evaluation for infertility or miscarriage. This questionnaire comprehensively addresses relevant issues for your evaluation and treatment. It was designed by physicians working with Natural Procreative Technology.

### **How this questionnaire will be used**

Your physician will use the information from this questionnaire and the separate questionnaire from your partner to provide important information for the medical evaluation and your desires for treatment. We will discuss your responses to many of the items in this questionnaire during our initial visit, and subsequent visits, as needed.

### **Natural Procreative Technology (NPT, NaProTechnology)**

Our approach to evaluating and treating fertility or pregnancy problems is based on Natural Procreative Technology (NPT, NaProTechnology). During our visits, we will explain to you specific recommendations for your unique situation. General information about NPT is available at [www.reproductiveinstitute.com](http://www.reproductiveinstitute.com).

### **What to bring to your first (or next) visit**

Please bring this questionnaire, even if you haven't finished filling it out.

Please also bring copies of medical records from any previous evaluations or treatments for infertility that you may have had. In some cases, it may be more convenient for you to mail these items.

It is best if both you and your partner can attend the initial consultation.

### **Why there are two questionnaires: woman's and man's**

Our experience has shown that women and men remember and perceive things differently with regard to a couple's fertility problems. In addition, some information is specific to the woman or the man.

### **Sensitive questions**

You may skip any question you are uncomfortable answering. If you choose to skip a question, please place a line through the question rather than leaving it blank. There may be items that you would prefer not to discuss in front of your partner. If so, you may CIRCLE the question number to tell us that your response to this question is confidential and that you prefer that this item NOT be discussed with your partner.

### **Estimated time to complete questionnaire**

It is estimated that this questionnaire will take about 45 minutes to complete for most women.

### **Questions or comments**

If you have any questions or comments or feel a question is inappropriate for your situation, please make a mark or write a comment at the question or at the end of questionnaire. You may also discuss any questions or comments with your health provider.

### **Where to return the questionnaire**

Please return the questionnaire to your health provider at the time of your next appointment. Alternatively, you may mail it to your provider.

### **Option to participate in the iNEST study**

Your health care provider may invite you to participate in an ongoing clinical study to assess live birth rates among those who consider or receive NPT treatment to conceive or maintain pregnancy. This study is known as the **international NaProTechnology Evaluation and Surveillance of Treatment (iNEST)**. The purpose of the iNEST study is to understand the use of NPT, and characteristics that may help us predict how successful NPT can be for each couple for infertility or miscarriage.

### **Whether or not you participate in the iNEST study will not affect the clinical care that you receive.**

When you are asked, you may choose whether or not to participate in the iNEST study. If you participate,

your answers from this questionnaire will be recorded confidentially for the study. If you do not participate, your answers from this questionnaire will not be reported to the study.

**Natural Procreative Technology Evaluation for Infertility or Miscarriage**  
**Woman's Initial Questionnaire**

**MorningStar Family Health Center #11**

**Couple ID#** \_\_\_\_\_

**NPT Physician Name** \_\_\_\_\_

**Your Family (Last) Name** \_\_\_\_\_

**Your Given (First) Name** \_\_\_\_\_

**A. Initial Information**

(A-01) Today's Date |\_\_|\_\_| / |\_\_|\_\_|\_\_| / |\_\_|\_\_|\_\_| (example: 17 / Mar / 2005)  
**Day / Month / Year**

(A-02) What is your month and year of birth? |\_\_|\_\_|\_\_| / |\_\_|\_\_|\_\_| (example: Mar / 1985)  
**Month / Year**

(A-03) What is your marital status? (Please mark  one)  
 Never married     Married     Widow     Divorced

→If **not** married, please skip to question A-06 below; if married, continue to question A-04.

(A-04) In what month and year did you marry? |\_\_|\_\_|\_\_| / |\_\_|\_\_|\_\_|  
**Month / Year**  
(example: Mar / 1985)

(A-05) Is this your first marriage?  
 Yes     No

(A-06) How did you learn about Natural Procreative Technology (NPT, NaPro)?  
(Please mark  all that apply)

- Physician or other health professional
- On the web
- Written flyer or brochure
- A friend or acquaintance who had NPT treatment
- Public presentation
- Church
- Newspaper or magazine article
- Other, please describe: \_\_\_\_\_

(A-07) Why have you decided to try NPT?

\_\_\_\_\_  
\_\_\_\_\_

(A-08) In order to conceive or maintain pregnancy, have you at any time previously used Natural Procreative Technology (NPT, NaPro)?

Yes     No

If yes, in what month and year did you start NPT treatment previously? \_\_\_\_\_

(A-09) Have you ever consulted a different physician for NPT treatment?

Yes  No

If yes, please give name of physician \_\_\_\_\_

(A-10) Have you started medical treatment with NPT?

Yes  No

If yes, in what month and year did you start? \_\_\_\_\_

If no, in what month and year do you expect to start? \_\_\_\_\_

Still undetermined (waiting or considering)

(A-11) Have you started charting with the Creighton Model Fertility Care System?

Yes  No

If yes, in what month and year did you start? \_\_\_\_\_

If no, in what month and year do you expect to start? \_\_\_\_\_

Still undetermined (waiting or considering)

### **B. Trying to Have a Baby**

For the purposes of this questionnaire, "trying to have a baby" means having regular sexual intercourse without any contraception, whether or not you were doing anything else to try to get pregnant.

(B-01) Using this definition, in what month and year did you start trying to have a baby with your partner?

|\_\_| |\_\_| |\_\_| / |\_\_| |\_\_| |\_\_| |\_\_| (example: Mar / 1985)  
 **Month / Year**

(B-02) During the time you have been trying to have a baby, was there any time when you or your partner did something to avoid pregnancy (such as abstinence during fertile days, condoms, withdrawal, or other contraception of any kind) for more than one month?

Yes  No

If yes, for how many months total? \_\_\_\_\_

(B-03) During the time you have been trying to have a baby, was there any time when you and your partner did not have intercourse for more than one month?

Yes  No

If yes, for how many months total? \_\_\_\_\_

(B-04) During the time you have been trying to have a baby, how often do you and your partner have intercourse, in general?

\_\_\_\_\_ Times per month **OR** \_\_\_\_\_ Times per week

(B-05) How often do you use lubricants when you have intercourse? (Please mark  one)

Always  Often  Sometimes  Rarely  Never

(B-06) How often is intercourse physically painful for you? (Please mark  one)

Always  Often  Sometimes  Rarely  Never

### **C. Menstrual History**

(C-01) At what age did you have your first menstrual period? \_\_\_\_\_ (Age)

(C-02) On average, how many days of menstrual bleeding do you have?

1-2  3-4  5-6  7-8  9 or more

(C-03) In the last year, what is the shortest menstrual cycle you have had (number of days from the beginning of one menstrual period to the next menstrual period)?  
\_\_\_\_\_ number of days

(C-04) In the last year, what is the longest menstrual cycle you have had (number of days from the beginning of one menstrual period to the next menstrual period)?  
\_\_\_\_\_ number of days

(C-05) What is the beginning date of your last menstrual period?  
|\_|\_|/|\_|\_|/|\_|\_| (example: 17 / Mar / 2005)  
**Day / Month / Year**

(C-06) How would you describe your cycles currently?  
 Regular     Irregular     Both     Other (describe): \_\_\_\_\_

(C-07) Have your menstrual cycles ever stopped for any reason?  
 Yes     No     Unsure  
If yes or unsure, please explain: \_\_\_\_\_

(C-08) Do you usually have any kind of symptoms for 4 or more days before your menstrual bleeding starts?  
 Yes     No     Unsure

→If **no** symptoms experienced for 4 or more days, skip to question C-12 below; if **yes**, continue to question C-09.

(C-09) Please indicate which of the following symptoms you have for 4 or more days before your menstrual bleeding starts: (Please mark  all that apply)  
 Irritability     Insomnia     Bloating     Weight gain  
 Salt/sweet cravings     Cry easily     Depression     Headache  
 Fatigue     Breast tenderness     Loss of control     Feeling "wired"  
 Other (describe): \_\_\_\_\_

(C-10) Referring to all the symptoms marked in question D-21, on the whole, how severe would you rate these symptoms? (Please mark  one)  
Minimal    Extreme  
 1     2     3     4     5     6     7     8     9     10

(C-11) Are these symptoms relieved with menstruation?  
 Yes     No     Unsure

(C-12) How painful are your menstrual periods? (Please mark  one)  
Minimal    Extreme  
 1     2     3     4     5     6     7     8     9     10

(C-13) Do you suffer from constipation and/or diarrhea at the time of your period?  
 Yes     No     Unsure

**D. Gynecologic History (Female Sexual Health)**

The next questions are about your health history that might affect fertility. Please answer according to your best recollection.

(D-01) How many sexual partners have you had over your lifetime? \_\_\_\_\_ (Number)

(D-02) Have you ever had a vaginal yeast infection?  
 Yes     No     Unsure

(D-03) Have you ever had bacterial vaginosis?

Yes  No  Unsure

(D-04) Have you ever been diagnosed with vaginal trichomoniasis?

Yes  No  Unsure

(D-05) Have you ever had a vaginal infection but you are not sure what kind?

Yes  No  Unsure

(D-06) Have you ever been diagnosed with pelvic inflammatory disease or pelvic infection?

Yes  No  Unsure

(D-07) Have you ever been diagnosed with Chlamydia?

Yes  No  Unsure

(D-08) Have you ever been diagnosed with gonorrhea?

Yes  No  Unsure

(D-09) Have you ever been diagnosed with genital warts?

Yes  No  Unsure

(D-10) Have you ever been diagnosed with genital herpes?

Yes  No  Unsure

(D-11) Have you ever been diagnosed with any other sexually transmitted infection?

Yes  No  Unsure

If yes or unsure, please describe: \_\_\_\_\_

(D-12) Have you ever been tested for any sexually transmitted infection (even if the test was negative)?

Yes  No  Unsure

(D-13) Have you ever had symptoms of menopause such as hot flushes?

Yes  No  Unsure

(D-14) Have you ever had irregular bleeding from the vagina or uterus?

Yes  No  Unsure

(D-15) Have you ever had ovarian cysts?

Yes  No  Unsure

(D-16) What is the month and year of your last Pap smear?

\_\_\_\_\_Month \_\_\_\_\_Year

(D-17) Have you ever had an abnormal Pap smear?

Yes  No  Unsure

→If **no**, skip to question D-19 below; if **yes**, continue to question D-18.

(D-18) If yes or unsure, what kind of abnormality(ies) were noted on your Pap smear?

(Please mark  all that apply)

Inflammation  Dysplasia  Cancer  Papilloma (wart) virus  
 Abnormal cells  Unsure

(D-19) Have you ever had surgery or freezing of the cervix (such as CRYO, laser, LEEP, hot cautery)?

Yes  No  Unsure

If yes, which procedure(s)? \_\_\_\_\_

**E. Family Planning History**

(E-01) Have you ever used natural family planning (NFP)?

Yes  No

If yes:

Which NFP method(s)? \_\_\_\_\_

Over your lifetime, how long did you use or have you used NFP? \_\_\_\_\_Year(s) \_\_\_\_\_Month(s)

What is the date of your last use of NFP? |\_\_|\_|\_| / |\_\_|\_|\_|\_|\_| (example: Mar / 1985)  
**Month / Year**

(E-02) Have you ever used condoms?

Yes  No

If yes:

Over your lifetime, how long did you use or have you used condoms? \_\_\_\_\_Year(s) \_\_\_\_\_Month(s)

What is the date of your last use of condoms?

|\_\_|\_|\_| / |\_\_|\_|\_|\_|\_| (example: Mar / 1985)  
**Month / Year**

(E-03) Have you ever used oral contraceptives (birth control pills)?

Yes  No

If yes:

Over your lifetime, how long did you use or have you used birth control pills?

\_\_\_\_\_Year(s) \_\_\_\_\_Month(s)

What is the date of your last use of birth control pills?

|\_\_|\_|\_| / |\_\_|\_|\_|\_|\_| (example: Mar / 1985)  
**Month / Year**

(E-04) Have you ever used the 3-month contraceptive injection (Depo Provera®)?

Yes  No

If yes:

Over your lifetime, how long did you use or have you used the contraceptive injection?

\_\_\_\_\_Year(s) \_\_\_\_\_Month(s)

What was the date of your last injection?

|\_\_|\_|\_| / |\_\_|\_|\_|\_|\_| (example: Mar / 1985)  
**Month / Year**

(E-05) Have you ever used any other hormone contraceptives such as Norplant®, a hormone patch, or a hormonal vaginal ring?

Yes  No

If yes:

Please specify name: \_\_\_\_\_

Over your lifetime, how long did you use or have you used these other hormone contraceptives?

\_\_\_\_\_Year(s) \_\_\_\_\_Month(s)

What is the month and year of your last use of these other hormone contraceptives?

|\_\_|\_|\_| / |\_\_|\_|\_|\_|\_| (example: Mar / 1985)  
**Month / Year**

(E-06) Have you ever used an intrauterine device (also called IUD, IUCD, or "the coil")?

Yes                       No

If yes:

Over your lifetime, how long did you use or have you used an IUD? \_\_\_\_\_Year(s) \_\_\_\_\_Month(s)

What is the month and year of your last use of an IUD?

|\_|\_|\_|\_|\_| / |\_|\_|\_|\_|\_|\_| (example: Mar / 1985)  
**Month / Year**

(E-07) Have you ever used emergency contraception (the "morning after pill")?

Yes                       No

If yes:

How many times? \_\_\_\_\_

What is the month and year of your last use of emergency contraception?

|\_|\_|\_|\_|\_| / |\_|\_|\_|\_|\_|\_| (example: Mar / 1985)  
**Month / Year**

(E-08) Have you ever used any other method(s) of family planning?

Yes                       No

If yes:

Please describe any other method(s) used? \_\_\_\_\_

Over your lifetime, how long did you use or have you used any other method(s)?

\_\_\_\_\_Year(s) \_\_\_\_\_Month(s)

What is the date of your last use of any other method(s)?

|\_|\_|\_|\_|\_| / |\_|\_|\_|\_|\_|\_| (example: Mar / 1985)  
**Month / Year**

## **F. Pregnancy History**

The next questions are about your past pregnancies, if any.

(F-01) How many times have you ever been pregnant, counting all pregnancies, regardless of the outcome?  
\_\_\_\_\_ (Number)

→If you have **never** been pregnant at all, please skip to question F-03, page 10

→If you have been pregnant, please continue on the next page

(F-02) Please complete the chart below as completely as possible for each pregnancy you have ever had. If unsure of dates, please provide your best estimate.

#	Month/year conception occurred		How long did it take you to get pregnant with this pregnancy?		Date pregnancy ended	How far along were you when this pregnancy ended? (i.e., 12 weeks gestation)	How did this pregnancy end? L = live birth M = miscarriage E = ectopic preg. S = stillbirth ML = molar preg. A = abortion O = other	Was this pregnancy with your current partner?	Was this pregnancy twins or more?	What was the sex of the baby(ies)? M = male F = female	What was the birth weight(s) of the baby(ies)?	Did you have medical assistance to help you conceive or maintain the pregnancy?	Did you or the baby have any complications or problems during or after the pregnancy? (If yes, please comment below)
	Month/Year	Years	Months	Mo/Day/Yr	Weeks gestation	Please use abbreviations above to describe outcome	Please circle Y=yes N=no for each	Please circle Y=yes N=no for each	Please list all sexes or NA = not applicable	Please list all birth weights or NA = not applicable	Please circle Y=yes N=no for each	Please circle Y=yes N=no for each	
1							Y N	Y N			Y N	Y N	
2							Y N	Y N			Y N	Y N	
3							Y N	Y N			Y N	Y N	
4							Y N	Y N			Y N	Y N	
5							Y N	Y N			Y N	Y N	
6							Y N	Y N			Y N	Y N	
7							Y N	Y N			Y N	Y N	
8							Y N	Y N			Y N	Y N	
9							Y N	Y N			Y N	Y N	
10							Y N	Y N			Y N	Y N	
11							Y N	Y N			Y N	Y N	
12							Y N	Y N			Y N	Y N	
13							Y N	Y N			Y N	Y N	
14							Y N	Y N			Y N	Y N	
15							Y N	Y N			Y N	Y N	

**Complications** (please indicate which pregnancy number for each comment): \_\_\_\_\_

\_\_\_\_\_

(F-03) Has your current partner ever fathered children with another partner?  
 Yes       No       Unsure  
If yes, what year(s) were they born?

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### **G. Previous Fertility-Related Efforts**

The following questions ask about things you may have done to enhance fertility, either on recommendation of a doctor, or on your own.

In order to conceive, have you at any time:

<b>Question</b>	<b>Answer</b>
(G-01) Timed intercourse by counting the number of days in your menstrual cycle?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
(G-02) Taken your basal body temperature?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
(G-03) Used urine LH test kits (urine ovulation test kits)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
(G-04) Taken herbs intended to enhance fertility?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
(G-05) Taken vitamins intended to enhance fertility?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
(G-06) Monitored vaginal discharge, cervical mucus, or cervical fluid?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure

### **H. Previous Fertility-Related Investigations**

Questions H-01 through H-11 are found on the next page.

Question	Answer	Date of Most Recent Test (Month/Year)	Result
(H-01) Have you had an ultrasound of the uterus and ovaries?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unsure
(H-02) Have you had an ultrasound scan of the ovaries to look at ovulation (follicle tracking)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unsure
(H-03) Have you had a hysterosalpingogram (x-ray assessment of the uterus and fallopian tubes)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unsure
(H-04) Have you had a hysteroscopy (camera visualization of uterine cavity)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unsure
(H-05) Have you had an endometrial biopsy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unsure
(H-06) Have you had a D&C (scraping of lining of the womb)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unsure
(H-07) Have you had a post-coital test (looking at sperm taken from your cervix after intercourse)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unsure
(H-08) Have you had day 3 or early cycle blood tests?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unsure
(H-09) Have you had day 21 or late cycle blood tests (progesterone or ovulation)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unsure
(H-10) Have you had other blood tests?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unsure

(H-11) Have you had any other investigations?

Yes  No

If yes, please describe: \_\_\_\_\_

**I. Previous Fertility-Related Diagnoses**

Please mark  all that you or your partner have ever been told you have or suspect that you might have:

(I-01) Unexplained infertility  
 Yes             No             Unsure

(I-02) Unexplained recurrent miscarriage  
 Yes             No             Unsure

(I-03) Endometriosis  
 Yes             No             Unsure

(I-04) Polycystic ovaries (PCOD, PCOS)  
 Yes             No             Unsure

(I-05) Low progesterone  
 Yes             No             Unsure

(I-06) Low estrogen  
 Yes             No             Unsure

(I-07) Not ovulating  
 Yes             No             Unsure

(I-08) Abnormal ovulation  
 Yes             No             Unsure

(I-09) Hostile or limited cervical mucus  
 Yes             No             Unsure

(I-10) Pelvic adhesions or scar tissue  
 Yes             No             Unsure

(I-11) Blocked or damaged fallopian tubes  
 Yes             No             Unsure

(I-12) Fibroids in or on the uterus  
 Yes             No             Unsure

(I-13) Polyps in the uterus  
 Yes             No             Unsure

(I-14) Luteinized unruptured follicle (LUF)  
 Yes             No             Unsure

(I-15) Male factor infertility or sperm abnormality  
 Yes             No             Unsure

(I-16) Other  
 Yes             No

If yes, please specify: \_\_\_\_\_

**J. Previous Fertility-Related Surgeries**

(J-01) Which of the following surgeries have you had? Please include month and year of the surgery.

Yes	No	Surgery	Date(s) of Surgery
		Diathermy, cautery, or laser treatment for <b>endometriosis</b>	
		Ovarian diathermy, cautery, or drilling for <b>polycystic ovaries</b>	
		Laparoscopy ("keyhole surgery")	
		Laparotomy (major abdominal or pelvic surgery)	
		Ovarian Cystectomy (removal of ovarian cyst)	
		Myomectomy (removal of fibroid tumors)	
		Polypectomy (removal of polyps)	
		Tubal Reconstruction (microsurgery)	

(J-02) Have you ever had any surgery in the pelvis or reproductive organs that was not described above?  
 Yes  No  
If yes, please describe: \_\_\_\_\_

(J-03) Have you ever had any other surgery anywhere in the body that was not described above?  
 Yes  No  
If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

**K. Previous Fertility-Related Medical Treatments**

(K-01) Have you taken clomiphene?  
 Yes  No

(Clomiphene is sold in different countries under different brand names, including: Clomid, Serophene, Milophene, Ardomon, Clom, Clomifene, Clomifeno, Clomifenum, Clomiphene Citrate, Clomipheni, Clomipheni Citrate, Clomivid, Clostilbegyt, C-ratioph, Dufine, Dyneric, Fertomid, Gravosan, Indovar, Klomifen, Kyliformon, Omifin, Pergotime, Phenate, Pioner, Prolifen, Serpafar, Tokormon.)

→If **no**, please skip to question K-09 on the next page; if **yes**, continue to question K-02.

(K-02) For how many cycles have you taken clomiphene?  
\_\_\_\_\_ Total number of cycles

(K-03) What is the **maximum** dose you have taken **per day**? (Note: One tablet = 50 mg)  
(Please mark  one)  
 25 mg  50 mg  100 mg  150 mg  200 mg  Other, please specify: \_\_\_\_\_

(K-04) What is the number of days you took this dose? (Please mark  one)  
 3  4  5  Other, please specify: \_\_\_\_\_

(K-05) Did you take anything along with the clomiphene to enhance mucus?  
 Yes  No  
If yes, what medication did you take? \_\_\_\_\_

(K-06) Was the treatment with clomiphene monitored with blood tests?  
 Yes  No

(K-07) Was the treatment with clomiphene monitored with ultrasound?  
 Yes  No

(K-08) How severe were the side effects you experienced while taking clomiphene?

(Please mark  one)

None  Mild  Moderate  Severe  Unsure

(K-09) Other than clomiphene, have you at any time taken any other medication by mouth to induce ovulation?

Yes  No

If yes, what medication(s) did you take? \_\_\_\_\_

(K-10) In order to achieve pregnancy, have you at any time taken any medication by injection to induce ovulation?

Yes  No

If yes, what medication(s) did you take? \_\_\_\_\_

(K-11) In order to achieve pregnancy, have you at any time taken progesterone by prescription?

Yes  No

(K-12) In order to achieve pregnancy, have you at any time taken any other medications to enhance fertility?

Yes  No

If yes, please describe: \_\_\_\_\_

(K-13) Have you had artificial insemination?

Yes  No

If yes, please indicate the following:

How many cycles with husband's sperm? \_\_\_\_\_

How many cycles with donor sperm? \_\_\_\_\_

**L. Previous Assisted Reproductive Technology (ART)**

These next questions are about in-vitro fertilization (IVF) or similar ART treatments, such as intra-cytoplasmic sperm injection (ICSI), gamete intra-fallopian transfer (GIFT), or zygote intra-fallopian transfer (ZIFT). By ART treatment, we mean any treatment that involves removing the egg from the woman's body and then replacing the egg or embryo back into the body.

(L-01) Have you ever been advised by a physician or practitioner to try IVF, ICSI, or any other ART?

Yes  No

(L-02) Have you ever attempted IVF, ICSI or any other ART?

Yes  No

→If no, please skip to Section M, Experience of Past Fertility Treatment on the next page; if yes, continue to question L-03.

(L-03) If yes, please complete the following table for **all** IVF, ICSI, or any ART attempts, regardless of outcome:

Attempt	Date of Attempt		Number of eggs retrieved	Number of embryos created	Number of embryos transferred	Number of embryos frozen
	Month	Year				
1						
2						
3						
4						
5						
6						

**M. Experience of Past Fertility Treatment**

These questions help us understand your previous experiences with evaluation and treatment.

(M-01) Have you or your partner ever been evaluated or treated for fertility problems or miscarriage in the past, not including NPT (NaPro Technology)?

Yes                       No

→If **no**, please skip to **Section N, Adoption, page 16**; if **yes**, continue to question **M-02**.

In the next questions, please consider your overall experience with medical evaluation and treatment for infertility or miscarriage that you and your partner have had in the past (not including NPT). Please answer from your own perspective, not necessarily your partner's.

How do you assess the doctors and the staff that you have worked with?

(M-02) Did they make you feel you had enough time during the consultations? (Please mark  one)

Bad				Excellent	
1	2	3	4	5	Don't know/not relevant
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(M-03) Did they involve you in decisions? (Please mark  one)

Bad				Excellent	
1	2	3	4	5	Don't know/not relevant
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(M-04) Did they listen to you? (Please mark  one)

Bad				Excellent	
1	2	3	4	5	Don't know/not relevant
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(M-05) Did they explain the purpose of examinations, tests, and treatments? (Please mark  one)

Bad				Excellent	
1	2	3	4	5	Don't know/not relevant
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(M-06) Did they tell you what you wanted to know about the causes of infertility and/or miscarriage? (Please mark  one)

Bad				Excellent	
1	2	3	4	5	Don't know/not relevant
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(M-07) Did they tell you what you wanted to know about the treatment of infertility and/or miscarriage? (Please mark  one)

Bad				Excellent	
1	2	3	4	5	Don't know/not relevant
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(M-08) Did they deal with emotional consequences of your infertility or miscarriage and treatment? (Please mark  one)

Bad				Excellent	
1	2	3	4	5	Don't know/not relevant
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(M-09) Did they make a treatment plan adjusted to your special situation? (Please mark  one)

Bad				Excellent	
1	2	3	4	5	Don't know/not relevant
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(M-10) What have you liked most about you and your partner's past treatment?

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(M-11) What have you liked least about you and your partner's past treatment?

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(M-12) What is your overall satisfaction rating for you and your partner's past treatment, rated from 1-10? (Please mark  one)

Not at all satisfied										Very Satisfied
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	

### **N. Adoption**

(N-01) Have you ever applied for adoption?

Yes                       No

(N-02) Do you have any adopted children?

Yes                       No

(N-03) Have you ever had foster children?

Yes                       No

(N-04) Do you currently have any foster children?

Yes                       No

### **P. General Health History**

(P-01) Which of the following conditions have you ever had? (Please mark  all that apply)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Migraine headaches                      | <input type="checkbox"/> Anemia                      | <input type="checkbox"/> Urinary tract infections            |
| <input type="checkbox"/> Varicose veins                          | <input type="checkbox"/> Allergies such as hay fever | <input type="checkbox"/> Allergic skin reaction              |
| <input type="checkbox"/> Seizures                                | <input type="checkbox"/> Thyroid disease             | <input type="checkbox"/> Rheumatoid arthritis                |
| <input type="checkbox"/> High blood pressure                     | <input type="checkbox"/> Heart disease               | <input type="checkbox"/> Blood clots                         |
| <input type="checkbox"/> Kidney disease                          | <input type="checkbox"/> Liver disease               | <input type="checkbox"/> Chronic fatigue syndrome            |
| <input type="checkbox"/> Fibromyalgia                            | <input type="checkbox"/> Multiple sclerosis          | <input type="checkbox"/> Crohn's disease                     |
| <input type="checkbox"/> Ulcerative colitis                      | <input type="checkbox"/> Lupus erythematosus         | <input type="checkbox"/> Sjogren's syndrome                  |
| <input type="checkbox"/> Scleroderma                             | <input type="checkbox"/> Frequent diarrhea           | <input type="checkbox"/> Frequent constipation               |
| <input type="checkbox"/> Non-insulin-dependent diabetes mellitus |  | <input type="checkbox"/> Insulin-dependent diabetes mellitus |

- Cancer (describe): \_\_\_\_\_
- Hormone problems (describe): \_\_\_\_\_
- Other autoimmune disease (describe): \_\_\_\_\_
- Food intolerance (describe): \_\_\_\_\_
- Other medical problems (describe): \_\_\_\_\_
- None

(P-02) Do you have any drug allergies?

Yes  No

If yes, please describe: \_\_\_\_\_

(P-03) Please list all drugs, vitamins, or herbs you are currently taking on a regular basis, whether they are prescribed or over-the-counter:

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(P-04) What has been your lowest weight as an adult?

\_\_\_\_\_ Pounds  
or \_\_\_\_\_ Kilograms  
or \_\_\_\_\_ Stones **and** \_\_\_\_\_ Pounds

(P-05) What has been your highest weight as an adult (not including any pregnancy)?

\_\_\_\_\_ Pounds  
or \_\_\_\_\_ Kilograms  
or \_\_\_\_\_ Stones **and** \_\_\_\_\_ Pounds

(P-06) What is your current weight?

\_\_\_\_\_ Pounds  
or \_\_\_\_\_ Kilograms  
or \_\_\_\_\_ Stones **and** \_\_\_\_\_ Pounds

(P-07) Have you ever experienced unexplained increases in your weight?

Yes  No  Unsure

(P-08) Have you ever experienced unexplained decreases in your weight?

Yes  No  Unsure

(P-09) Has a medical professional ever expressed a concern about your weight?

Yes  No  Unsure

(P-10) Have you ever had an eating disorder (such as anorexia, bulimia, or others)?

Yes  No

(P-11) Have you been immunized against rubella (German measles)?

Yes  No  Unsure

In general, how much do you experience the following symptoms: (Please mark  one for each)

(P-12) Fatigue

Minimal  1  2  3  4  5  6  7  8  9 Extreme  10

(P-13) Sleep Disturbance

Minimal  1  2  3  4  5  6  7  8  9 Extreme  10

(P-14) Low Mood or Feeling Depressed

Minimal  1  2  3  4  5  6  7  8  9 Extreme  10

(P-15) Anxiety

Minimal  1  2  3  4  5  6  7  8  9 Extreme  10

Please continue on the next page.

(P-16) Do you have unwanted/excessive hair growth?  
 Yes                       No                       Unsure

(P-17) Do you suffer from acne?  
 Yes                       No                       Unsure

(P-18) Do you have dizziness or light headedness before meals?  
 Yes                       No                       Unsure

The next 10 questions address potential environmental or occupational exposures. Please indicate whether you have had a significant exposure to each of these. (Please mark  one for each)

(P-19) Ionizing radiation other than medical x-rays (gamma rays, x-rays, alpha and beta particles, neutrons).  
 Yes                       No                       Unsure

(P-20) Magnetic radiation from towers (electromagnetic energy radiated or transmitted as rays or waves).  
 Yes                       No                       Unsure

(P-21) Chemical solvents (liquid substance capable of dissolving other substances).  
 Yes                       No                       Unsure

(P-22) High noise levels (such as jack hammering, rock concerts, headsets with high volume).  
 Yes                       No                       Unsure

(P-23) Heavy metals (such as lead, cadmium, or mercury).  
 Yes                       No                       Unsure

(P-24) Pesticides (chemicals used to kill insects).  
 Yes                       No                       Unsure

(P-25) Herbicides (chemicals used to kill weeds or unwanted plants).  
 Yes                       No                       Unsure

(P-26) Water pollution (water contaminated with sewage, chemicals, or fertilizers).  
 Yes                       No                       Unsure

(P-27) Air pollution (smog or particular matter).  
 Yes                       No                       Unsure

(P-28) Other  
 Yes                       No                       Unsure

If yes, please describe: \_\_\_\_\_

### **Q. Family History**

The next few questions are about family history that might relate to your fertility.

(Q-01) Do your biologic mother or father or your siblings have a history of infertility, miscarriages, or other reproductive problems?  
 Yes                       No                       Unsure

If yes or unsure, please describe: \_\_\_\_\_

(Q-02) Did your biologic mother take hormones (such as DES) when she was pregnant with you?  
 Yes                       No                       Unsure

(Q-03) Which of the following conditions has your biologic mother, father, siblings, grandparents, cousins, nieces, or nephews ever had? (Please mark  all that apply)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Rheumatoid arthritis                       | <input type="checkbox"/> Multiple sclerosis  | <input type="checkbox"/> Crohn's disease                     |
| <input type="checkbox"/> Ulcerative colitis                         | <input type="checkbox"/> Lupus erythematosus | <input type="checkbox"/> Sjogren's syndrome                  |
| <input type="checkbox"/> Scleroderma                                | <input type="checkbox"/> Thyroid disease     | <input type="checkbox"/> Insulin-dependent diabetes mellitus |
| <input type="checkbox"/> Non-insulin-dependent diabetes mellitus    |  |  |
| <input type="checkbox"/> Other autoimmune disease (describe): _____ |  |  |
| <input type="checkbox"/> None                                       |  |  |

(Q-04) Does your biologic family have genetic conditions that may be passed on?

- Yes                       No                       Unsure

If yes or unsure, please describe: \_\_\_\_\_

(Q-05) Does your partner's biologic family have genetic conditions that may be passed on?

- Yes                       No                       Unsure

If yes or unsure, please describe: \_\_\_\_\_

**R. Health Habits**

(R-01) On how many of the past 7 days did you exercise or participate in sports activities for at least 20 minutes that made you SWEAT and BREATHE HARD, such as fast walking, jogging, swimming laps, playing tennis, fast bicycling, heavy yard work or housework, or similar aerobic activities? (Please mark  one)

0    1    2    3    4    5    6    7

(R-02) On how many of the past 7 days did you exercise or participate in sports activities for at least 20 minutes but less vigorously than described above? (Please mark  one)

0    1    2    3    4    5    6    7

(R-03) Have you ever smoked cigarettes?

Yes    No

→If no, please skip to question R-05 below; if yes, continue to question R-04.

(R-04) Do you currently smoke cigarettes?

Yes    No

If yes, how many cigarettes do you usually smoke per day? \_\_\_\_\_

If no, in what month and year did you quit smoking cigarettes?

  |\_|\_|\_|\_|\_| / |\_|\_|\_|\_|\_| (example: Mar / 1985)

          Month /           Year

(R-05) Have you ever used tobacco in any other form (pipes, cigars, snuff, chewing tobacco, etc.)?

Yes    No

→If no, please skip to question R-07 below; if yes, continue to question R-06.

(R-06) Do you currently use tobacco in some form?

Yes    No

If no, in what month and year did you quit using tobacco?

  |\_|\_|\_|\_|\_| / |\_|\_|\_|\_|\_| (example: Mar / 1985)

          Month /           Year

(R-07) On average during the last month, how many cups of coffee did you drink per day? (Do not count espresso) (Please mark  one)

0    less than 1    1    2    3    4    5    6    7 or more

(R-08) On average during the last month, how many cups of espresso did you drink per day? (Please mark  one)

0    less than 1    1    2    3    4    5    6    7 or more

(R-09) On average during the last month, how many cans or bottles of caffeinated soda drinks did you drink per day, including Coca Cola, Pepsi, and others? (Please mark  one)

0    less than 1    1    2    3    4    5    6    7 or more

(R-10) On average, how many units of alcohol do you drink per week? (Please mark  one)  
(1 unit = glass (half-pint) of beer, 1 measure of spirits, 1 small glass of wine)

0    less than 1    1    2    3    4    5    6    7 or more

(R-11) In the last month, what is the highest number of units of alcohol you had in a 24-hour period? (Please mark  one)

0    1-2    3-4    5-7    8-9    10-12    13-15    over 15

**S. Stress and Social Situation**

Please answer the following questions from your own perspective, not necessarily your partner's.

(S-01) With reference to you or your partner's fertility problems and treatment, do you feel that:  
 [Please mark  one answer for each line]

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
My life has changed very much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My life has been disrupted as a result	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It is stressful for me to deal with	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(S-02) How have you or your partner's fertility problems affected your marriage/partnership?  
 [Please mark  one answer for each line]

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Brought us closer together	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strengthened our relationship	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caused crisis in our relationship	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caused thoughts of divorce	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(S-03) How much stress has you or your partner's fertility problems placed on the following?  
 [Please mark  one answer for each line]

	A lot	Some	A little	None
Your marriage/partnership	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your sex life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your relationships with your family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your relationships with your family-in-law	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your relationships with friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your relationships with workmates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your relationships to people with children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your relationships to pregnant women	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your physical health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your mental health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your financial condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(S-04) Do you get support and understanding from any of the following people in relation to you or your partner's fertility problems or treatment? [Please mark  one answer for each line]

	Always	Often	Sometimes	Rarely	Never	Don't have
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Partner's Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colleagues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Who? \_\_\_\_\_

(S-05) Do you experience that some people react negatively to you or your partner's fertility problems or treatment? [Please mark  one answer for each line]

	Always	Often	Sometimes	Rarely	Never	Don't have
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Partner's Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colleagues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Who? \_\_\_\_\_

**T. Demographic Information**

The following information is helpful for us to understand who is receiving NPT evaluation and treatment.

- (T-01) How many years of schooling have you had? (Please mark  one)  
 8 or less     9-10     11-12     13-15     16-18     more than 18
- (T-02) What is your race and ethnicity? (Please mark  all that apply)  
 Aborigine     Alaskan Native     American Indian/Native American     Asian  
 Black     Hawaiian Native     Hispanic/Latino     Pacific Islander     White  
 Other, please specify: \_\_\_\_\_
- (T-03) What is your religious preference? (Please mark  one)  
 Catholic     Islamic     Jewish     Latter-day Saint     Orthodox Christian  
 Protestant     None     Other, please specify: \_\_\_\_\_
- (T-04) About how often do you usually attend religious or worship services? (Please mark  one)  
 More than once per week     Weekly     Monthly     Less than monthly     Never
- (T-05) What is your current occupation? (Please mark  one)  
 Professional     Technical     Clerical/Sales     Skilled laborer     Unskilled laborer  
 Homemaker     Student     Educator  
 Other, please specify: \_\_\_\_\_
- (T-06) What is your approximate yearly total household income? (Please mark  one)  
 Under \$12,000     \$12,001-25,000     \$25,001-50,000     \$50,001-75,000  
 \$75,001-100,000     \$Over 100,000

**U. Additional Comments or Questions**

Please write any additional comments or questions you have about the issues addressed by this questionnaire:

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**MAN'S INITIAL QUESTIONNAIRE**  
**Natural Procreative Technology Evaluation for Infertility or Miscarriage**

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(\* To avoid confusion with zero, there is no section O.)

## **Introduction and Purpose of the Man's Initial Questionnaire**

### **Why you are receiving this questionnaire**

You are being given this Man's Questionnaire because you or your partner have scheduled an initial evaluation for infertility or miscarriage. This questionnaire comprehensively addresses relevant issues for your evaluation and treatment. It was designed by physicians working with Natural Procreative Technology.

### **How this questionnaire will be used**

Your physician will use the information from this questionnaire and the separate questionnaire from your partner to provide important information for the medical evaluation and your desires for treatment. We will discuss your responses to many of the items in this questionnaire during our initial visit, and subsequent visits, as needed.

### **Natural Procreative Technology (NPT, NaProTechnology)**

Our approach to evaluating and treating fertility or pregnancy problems is based on Natural Procreative Technology (NPT, NaProTechnology). During our visits, we will explain to you specific recommendations for your unique situation. General information about NPT is available at [www.reproductiveinstitute.com](http://www.reproductiveinstitute.com).

### **What to bring to the first (or next) visit**

Please bring this questionnaire, even if you haven't finished filling it out.

Please also bring copies of medical records from any previous evaluations or treatments for infertility that you or your partner may have had. In some cases, it may be more convenient for you to mail these items.

It is best if both you and your partner can attend the initial consultation.

### **Why there are two questionnaires: woman's and man's**

Our experience has shown that women and men remember and perceive things differently with regard to a couple's fertility problems. In addition, some information is specific to the woman or the man.

### **Sensitive questions**

You may skip any question you are uncomfortable answering. If you choose to skip a question, please place a line through the question rather than leaving it blank. There may be items that you would prefer not to discuss in front of your partner. If so, you may CIRCLE the question number to tell us that your response to this question is confidential and that you prefer that this item NOT be discussed with your partner.

### **Estimated time to complete questionnaire**

It is estimated that this questionnaire will take about 30 minutes to complete for most men.

### **Questions or comments**

If you have any questions or comments or feel a question is inappropriate for your situation, please make a mark or write a comment at the question or at the end of questionnaire. You may also discuss any questions or comments with your health provider.

### **Where to return the questionnaire**

Please return the questionnaire to your health provider at the time of your or your partner's next appointment. Alternatively, you may mail it to your provider.

### **Option to participate in the iNEST study**

Your health care provider may invite you to participate in an ongoing clinical study to assess live birth rates among those who consider or receive NPT treatment to conceive or maintain pregnancy. This study is known as the **international NaProTechnology Evaluation and Surveillance of Treatment (iNEST)**. The purpose of the iNEST study is to understand the use of NPT, and characteristics that may help us predict how successful NPT can be for each couple for infertility or miscarriage.

### **Whether or not you participate in the iNEST study will not affect the clinical care that you receive.**

When you are asked, you may choose whether or not to participate in the iNEST study. If you participate,

your answers from this questionnaire will be recorded confidentially for the study. If you do not participate, your answers from this questionnaire will not be reported to the study.

**Natural Procreative Technology Evaluation for Infertility or Miscarriage**  
**Man's Initial Questionnaire**

**MorningStar Family Health Center #11**

Couple ID# \_\_\_\_\_

NPT Physician Name \_\_\_\_\_

Your Family (Last) Name \_\_\_\_\_

Your Given (First) Name \_\_\_\_\_

**A. Initial Information**

(A-01) Today's Date |\_\_| |\_\_| / |\_\_| |\_\_| / |\_\_| |\_\_| |\_\_| (example: 17 / Mar / 2005)  
Day / Month / Year

(A-02) What is your month and year of birth? |\_\_| |\_\_| / |\_\_| |\_\_| |\_\_| (example: Mar / 1985)  
Month / Year

(A-03) What is your marital status? (Please mark  one)  
 Never married     Married     Widow     Divorced

→If **not** married, please skip to question A-06 below; if yes, continue to question A-04.

(A-04) In what month and year did you marry? |\_\_| |\_\_| / |\_\_| |\_\_| |\_\_|  
Month / Year  
(example: Mar / 1985)

(A-05) Is this your first marriage?  
 Yes     No

(A-06) How did you learn about Natural Procreative Technology (NPT, NaPro)?

(Please mark  all that apply)

- Physician or other health professional
- On the web
- Written flyer or brochure
- A friend or acquaintance who had NPT treatment
- Public presentation
- Church
- Newspaper or magazine article
- Other, please describe: \_\_\_\_\_

(A-07) Why have you decided to try NPT?

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**B. Trying to Have a Baby**

For the purposes of this questionnaire, "trying to have a baby" means having regular sexual intercourse without any contraception, whether or not you were doing anything else to try to get pregnant.

(B-01) Using this definition, in what month and year did you start trying to have a baby with your partner?

\_\_\_\_|\_\_\_\_|\_\_\_\_| / \_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_| (example: Mar / 1985)  
**Month / Year**

(B-02) During the time you have been trying to have a baby, was there any time when you or your partner did something to avoid pregnancy (such as abstinence during fertile days, condoms, withdrawal, or other contraception of any kind) for more than one month?

Yes  No

If yes, for how many months total? \_\_\_\_\_

(B-03) During the time you have been trying to have a baby, was there any time when you and your partner did not have intercourse for more than one month?

Yes  No

If yes, for how many months total? \_\_\_\_\_

(B-04) During the time you have been trying to have a baby, how often do you and your partner have intercourse, in general?

\_\_\_\_ Times per month **OR** \_\_\_\_ Times per week

(B-05) How often do you use lubricants when you have intercourse? (Please mark  one)

Always Often Sometimes Rarely Never

(B-06) How often is intercourse physically painful for you? (Please mark  one)

Always Often Sometimes Rarely Never

(B-07) How often do you have difficulty achieving or maintaining an erection? (Please mark  one)

Always Often Sometimes Rarely Never

(B-08) How often do you have difficulty with penetration? (Please mark  one)

Always Often Sometimes Rarely Never

(B-09) When you have intercourse, how often do you ejaculate inside the vagina? (Please mark  one)

Always Often Sometimes Rarely Never

**C. Andrologic History (Male Sexual Health)**

(C-01) How many sexual partners have you had over your lifetime? \_\_\_\_\_ (Number)

(C-02) Have you ever been diagnosed with Chlamydia?

Yes  No  Unsure

(C-03) Have you ever been diagnosed with gonorrhea?

Yes  No  Unsure

(C-04) Have you ever been diagnosed with genital warts?

Yes                       No                       Unsure

(C-05) Have you ever been diagnosed with genital herpes?

Yes                       No                       Unsure

(C-06) Have you ever been diagnosed with any other sexually transmitted infection?

Yes                       No                       Unsure

If yes or unsure, please describe: \_\_\_\_\_

(C-07) Have you ever been tested for any sexually transmitted infection (even if the test was negative)?

Yes                       No                       Unsure

**D. Family Planning History**

(D-01) Have you ever used natural family planning (NFP)?

Yes                       No

If yes:

Which NFP method(s)? \_\_\_\_\_

Over your lifetime, how long did you use or have you used NFP? \_\_\_\_\_Year(s) \_\_\_\_\_Month(s)

What is the date of your last use of NFP? |\_\_|\_|\_|\_| / |\_\_|\_|\_|\_|\_| (example: Mar / 1985)  
Month / Year

(D-02) Have you ever used condoms?

Yes                       No

If yes:

Over your lifetime, how long did you use or have you used condoms? \_\_\_\_\_Year(s) \_\_\_\_\_Month(s)

What is the date of your last use of condoms?  
|\_\_|\_|\_|\_| / |\_\_|\_|\_|\_|\_| (example: Mar / 1985)  
Month / Year

(D-03) Have you ever used any other method(s) of family planning?

Yes                       No

If yes:

Please describe any other method(s) used? \_\_\_\_\_

Over your lifetime, how long did you use or have you used any other method(s)?

\_\_\_\_\_Year(s) \_\_\_\_\_Month(s)

What is the date of your last use of any other method(s)?  
|\_\_|\_|\_|\_| / |\_\_|\_|\_|\_|\_| (example: Mar / 1985)  
Month / Year

(D-04) Have you ever gotten any woman pregnant, regardless of how long ago or the outcome of the pregnancy?

Yes                       No                       Unsure

**E. Previous Fertility-Related Investigations**

(E-01) Have you had an analysis of seminal fluid (sperm count)?

Yes                       No

→If **no**, please skip to question E-03 on next page; if **yes**, continue to question E-02.

(E-02) If yes, what was the result of the most recent analysis? (Please mark  one)

Very abnormal     Moderately abnormal     Minimally abnormal     Normal     Unsure

(E-03) Have you and your partner had a post-coital test (a test for sperm in woman's cervix after intercourse)?

Yes                       No                       Unsure

If yes, in what month and year was the most recent test?

|\_|\_|/|\_|\_|/|\_|\_| (example: Mar / 1985)

Month / Year

What was the result of the most recent test?     Normal     Abnormal     Unsure

(E-04) Have you been seen by an urologist?

Yes                       No                       Unsure

If yes, please describe: \_\_\_\_\_

(E-05) Have you had any other investigations?

Yes                       No

If yes, please describe: \_\_\_\_\_

**F. Previous Fertility-Related Diagnoses**

Please mark  all of the following that you have ever been told you have or suspect you might have had:

(F-01) Undescended testicle

Yes                       No                       Unsure

(F-02) Mumps

Yes                       No                       Unsure

(F-03) Testicular trauma

Yes                       No                       Unsure

(F-04) Varicocele (excess veins in the scrotum)

Yes                       No                       Unsure

(F-05) Infection of the prostate

Yes                       No                       Unsure

(F-06) Infection of the epididymis

Yes                       No                       Unsure

(F-07) Infection of the testes

Yes                       No                       Unsure

(F-08) Problems with orgasm/ejaculation

Yes                       No                       Unsure

(F-09) Other

Yes                       No

If yes, please specify: \_\_\_\_\_



(I-03) Did they involve you in decisions? (Please mark  one)

Bad				Excellent	
1	2	3	4	5	Don't know/not relevant
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(I-04) Did they listen to you? (Please mark  one)

Bad				Excellent	
1	2	3	4	5	Don't know/not relevant
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(I-05) Did they explain the purpose of examinations, tests, and treatments? (Please mark  one)

Bad				Excellent	
1	2	3	4	5	Don't know/not relevant
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(I-06) Did they tell you what you wanted to know about the causes of infertility and/or miscarriage?  
(Please mark  one)

Bad				Excellent	
1	2	3	4	5	Don't know/not relevant
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(I-07) Did they tell you what you wanted to know about the treatment of infertility and/or miscarriage?  
(Please mark  one)

Bad				Excellent	
1	2	3	4	5	Don't know/not relevant
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(I-08) Did they deal with emotional consequences of your infertility or miscarriage and treatment?  
(Please mark  one)

Bad				Excellent	
1	2	3	4	5	Don't know/not relevant
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(I-09) Did they make a treatment plan adjusted to your special situation? (Please mark  one)

Bad				Excellent	
1	2	3	4	5	Don't know/not relevant
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(I-10) What have you liked most about you and your partner's past treatment?

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(I-11) What have you liked least about you and your partner's past treatment?

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(I-12) What is your overall satisfaction rating for you and your partner's past treatment,  
rated from 1-10? (Please mark  one)

Not at all satisfied

Very Satisfied

1    2    3    4    5    6    7    8    9    10

**J. Adoption**

(J-01) Have you ever applied for adoption?

Yes                       No

(J-02) Do you have any adopted children?

Yes                       No

(J-03) Have you ever had foster children?

Yes                       No

(J-04) Do you currently have any foster children?

Yes                       No

**K. General Health History**

(K-01) Which of the following conditions have you ever had? (Please mark  all that apply)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Migraine headaches                      | <input type="checkbox"/> Anemia                      | <input type="checkbox"/> Urinary tract infections            |
| <input type="checkbox"/> Varicose veins                          | <input type="checkbox"/> Allergies such as hay fever | <input type="checkbox"/> Allergic skin reaction              |
| <input type="checkbox"/> Seizures                                | <input type="checkbox"/> Thyroid disease             | <input type="checkbox"/> Rheumatoid arthritis                |
| <input type="checkbox"/> High blood pressure                     | <input type="checkbox"/> Heart disease               | <input type="checkbox"/> Blood clots                         |
| <input type="checkbox"/> Kidney disease                          | <input type="checkbox"/> Liver disease               | <input type="checkbox"/> Chronic fatigue syndrome            |
| <input type="checkbox"/> Fibromyalgia                            | <input type="checkbox"/> Multiple sclerosis          | <input type="checkbox"/> Crohn's disease                     |
| <input type="checkbox"/> Ulcerative colitis                      | <input type="checkbox"/> Lupus erythematosus         | <input type="checkbox"/> Sjogren's syndrome                  |
| <input type="checkbox"/> Scleroderma                             | <input type="checkbox"/> Frequent diarrhea           | <input type="checkbox"/> Frequent constipation               |
| <input type="checkbox"/> Non-insulin-dependent diabetes mellitus |  | <input type="checkbox"/> Insulin-dependent diabetes mellitus |

- Cancer (describe): \_\_\_\_\_
- Hormone problems (describe): \_\_\_\_\_
- Other autoimmune disease (describe): \_\_\_\_\_
- Food intolerance (describe): \_\_\_\_\_
- Other medical problems (describe): \_\_\_\_\_
- None

(K-02) Do you have any drug allergies?

Yes                       No

If yes, please describe: \_\_\_\_\_

(K-03) Please list all drugs, vitamins, or herbs you are currently taking on a regular basis, whether they are prescribed or over-the-counter:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(K-04) What has been your lowest weight as an adult?

\_\_\_\_\_ Pounds  
or \_\_\_\_\_ Kilograms  
or \_\_\_\_\_ Stones **and** \_\_\_\_\_ Pounds

(K-05) What has been your highest weight as an adult?

\_\_\_\_\_ Pounds  
or \_\_\_\_\_ Kilograms  
or \_\_\_\_\_ Stones **and** \_\_\_\_\_ Pounds

(K-06) What is your current weight?

\_\_\_\_\_ Pounds  
or \_\_\_\_\_ Kilograms  
or \_\_\_\_\_ Stones **and** \_\_\_\_\_ Pounds

(K-07) Have you ever experienced unexplained increases in your weight?

Yes  No  Unsure

(K-08) Have you ever experienced unexplained decreases in your weight?

Yes  No  Unsure

(K-09) Has a medical professional ever expressed a concern about your weight?

Yes  No  Unsure

(K-10) Have you ever had an eating disorder (such as anorexia, bulimia, or others)?

Yes  No

(K-11) Have you been immunized against rubella (German measles)?

Yes  No  Unsure

In general, how much do you experience the following symptoms: (Please mark  one for each)

(K-12) Fatigue

Minimal  1  2  3  4  5  6  7  8  9  10 Extreme

(K-13) Sleep Disturbance

Minimal  1  2  3  4  5  6  7  8  9  10 Extreme

(K-14) Low Mood or Feeling Depressed

Minimal  1  2  3  4  5  6  7  8  9  10 Extreme

(K-15) Anxiety

Minimal  1  2  3  4  5  6  7  8  9  10 Extreme

The next 10 questions address potential environmental or occupational exposures. Please indicate whether you have had a significant exposure to each of these. (Please mark  one for each)

(K-16) Ionizing radiation other than medical x-rays (gamma rays, x-rays, alpha and beta particles, neutrons).  
 Yes                       No                       Unsure

(K-17) Magnetic radiation from towers (electromagnetic energy radiated or transmitted as rays or waves).  
 Yes                       No                       Unsure

(K-18) Chemical solvents (liquid substance capable of dissolving other substances).  
 Yes                       No                       Unsure

(K-19) High noise levels (such as jack hammering, rock concerts, headsets with high volume).  
 Yes                       No                       Unsure

(K-20) Heavy metals (such as lead, cadmium, or mercury).  
 Yes                       No                       Unsure

(K-21) Pesticides (chemicals used to kill insects).  
 Yes                       No                       Unsure

(K-22) Herbicides (chemicals used to kill weeds or unwanted plants).  
 Yes                       No                       Unsure

(K-23) Water pollution (water contaminated with sewage, chemicals, or fertilizers).  
 Yes                       No                       Unsure

(K-24) Air pollution (smog or particular matter).  
 Yes                       No                       Unsure

(K-25) Other  
 Yes                       No                       Unsure

If yes, please describe: \_\_\_\_\_

**L. Family History**

The next few questions are about family history that might relate to your fertility.

(L-01) Do your biologic father or mother or your siblings have a history of infertility or other reproductive problems?

Yes                       No                       Unsure

If yes or unsure, please describe: \_\_\_\_\_

(L-02) Which of the following conditions has your biologic mother, father, siblings, grandparents, cousins, nieces, or nephews ever had? (Please mark  all that apply)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Rheumatoid arthritis                       | <input type="checkbox"/> Multiple sclerosis  | <input type="checkbox"/> Crohn's disease                     |
| <input type="checkbox"/> Ulcerative colitis                         | <input type="checkbox"/> Lupus erythematosus | <input type="checkbox"/> Sjogren's syndrome                  |
| <input type="checkbox"/> Scleroderma                                | <input type="checkbox"/> Thyroid disease     | <input type="checkbox"/> Insulin-dependent diabetes mellitus |
| <input type="checkbox"/> Non-insulin-dependent diabetes mellitus    |  |  |
| <input type="checkbox"/> Other autoimmune disease (describe): _____ |  |  |
| <input type="checkbox"/> None                                       |  |  |

(L-03) Does your biologic family have genetic conditions that may be passed on?

Yes                       No                       Unsure

If yes or unsure, please describe: \_\_\_\_\_

(L-04) Does your partner's biologic family have genetic conditions that may be passed on?

Yes                       No                       Unsure

If yes or unsure, please describe: \_\_\_\_\_

**M. Health Habits**

(M-01) On how many of the past 7 days did you exercise or participate in sports activities for at least 20 minutes that made you SWEAT and BREATHE HARD, such as fast walking, jogging, swimming laps, playing tennis, fast bicycling, heavy yard work or housework, or similar aerobic activities? (Please mark  one)

0    1    2    3    4    5    6    7

(M-02) On how many of the past 7 days did you exercise or participate in sports activities for at least 20 minutes but less vigorously than described above? (Please mark  one)

0    1    2    3    4    5    6    7

(M-03) Have you ever smoked cigarettes?

Yes    No

→If no, please skip to question M-05 below; if yes, continue to question M-04.

(M-04) Do you currently smoke cigarettes?

Yes    No

If yes, how many cigarettes do you usually smoke per day? \_\_\_\_\_

If no, in what month and year did you quit smoking cigarettes?

|\_|\_| / |\_|\_|\_| (example: Mar / 1985)  
**Month / Year**

(M-05) Have you ever used tobacco in any other form (pipes, cigars, snuff, chewing tobacco, etc.)?

Yes    No

→If no, please skip to question M-07 below; if yes, continue to question M-06.

(M-06) Do you currently use tobacco in some form?

Yes    No

If no, in what month and year did you quit using tobacco?

|\_|\_| / |\_|\_|\_| (example: Mar / 1985)  
**Month / Year**

(M-07) On average during the last month, how many cups of coffee did you drink per day?

(Do not count espresso) (Please mark  one)

0    less than 1    1    2    3    4    5    6    7 or more

(M-08) On average during the last month, how many cups of espresso did you drink per day?

(Please mark  one)

0    less than 1    1    2    3    4    5    6    7 or more

(M-09) On average during the last month, how many cans or bottles of caffeinated soda drinks did you drink per day, including Coca Cola, Pepsi, and others? (Please mark  one)

0    less than 1    1    2    3    4    5    6    7 or more

(M-10) On average, how many units of alcohol do you drink per week? (Please mark  one)

(1 unit = glass (half-pint) of beer, 1 measure of spirits, 1 small glass of wine)

0    less than 1    1    2    3    4    5    6    7 or more

(M-11) In the last month, what is the highest number of units of alcohol you had in a 24-hour period?

(Please mark  one)

0    1-2    3-4    5-7    8-9    10-12    13-15    over 15

**N. Stress and Social Situation**

Please answer the following questions from your own perspective, not necessarily your partner's.

(N-01) With reference to you or your partner's fertility problems and treatment, do you feel that:  
 [Please mark  one answer for each line]

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
My life has changed very much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My life has been disrupted as a result	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It is stressful for me to deal with	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(N-02) How have you or your partner's fertility problems affected your marriage/partnership?  
 [Please mark  one answer for each line]

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Brought us closer together	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strengthened our relationship	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caused crisis in our relationship	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caused thoughts of divorce	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(N-03) How much stress has you or your partner's fertility problems placed on the following?  
 [Please mark  one answer for each line]

	A lot	Some	A little	None
Your marriage/partnership	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your sex life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your relationships with your family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your relationships with your family-in-law	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your relationships with friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your relationships with workmates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your relationships to people with children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your relationships to pregnant women	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your physical health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your mental health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your financial condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(N-04) Do you get support and understanding from any of the following people in relation to you or your partner's fertility problems or treatment? [Please mark  one answer for each line]

	Always	Often	Sometimes	Rarely	Never	Don't have
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Partner's Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colleagues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Who? \_\_\_\_\_

(N-05) Do you experience that some people react negatively to you or your partner's fertility problems or treatment? [Please mark  one answer for each line]

	Always	Often	Sometimes	Rarely	Never	Don't have
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Partner's Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colleagues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Who? \_\_\_\_\_

**P. Demographic Information**

(P-01) How many years of schooling have you had? (Please mark  one)  
 8 or less     9-10     11-12     13-15     16-18     more than 18

(P-02) What is your race? (Please mark  all that apply)  
 Aborigine     Alaskan Native     American Indian/Native American     Asian  
 Black     Hawaiian Native     Hispanic/Latino     Pacific Islander     White  
 Other, please specify: \_\_\_\_\_

(P-03) What is your religious preference? (Please mark  one)  
 Catholic     Islamic     Jewish     Latter-day Saint     Orthodox Christian  
 Protestant     None     Other, please specify: \_\_\_\_\_

(P-04) About how often do you usually attend religious or worship services? (Please mark  one)  
 More than once per week     Weekly     Monthly     Less than monthly     Never

(P-05) What is your current occupation? (Please mark  one)  
 Professional     Technical     Clerical/Sales     Skilled laborer     Unskilled laborer  
 Homemaker     Student     Educator  
 Other, please specify: \_\_\_\_\_

(P-06) What is your approximate yearly total household income? (Please mark  one)  
 Under \$12,000     \$12,001-25,000     \$25,001-50,000     \$50,001-75,000  
 \$75,001-100,000     Over \$100,000

**Q. Additional Comments or Questions**

Please write any additional comments or questions you have about the issues addressed by this questionnaire:

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