Reproductive Life Goals Questionnaire

Name: _____ Date _____

Date of Birth: _____

Are you sexually active? ☐ Never ☐ Not currently ☐ Yes

Do you want to become pregnant in the next 12 months? ☐ Yes ☐ No ☐ Unsure

Total number of pregnancies _____ Total number of live births _____

How old would you like to be when you have children? _____

How many children would you like to have? _____

How many years apart would you like your children to be? _____

Have you required infertility treatment(s) in the past? ☐ Yes ☐ No

Are you currently using a method of contraception (birth control)? ☐ Yes ☐ No
If yes, what method are you using?

☐ Abstinence ☐ Condoms ☐ Depo shot ☐ Diaphragm ☐ Essure ☐ Hormonal implant ☐ IUD
☐ NuvaRing ☐ Patch ☐ Pills ☐ Rhythm Method ☐ Spermicide ☐ Tubal ligation
☐ Vasectomy ☐ Other ☐ None

Are you satisfied with your current method of contraception? ☐ Yes ☐ No ☐ Unsure

Have you tried other birth control methods in the past? ☐ Yes ☐ No

If so, which methods have you used? _____

Are you interested in learning about other methods of contraception? ☐ Yes ☐ No

Do you have a family history of:

☐ Children who died before birth or shortly after
☐ Cystic fibrosis
☐ Diabetes
☐ Down's syndrome
☐ Hemophilia
☐ Huntington's chorea
☐ Mental retardation
☐ Muscular dystrophy
☐ Neural tube defects
☐ Tay Sachs Disease
☐ Thalassemia
☐ Other chromosomal disorders/birth defects

Reproductive Life Goals Questionnaire

Please list all medications you are taking. Include any prescription medications, over-the-counter medications, vitamins, herbal supplements and topical medications:

_____

_____

Please list all medication allergies and adverse reactions:

_____

Do you smoke cigarettes or use other tobacco products? ☐ Yes ☐ No
How much per day? _____

Are you ☐ thinking about quitting ☐ ready to quit ☐ not ready ☐ does not apply

Do you consume caffeinated beverages? ☐ Yes – Amount/Day _____ ☐ No

What is your occupation: _____

In the last 12 months, have you traveled outside of the United States? ☐ Yes ☐ No

Do you have health insurance coverage? ☐ No ☐ Yes - Carrier _____

Would you like assistance with obtaining health insurance coverage? ☐ Yes ☐ No

*Thank you for completing the Reproductive Life Goals Questionnaire!

**You may return this form to your healthcare provider.