# MEDICAL HISTORY

## 1. Which REUMATIC DISEASE do you have and when were you diagnosed with it (year)?

<table>
<thead>
<tr>
<th>Disease</th>
<th>Year when you were diagnosed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatoid arthritis (RA)</td>
<td></td>
</tr>
<tr>
<td>Undifferentiated arthritis (UA)</td>
<td></td>
</tr>
<tr>
<td>Psoriatic arthritis (PsA)</td>
<td></td>
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<tr>
<td>Juvenile idiopathic arthritis/JIA (Childhood arthritis)</td>
<td></td>
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<tr>
<td>Spondylarthropathy/SpA (Bechterew’s disease)</td>
<td></td>
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<tr>
<td>Arthritis caused by Crohn’s disease or Colitis ulcerosa</td>
<td></td>
</tr>
<tr>
<td>Other, specify _____________________________________________________</td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td></td>
</tr>
</tbody>
</table>

## 2. Other diseases/comorbidities

Have you ever been diagnosed with?

<table>
<thead>
<tr>
<th>Disease</th>
<th>Year when you were diagnosed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Mellitus</td>
<td></td>
</tr>
<tr>
<td>Crohn’s disease or Colitis ulcerosa</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular diseases:</td>
<td></td>
</tr>
<tr>
<td>High blood pressure (arterial hypertension)</td>
<td></td>
</tr>
<tr>
<td>Chest pain (angina pectoris)</td>
<td></td>
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<tr>
<td>Heart attack (myocardial infarction)</td>
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<tr>
<td>Heart failure (cardiac insufficiency)</td>
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<tr>
<td>Narrowing of the artery in the arm or leg (peripheral vascular disease)</td>
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<tr>
<td>Stroke/brain attack (cerebrovascular accident (CVA))</td>
<td></td>
</tr>
<tr>
<td>Transient ischemic attack (TIA)</td>
<td></td>
</tr>
<tr>
<td>High cholesterol (cholesterolemia)</td>
<td></td>
</tr>
<tr>
<td>Other cardiovascular disease, other, specify __________________________</td>
<td></td>
</tr>
</tbody>
</table>
Cancer, specify ________________________________________  __ __ __

Disorder of the urinary tract or genital organs:

- Infection of urinary tract or genital organs specify ____________________________________________  __ __ __
- Sexually transmitted disease (STD) specify _________________________________________________  __ __ __
- Undescended testicle (cryptorchidism) _____________________________________________________  __ __ __
- Varicose vein rupture in scrotum (varicocele) ______________________________________________  __ __ __
- Twisted testicle (testicular torsion) ____________________________________________________________________  __ __ __
- Inflammation of the epididymis (epididymitis) ______________________________________________  __ __ __
- Inflammation of the prostate (prostatitis) ______________________________________________________  __ __ __
- Inguinal hernia _______________________________________________________________________________  __ __ __
- Genitourinary surgery
  - Circumcision ________________________________________________________________________________  __ __ __
  - Other ______________________________________________________________________________________  __ __ __
- Trauma, for example damage secondary to a kick ____________________________________________________________________  __ __ __
- Exposure to chemicals of radiation that can cause DNA damage ____________________________________________________________________  __ __ __
- Other, specify ____________________________________________________________  __ __ __

None of the above.

3. From which health care provider did you ever receive information concerning your disease and your desire to become a father?

For example, over the effect of your disease or treatment on your fertility, capacity to take care of children, etc.

- I never received information
- Urologist
- Fertility specialist
- Rheumatologist
- (Specialized) nurse
- Family doctor/General practitioner
- Gynecologist
The following questions are about the number of children that you have and about the number of children you wanted to have (family planning).

**A. Number of biological children (any child conceived with you)**

1. How many biological children have you had?

2. How many biological children did you actually want to have?

3. Are you satisfied with the total number of children that you had?
   - Yes
   - No, I wanted more children.
     - Why did you have fewer children than you actually wanted? Multiple answers are possible.
       - Because of my disease.
       - Because of my medication.
       - Other reason, specify: ______________
   - No, I wanted fewer children.
     - Why would you have liked to have fewer children?
       - Because of my disease.
       - Because of my medication.
       - Other reason, specify: ______________
B. Statements

Several statements follow. Please indicate on a scale of 0 to 10 whether you agree with the corresponding statement: 0 means that you completely disagree with the statement and 10 means that you completely agree with the statement:

1. My disease reduced my desire to have children.                   ____
2. Stopping or weaning off my medication because of my desire to have children was not possible because my disease was too active. ____
3. I was concerned that my medications would harm my child       ____
4. I was afraid my child would get the same disease as me         ____

C. Comments / additional information

If you have any additional information or comments you would like to share (e.g., about the effect of your disease on your desire to have children or the information you received on this topic), please write them down below:

_________________________________________________________________________
A. Have you ever been evaluated for fertility problems related to having a desire to have children?
   ○ No  ► Go to question B
   ○ Unknown
   ○ Yes:
     Which fertility studies did you have done?
     □ Ultrasound.
     □ Blood test (hormones).
     □ Semen analysis.
     □ Other, specify. _____________________________________________________

     What was the conclusion from the evaluation?
     □ There were no problems identified.
     □ Low sperm quality.
     □ Anatomical abnormality.
     □ I was determined to be infertile secondary to an unknown cause.
     □ Other, nl. _______________________________________________________

B. With how many partners did you actively try to have children?
   ______ partners

   Partner 1:  Initials __ __
   These initials are needed because questions about your partner(s) will be asked next.
   By using unique initials, you will know which partner these questions are about.
   a. Has this partner ever been evaluated for fertility problems related to having a desire to have children?
      ○ No
      ○ Unknown
      ○ Yes

      Which studies did your partner have done?
      □ Ultrasound.
      □ Blood test (hormones).
      □ Hysterosalpingography (Uterine X-Ray).
      □ Hysteroscopy (procedure to evaluate uterus with a camera).
      □ Laparoscopy (surgery).
      □ Other, specify. ___________________________________________________
What was the conclusion from the evaluation?

- There were no problems identified.
- Occluded fallopian tubes.
- Uterine abnormality.
- Early menopause.
- Endometriosis.
- Absent ovulation due to PCOS (Polycystic ovarian syndrome).
- Other, specify. __________________

b. Has this partner even become pregnant by you?

That is, any positive pregnancy test (even if it did not result in a liveborn child)

- No ► Fill in the data for your next partner, if there is no other partner: end of the questionnaire.
- Yes ► Fill in the information over pregnancy outcomes for this partner in section C.

<table>
<thead>
<tr>
<th>C. Course of conception and pregnancy</th>
<th>Pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1\textsuperscript{st}</td>
</tr>
<tr>
<td>Partner initials</td>
<td>............</td>
</tr>
<tr>
<td>In what year did the pregnancy occur?</td>
<td>............</td>
</tr>
<tr>
<td>How old was your partner at the time?</td>
<td>............ yr</td>
</tr>
<tr>
<td>How many months did it take for your partner to become pregnant?</td>
<td>............ months</td>
</tr>
</tbody>
</table>
GENERAL INFORMATION

1. What is your date of birth?  
   - [ ] - [ ] (month-year)

2. Where were you born?  
   - [ ] Netherlands  
   - [ ] Suriname  
   - [ ] Netherlands Antilles / Aruba  
   - [ ] Indonesia  
   - [ ] Turkey  
   - [ ] Morocco  
   - [ ] Germany  
   - [ ] United Kingdom (Great Britain + North Ireland)  
   - [ ] Belgium  
   - [ ] Other, specify  
   - [ ] No answer/unknown

3. Where was your mother born?  
   - [ ] Netherlands  
   - [ ] Suriname  
   - [ ] Netherlands Antilles / Aruba  
   - [ ] Indonesia  
   - [ ] Turkey  
   - [ ] Morocco  
   - [ ] Germany  
   - [ ] United Kingdom (Great Britain + North Ireland)  
   - [ ] Belgium  
   - [ ] Other, specify  
   - [ ] No answer/unknown

4. Where was your father born?  
   - [ ] Netherlands  
   - [ ] Suriname  
   - [ ] Netherlands Antilles / Aruba  
   - [ ] Indonesia  
   - [ ] Turkey  
   - [ ] Morocco  
   - [ ] Germany  
   - [ ] United Kingdom (Great Britain + North Ireland)  
   - [ ] Belgium  
   - [ ] Other, specify  
   - [ ] No answer/unknown
5. What is your current marital status?
- Unmarried
- Married
- Registered partnership
- Divorced after a marriage
- Divorced after registered partnership
- Widowed after a marriage
- Widowed after registered partnership

**EDUCATION/WORK**

What is currently the highest education you have completed? Choose one of the following answers:

- Elementary school (*basisonderwijs*)
- LBO, VSO (*LTS, LEAO, VBO, Huishoudschool, Ambachtsschool*)
- VMBO, LWOO (including theoretical learning path)
- MAVO (*ULO, MULO*)
- HBO (*MTS, MEAO, Middenstandsdiploma, PDB, MBA*)
- University education, including postgraduate courses and doctoral research
- I have completed another (business) education, specify:

**General information**

We would like to request information about your diagnosis from your rheumatologist or urologist/fertility specialist. May we contact you about this?
- Yes
- No

End of questionnaire -> Thank you very much for your cooperation