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Have you ever undergone or are you currently seeking/undergoing fertility evaluation and treatment?

- I am currently seeking/undergoing fertility evaluation and treatment
- I have undergone/completed fertility evaluation treatment in the past
- I have never sought fertility evaluation or treatment

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Sorry, but you are not eligible for this study. Thank you for your time.

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How many times have you been pregnant?

- 0
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10+

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How many living children do you have?

- 0
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10+

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Please indicate the gender(s) of your living children:

- Male
- Female

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Number of female children:

- 0
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10+

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Number of male children:

0  
 1  
 2  
 3  
 4  
 5  
 6  
 7  
 8  
 9  
 10+

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Have you ever had a miscarriage?  Yes  
 No

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How many miscarriages have you had?

1  
 2  
 3  
 4  
 5  
 6  
 7  
 8  
 9  
 10+

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How long (in months) did you attempt to get pregnant on your own before seeking fertility treatment?

\_\_\_\_\_ (MONTHS)

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Do you have an Ob/Gyn?  Yes  
 No

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Has your Ob/Gyn ever asked you about any fertility problems?  Yes  
 No

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What reason(s) has your doctor given as the cause(s) of your difficulty in having a baby? Please select all that apply:

- Ovulation problem
  - Blocked fallopian tubes
  - Advanced age/Decreased ovarian reserve
  - Uterine factor
  - Endometriosis
  - Male factor
  - Unexplained
  - Other
- 

Please specify "Other" cause of difficulty in having a baby: \_\_\_\_\_

Have you ever gone through or are you currently undergoing any of the following treatments?  
Please select all that apply.

- Clomid treatment with timed intercourse
- Letrozole treatment with timed intercourse
- Intrauterine insemination (IUI) cycle
- In vitro fertilization (IVF) cycle
- Egg freezing
- Using donor sperm
- Using donor egg
- Gestational surrogacy
- Using donor embryos
- Genetic testing of embryos (PGS, PGD)
- No fertility treatment
- Other

Please specify "other" treatment:

\_\_\_\_\_

Who referred you to our fertility center?

- Friend/Relative/Coworker
- Ob/Gyn Physician
- Primary Care Physician
- Insurance Company
- Internet
- Other

Please specify "other" referral:

\_\_\_\_\_

How far (in miles) did you travel to come to our fertility center?

\_\_\_\_\_ (MILES)

Do you have health insurance that covers fertility treatment?

- Yes
- No

About how much of the cost of fertility treatment does your insurance cover?

- 75-100%
- 50-74%
- Less than 50%

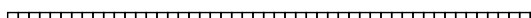
Would you seek fertility treatment if you had to pay the total cost out of pocket?

- Yes
- No

**Please indicate the level of difficulty the following scenarios have caused you**

Getting an appointment with a fertility doctor was:

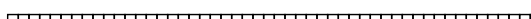
Easy Very Difficult



(Place a mark on the scale above)

Taking time off from your job to see the doctor was:

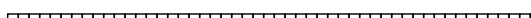
Easy Very Difficult



(Place a mark on the scale above)

Paying for the needed fertility treatment or medications was:

Easy Very Difficult



(Place a mark on the scale above)

Did any of the following aspects about you make it MORE DIFFICULT to get fertility treatment? (please select all that apply)

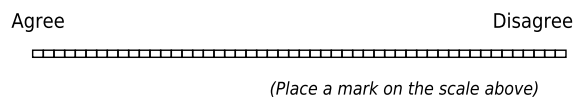
- Race/ethnicity
- Religion
- Age
- Profession
- Income level
- Insurance status
- Sexuality
- Citizen status
- Gender identity
- Weight
- Relationship status
- None
- Other

Please specify "other"

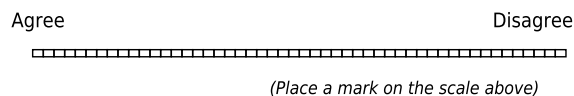
\_\_\_\_\_

**Please indicate your level of agreement or disagreement with the following statements:**

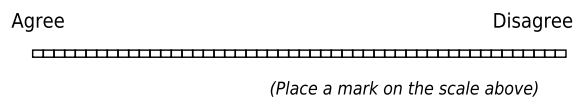
In general, the ability to bear children rests on Timing/Age



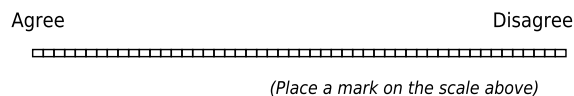
In general, the ability to bear children rests on stress levels



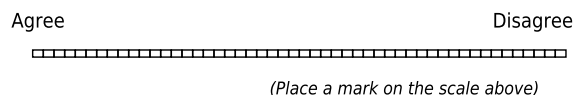
In general, the ability to bear children rests on God's will



In general, the ability to bear children rests on a couple's biology/physiology



In general, the ability to bear children rests on chance



**How worried are you about the following aspects of fertility treatment?**

	Not Worried	Somewhat Worried	Very Worried	Extremely Worried
Having twins	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having triplets, quadruplets, or more	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High financial costs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medication/treatment side effects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having a miscarriage	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having an ectopic pregnancy (in your fallopian tube)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Potential risk of birth defects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Violating my religious beliefs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using science/technology to conceive	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Negatively affecting my relationship with my partner	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Have you ever undergone genetic carrier screening to check if you are a carrier for a heritable condition (e.g. cystic fibrosis)?

- Yes  
 No  
 Not sure

Are you a carrier for any heritable conditions?

- Yes  
 No

Has your spouse/partner ever undergone genetic carrier screening?

- Yes  
 No  
 Not sure

Is your partner/spouse a carrier for any heritable condition?

- Yes  
 No

Are you and your partner/spouse both carriers for the same heritable condition(s)?

- Yes  
 No

**In your opinion, should the following scenarios be allowed?**

	Yes	No
Choosing the sex of your child	<input type="radio"/>	<input type="radio"/>
Using left-over embryos for research	<input type="radio"/>	<input type="radio"/>
Genetically modifying embryos for physical traits (e.g. eye color, hair color, height, etc.)	<input type="radio"/>	<input type="radio"/>
Genetically modifying embryos to correct disease risk (e.g. cancer, diabetes, heart disease, etc.)	<input type="radio"/>	<input type="radio"/>

**Have you used any of the following methods to improve your chances of getting pregnant?****Please select all that apply.**

Traditional Alternative Medicine

- Acupuncture  
 Ayurveda  
 Naturopathy (ex. Homeopathy)  
 Chinese medicine  
 None of the above

Body

- Chiropractor  
 Massage  
 Tai Chi  
 Yoga  
 Energy-field therapy  
 None of the above

Diet

- Vitamin D  
 CoQ10  
 DHEA  
 Other vitamins  
 Herbal Supplements  
 Nutrition/weight loss regimens (vegetarian, vegan, keto, other diets)  
 Specific fruits and/or vegetables (e.g. pineapple)  
 None of the above

Mind

- Meditation/Hypnosis  
 Psychotherapy  
 Biofeedback  
 None of the above

Senses Therapy

- Dance  
 Music  
 Visualization and guided imagery  
 None of the above

Have you used any OTHER METHODS not listed above to improve your chances of getting pregnant?

- Yes  
 No

Please specify other method used

\_\_\_\_\_

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Do you have a physician diagnosis of any of the following medical conditions? Please select all that apply.

- Child-onset food allergy
- Adult-onset food allergy
- Asthma
- Eczema
- Seasonal allergies
- Diabetes
- High Blood Pressure (Hypertension)
- Anxiety
- Depression
- Other
- None of the above

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Please specify other physician diagnosis

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Do you believe that emotional stress:  
(Please select all that apply)

- Can cause infertility
- Can reduce success with fertility treatment
- Can cause a miscarriage
- Has no impact on fertility

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Do you regularly access any of the following Internet-based resources for fertility education or support? Please select all that apply.

- Blogs
- Discussion groups
- YouTube
- Search engines (Google, Yahoo, Bing)
- Facebook
- Twitter
- Instagram
- Other
- None of the above

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Please specify other internet-based resource used:

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What best describes your racial/ethnic background? Please select all that apply.

- White
- Black or African American
- Hispanic/Latinix
- Asian
- American Indian/Alaskan Native
- Native Hawaiian or other Pacific Islander
- Other

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Please specify other race/ethnicity:

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What is your religious preference? Please select one religion.

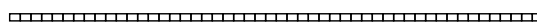
- Catholic
- Protestant
- Islam
- Judaism
- Secular/Agnosticism/Non-religious
- Buddhism
- Hinduism
- Chinese traditional/Chinese folk
- Other

Please specify other religion:

\_\_\_\_\_

How strongly do you identify with your religion?

Not at all Very Strongly



(Place a mark on the scale above)

Do you feel that your fertility physician understands your cultural background?

- Yes
- No

What is your zip code?

\_\_\_\_\_

With which gender do you identify?

- Female
- Male
- Other

Please specify other gender:

\_\_\_\_\_

What is your current relationship status? Please select one option.

- Single
- Heterosexual Relationship
- Divorced or Separated
- Same Sex Relationship
- Other

Please specify "other" relationship status:

\_\_\_\_\_

What is your age?

\_\_\_\_\_ (YEARS OLD)



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What is the highest education level you have completed? Please select one option.

- Less than high school
- High school diploma
- Some college
- 2-year college (Associate's Degree)
- 4-year college (Bachelor's Degree)
- Master's degree
- Professional Degree

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What is your yearly total household income (before taxes)? Please select one option.

- < \$50,000
- \$50,001 - \$100,000
- \$100,001 - \$200,000
- \$200,001 - \$400,000
- > \$400,000