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

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

How many times have you been pregnant?	◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10+
How many living children do you have?	◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10+
Please indicate the gender(s) of your living children:	☐ Male ☐ Female
Number of female children:	◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10+

Number of male children:	◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10+
Have you ever had a miscarriage?	◯ Yes ◯ No
How many miscarriages have you had?	◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10+
How long (in months) did you attempt to get pregnant on your own before seeking fertility treatment?	_____ (MONTHS)
Do you have an Ob/Gyn?	◯ Yes ◯ No
Has your Ob/Gyn ever asked you about any fertility problems?	◯ Yes ◯ No

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

Agree — Disagree

(Place a mark on the scale above)

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

Agree — Disagree

(Place a mark on the scale above)

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

Agree — Disagree

(Place a mark on the scale above)

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

Agree — Disagree

(Place a mark on the scale above)

In general, the ability to bear children rests on chance

Agree — Disagree

(Place a mark on the scale above)

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

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

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	◯	◯
Using left-over embryos for research	◯	◯
Genetically modifying embryos for physical traits (e.g. eye color, hair color, height, etc.)	◯	◯
Genetically modifying embryos to correct disease risk (e.g. cancer, diabetes, heart disease, etc.)	◯	◯

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	_____

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

Please specify other physician diagnosis

_____

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

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

Please specify other internet-based resource used:

_____

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

Please specify other race/ethnicity:

_____

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)

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

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