Fertility Initial Questionnaire & Medical History Intake Form

Referring Physician _____ Date: _____

Patient Name: _____ Marital Status: _____

SSN or History #: _____ Partner Name: _____

Date of Birth: _____ Partner SSN: _____

Height: _____ Weight: _____ Partner DOB: _____

Race:_____Hispanic or Latino? Partner Race: _____

Phone (day): _____

Phone (night): _____ Address: _____

E-mail: _____ _____

Education level: _____ _____

Occupation: _____

II. Pregnancy History

How many Pregnancies (including abortions) have you had? _____

	When? (year)	How long To conceive? (months)	Fertility therapy used? Y/N	Is current partner father? Y/N	Duration of Pregnancy (months)	Outcome*	Complications
1st Pregnancy							
2nd pregnancy							
3rd pregnancy							
4th pregnancy							
5th pregnancy							

*Outcomes: Vaginal Delivery=VD; Cesarean section=CS; Abortion=AB; Miscarriage=MS; Ectopic=EP

III. Fertility History How long have you and your present partner been trying to conceive? _____

Have you ever been infertile with a past partner? _____ If so, How long? _____

Have you had any of the following tests performed on you? Check all that apply and the results.

		Date	Results
☐	Basal Body Temperature	_____	_____
☐	Urinary LH (Ovulation) Predictor Kits	_____	_____
☐	Postcoital Test	_____	_____
☐	Hormone Tests	_____	_____
☐	Endometrial Biopsy	_____	_____

	Date	Results
☐ Hysterosalpingogram (HSG)		
☐ Sonohysterogram		
☐ Ultrasound		
☐ Antisperm Antibodies		
☐ Laparoscopy		
☐ Hysteroscopy		
☐ Gonorrhea/Chlamydia Cultures		
☐ Rubella (German Measles)		
☐ Hepatitis B or C		
☐ HIV		
☐ RPR (Syphilis)		
☐ Blood Type and Rh		
☐ Antibody Screen		

What types of fertility therapy have you received in the past?

Drug/Treatment	Dose	How long or how many cycles?	When?
Clomiphene citrate (Clomid, Seraphene)			
Gonadotropins (Pergonal, Repronex,Humegon, Metrodin, Fertinex, Gonal-F, Follistim)			
HCG (Profasi, Pregnyl)			
GnRH Agonists (Lupron, Zoladex, Synarel)			
Progesterone			
Prednisone or Dexamethasone			
Bromocriptine (Parlodel, Dostinex)			
Artificial Insemination			
Donor Insemination			
In Vitro Fertilization=ICSI			

IV. Gynecological History

How old were you when you started having periods?_____Date your last period started _____
Are your periods regular?_____
If yes, how many days between periods (start until start)? _____
If no, how many periods per year do you have? _____
How many days do your periods last? _____
Do you have cramps with your periods?_____
If yes, are they: D Mild D Moderate D Severe
Have you ever missed work or school do to menstrual pains?_____
Do you have pain with intercourse?_____

Where you ever diagnosed with endometriosis? _____

What type of contraception have you used in the past?

- ☐ Birth
- ☐ Diaphragm
- ☐ Tubal Ligation
- ☐ IUD
- ☐ Foams/Jellies
- ☐ Depo Provera (birth control shots)
- ☐ Withdrawal
- ☐ Cond
- ☐ Rhyth

Contraceptive Complications: _____

_____

When did you last use contraception? _____

Have you ever had an abnormal Pap smear? _____

If so, when? _____

What was done about it? _____

When was your last Pap smear? _____

Have you ever had any of the following (check all that apply):

- ☐ Gonorrhea
- ☐ Chlamydia
- ☐ Venereal Warts
- ☐ Genital Herpes
- ☐ Syphilis
- ☐ Pelvic Inflammatory Disease (PHD)

Have you ever had an abnormal Mammogram? _____

If so, when? _____

What was done about it? _____

When was your last mammogram? _____

V. Medical History Do you have or have you ever had (check all that apply)

- ☐ Anemia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Blood Transfusions
- ☐ Breast Milky Discharge
- ☐ Breast pain
- ☐ Chicken Pox or vaccination
- ☐ Chronic Bronchitis
- ☐ Chronic Headaches
- ☐ Colitis
- ☐ Diabetes
- ☐ Gallbladder Problems
- ☐ Heart Disease
- ☐ hepatitis
- ☐ Hirsutism (Excess facial hair)
- ☐ High Blood Pressure
- ☐ Kidney Infections
- ☐ Liver Problems
- ☐ Migraine Headaches
- ☐ Neurological problems
- ☐ Ovarian cysts
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Rubella (German Measles)
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Thyroid Problems
- ☐ Tuberculosis (TB)
- ☐ Ulcers
- ☐ Vision Problems

Current Medications _____

_____

_____

_____

Are you allergic to any medications? _____

What? _____

Have you ever had surgery before? _____

Date and type _____

VI. Social History

Current or Recent Employer/Position _____

Do you drink alcohol? _____

Number of drinks per week _____

Do you smoke? _____

Number of cigarettes per day _____ Number of years smoking _____

Do you now, or have you ever, used illicit drugs (marijuana, cocaine, etc.)? _____

Specify _____

Do you have a special exercise program? _____

Type _____ Number of hours per week _____

Are you on a special diet? _____

Type _____

VII. Review of Systems

Have you had more than a 10-pound weight gain or loss in the past 12 months? _____

Do you have problems with your vision (besides usual glasses), hearing, swallowing, sinuses or throat?

If yes, specify: _____

Do you have heart problems, chest pain, irregular heartbeat, or mitral valve prolapse? _____

If yes, specify: _____

Do you have asthma, wheezing, shortness of breath or trouble breathing? _____

If yes, specify: _____

Do you have breast pain, breast discharge, or a lump in your breast? _____

If yes, specify: _____

Do you have chronic nausea or vomiting, stomach pain, diarrhea or constipation, blood in your stool or a history of ulcers?

_____

If yes, specify: _____

Do you have urinary burning, incontinence, kidney stones or blood in your urine? _____

If yes, specify: _____

Do you have chronic joint or muscle pain or swelling? _____

If yes, specify: _____

Do you have any chronic skin rashes or moles that have changed in size or appearance? _____

If yes, specify: _____

Do you have changes in cold or hot tolerance, changes in skin tone or color, your nails or body hair growth? _____

If yes, specify: _____

Do you have any history of seizures, recurrent headaches or numbness in your extremities? _____

If yes, specify: _____

Do you have any symptoms of depression such as sadness, frequent crying or anger, emotional lability? _____

If yes, specify: _____

VIII. Family History

Did your mother take diethylstilbestrol (DES; a tablet given to women with a history of miscarriage or bleeding during pregnancy) when she was pregnant with you? _____

Do any family members have significant health problems or inherited diseases?_____

Check all that apply:

- ☐ Birth Defects
- ☐ Brain/Spinal
- ☐ Cancer
- ☐ Cystic Fibrosis
- ☐ Diabetes
- ☐ Down Syndrome
- ☐ Fragile X Syndrome
- ☐ Heart Disease
- ☐ Hemophilia
- ☐ High Blood Pressure
- ☐ Muscular Dystrophy
- ☐ Sickle Cell Disease
- ☐ Tay-Sachs Disease
- ☐ Thalassemia
- ☐ Thyroid Disease

Who?

_____

_____

Are you from any of these ethnic backgrounds: (check all that apply)

- ☐ Italian
- ☐ Greek
- ☐ Middle
- ☐ Spanish
- ☐ Southern
- ☐ Asian Indian
- ☐ French Canadian/Cajun
- ☐ Caucasian
- ☐ Jewish
- ☐ African American
- ☐ Taiwanese
- ☐ Filipino
- ☐ Southeast Asian
- ☐ African
- ☐ Hispanic
- ☐ Other: _____

If yes, have you had any specific genetic testing to see if you are a carrier of a genetic disease? _____

IX. Additional Health Information

_____

_____

_____

_____

Please bring this form with you to your first appointment. Ensure that records from your current or past physician have been sent or faxed to the address below at least one-week in advance of your visit. We look forward to meeting you.

be. Women's Health & Wellness

Name: _____ Date: _____

Ovulatory Dysfunction History Questionnaire

1. At what age did you reach puberty?_____Years old
2. How tall are you?_____feet_____inches
3. How much do you weigh?_____Pounds
4. Are you having trouble getting pregnant?_____yes _____no
    a. If yes, why do you think that you are having trouble?
    _____
5. Has anyone ever told you that you have polycystic ovarian syndrome?
    _____ Yes _____no
6. Has a doctor ever told you that you have a problem ovulating?
    _____ Yes_____no
7. Do you have diabetes?_____yes_____no_____I don't know
8. Do you have insulin resistance?_____yes_____no_____I don't know
9. Have you taken any medications to help you get pregnant?_____yes _____no
    a. If yes, check the medicine that you were given
    (you may check more than one)
        i. ☐ Clomiphene citrate
        ii. ☐ Glucophage (metformin)
        iii. ☐ Gonadotropins (FSH)
        iv. ☐ Other (please list) _____
10. Approximately how many menstrual cycles do you have per year when you are not on any medication? _____

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F: 940-365-9009

11. Are your menstrual cycles regular and predictable?
_____ yes_____no
    a. If yes, approximately how often did your menstrual cycles come? (check the box that best describes most of your menstrual cycles)
        i. ☐ More frequently than every 27 days
        ii. ☐ Every 27 – 29 days
        iii. ☐ Every 30 – 32 days
        iv. ☐ Every 33 – 35 days
        v. ☐ Less frequently than every 35 days

    b. If your periods are not regular and predictable, what is the shortest and longest interval that you have had between periods
    Longest_____days
    Shortest_____days

    c. If your periods are not regular and predictable, at what age did this begin?

    _____Years old

12. Have you ever taken medicine to regulate your menstrual cycles?
_____ Yes_____No

    a. If yes, check all of the medicines that you were given?
        i. ☐ Birth control pills
        ii. ☐ Provera
        iii. ☐ Other (please name if you remember) _____

    b. If yes, when was the last time? _____

13. As an adult have you had acne?_____yes _____no

    a. If yes, do you have acne now? _____
14. Do you have any problem with hair loss on your head? _____

15. Have you ever removed hair from one of these areas of your body?_____yes_____no

    a. If yes, what area did you remove hair from? _____

16. Do you think that you have more hair than most women on some areas of your body?
_____ Yes_____No

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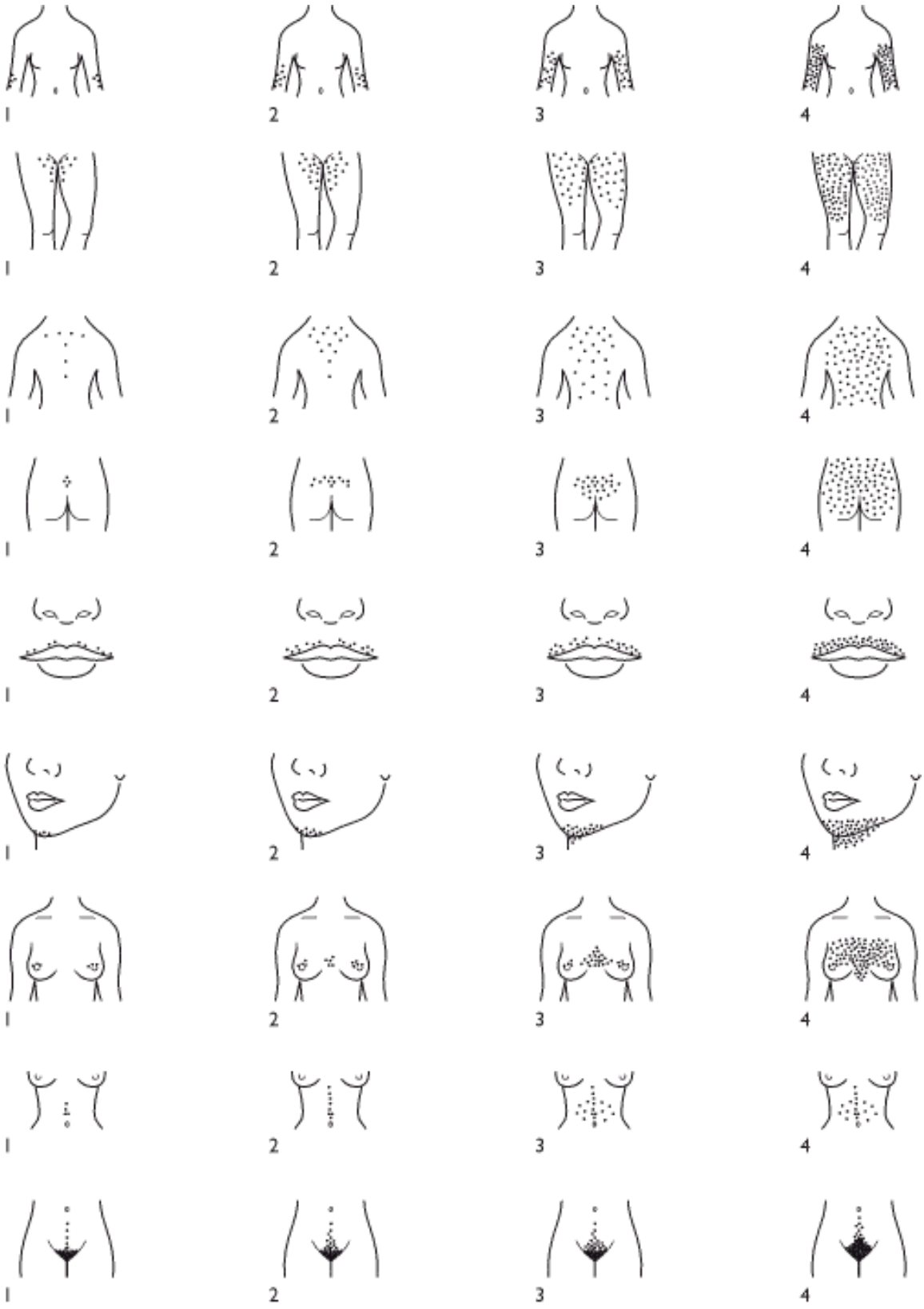
If yes, please check one picture on each row that looks most like the hair pattern that you have or write none next to the row.



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