NEW PATIENT HISTORY QUESTIONNAIRE

Patient Information: Date ____________________

Name: ____ Birth date: ______________________

Who referred you to this clinic? ____

Who is your primary physician? ____

Location/Address: ____

Do you need a referral? ☐ Yes ☐ No

Would you like a copy of your visit or consult sent to your primary physician?

☐ Yes ☐ No

Partner Information:

Name: ____ ☐ Male ☐ Female ☐ None

Pregnancy History:

How long have you been having intercourse without using contraception? ____________ ☐N/A

How long have you been attempting pregnancy? ____

What things have you done to increase your chances of pregnancy (BBT graph, ovulation testing, timed intercourse)?____

Have you been seen at any other clinics for infertility? ☐ YES ☐ NO

If so, what tests have you had done? ____

Have you ever had IVF? ☐ YES ☐ NO

If so, when did you have IVF and with whom? ____

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Please list all pregnancies (include all miscarriage, abortions, tubals, etc):

Delivery Date or Date of Loss	Length of Prenancy	How Long to Conceive	Complications	Infertility Theraphy?
1.	wks			
2.	wks			
3.	wks			
4.	wks			
5.	wks			

Infertility History
Female Factor

Age at first period: ______________________ Date of the first day of your last period: ______/______/_____

If your menstrual cycles are regular, what is the usual number of days from the first day of one period to the first day of the next (without using medications)? ____

Have your periods ever been irregular or unpredictable? ☐ YES ☐ NO

If yes:

1. When____
2. Average # of periods per year________________________________
3. Shortest time between periods______________________________
4. Longest time between periods ______________________________

How many days does your menstrual flow last? ___________________

Do you consider your menstrual flow abnormal? ☐ YES ☐ NO

(Circle): light heavy short long painful other________________

Do you have cramps accompanying flow? ☐ YES ☐ NO

(Circle): severe moderate mild

Before during after

Number of days______________________________________

Medications used_______________________________ Dose:__________________________

How often: ____

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Do you spot or bleed between periods? ☐ YES ☐ NO

If yes, when? mid-cycle before menses

Do you have pelvic pain anytime in your cycle? ☐ YES ☐ NO

If yes, when? ____

Do you have premenstrual symptoms? ☐ YES ☐ NO

If yes, what? ____

Do you ever experience hot flashes? ☐ YES ☐ NO

When did they start?____

Has medication been prescribed to start menstrual flow? ☐ YES ☐ NO

Have you ever taken oral contraceptives? ☐ YES ☐ NO

Dates: ____________________________________

Did you or your doctor note any complications? ☐ YES ☐ NO

If yes, explain: ____

____

Have you ever had a sudden weight change? ☐ YES ☐ NO

If so, how many #'s? ______ Over what period of time? ________________

Do you exercise? ☐ YES ☐ NO

What type of exercise? ____________________________

How many times a week: ___________________________

Ovulation:

Indicate the tests that have been used to detect ovulation.

- ☐ Basel Temperatures
- ☐ Ovulation Predictor Test
- ☐ Ultrasound
- ☐ Lab Work

Have you ever taken any of the following medications?

- ☐ Clomid/Serophene
- ☐ Metformin
- ☐ Progesterone
- ☐ HCG
- ☐ Ovidrel
- ☐ Dexamethasone
- ☐ Lupron
- ☐ Letrozole
- ☐ Other ______________________________________

DATES	MEDICATION	DOSE	RESULT

Did you have any ultrasound monitoring when on medication? ☐ YES ☐ NO

<u>Uterine, Tubal, Pelvic:</u>

Have you ever had an infection of your pelvis (uterus, fallopian tubes, or ovaries)? ☐ YES ☐ NO

Were you hospitalized? ☐ YES ☐ NO

If yes, explain: ____

Have you ever been treated for a sexually transmitted disease (chlamydia, gonorrhea, syphilis, genital warts)? ☐ YES ☐ NO

If yes, explain: ____

Have you ever had an abnormal pap? ☐ YES ☐ NO

If yes, explain: ____

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Have you had any of the following?

Procedure	Dates	Reason/Results
Abdominal Surgery		
Appendectomy		
Cervical Cone or LEEP		
D&C		
Hysterosalpingogram (HSG)		
Hysteroscopy		
Laparoscopy		
Laparotomy		
Other Pelvic Surgery		

Infertility History
Male Factor

Does your partner have any health problems? ☐ YES ☐ NO

If yes, explain: ____

____

Does your partner take any medications? ☐ YES ☐ NO

If yes, explain: ____

____

Has your partner had any injuries to or problems with his penis? ☐ YES ☐ NO

If yes, explain: ____

Has your partner had an infection of the prostate or semen? ☐ YES ☐ NO

When? ______________ Type of treatment? ______________

How long? ______________ Were both of you treated? ______________

Has your partner ever been diagnosed with a varicocele? ☐ YES ☐ NO

If yes, explain: ______________________________

____

Has your partner ever had mumps? ☐ YES ☐ NO

If yes, explain: ______________________________

____

Has your partner ever been exposed to excessive heat (work, biking, hot tubs)? ☐ YES ☐ NO

Does your partner drink alcohol? ☐ YES ☐ NO

If yes, how much: ______________________________

Has your partner been to alcohol treatment? ☐ YES ☐ NO

If yes, when: ______________________________

Does your partner smoke? ☐ YES ☐ NO

If yes, how many per day ______________

Does your partner use marijuana or any other street drugs? ☐ YES ☐ NO

Has your partner been to drug treatment? ☐ YES ☐ NO

If yes, explain: ______________________________

Has your partner ever fathered any children? ☐ YES ☐ NO

Has your partner ever had vasectomy or reversal of vasectomy? ☐ YES ☐ NO

Has your partner been examined by a urologist? ☐ YES ☐ NO

If yes, physicians name: ______________________________

Date	Test	Results

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Has your partner had fertility treatment? ☐ YES ☐ NO

Date	Procedure	Results

Has your partner had a semen analysis? ☐ YES ☐ NO

Date	Results	Location

Have you or your partner had testing for antisperm antibody? ☐ YES ☐ NO

If yes, explain: ____

____

Couple Factors:

How frequently do you have sexual intercourse? ____________________ ☐ N/A

Do you attempt to time intercourse with temperature rise or ovulation testing?

☐ YES ☐ NO ☐ N/A

Do you or your partner have problems with initiating or completing sexual intercourse?

☐ YES ☐ NO ☐ N/A

Do you use a lubricant for intercourse? ☐ YES ☐ NO ☐ N/A

Do you douche before or after intercourse? ☐ YES ☐ NO ☐ N/A

Do you feel that your fertility problem is?

1. Causing personal stress? ☐ YES ☐ NO
2. Causing stress between you and your partner? ☐ YES ☐ NO
3. Interfering with a satisfactory sex life? ☐ YES ☐ NO

Have you ever sought counseling for your infertility problem? ☐ YES ☐ NO

Have you ever had artificial insemination? ☐ YES ☐ NO

If yes, circle all that apply:

Cervical/Intrauterine

Washed/Unwashed

Husband/Donor

Date: ____________________________________ Frozen or Fresh (circle one)

How was it timed? (circle one) LH-Kit, U/S, BBT

How many cycles? _____________________________________

Medical History (Patient Only):

Are you allergic to any medications, drugs, foods, metals, other? ☐ YES ☐ NO

If yes, explain: ____

Do you regularly take medications? ☐ YES ☐ NO

Over-The-Counter

Medication	Dosage	How Often?

Prescriptions

Medication	Dosage	How Often

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Do you have or have you ever had (please check all that apply):

☐ Abnormal Pap	☐ Eating Disorder	☐ Neurological Problems
☐ Acne	☐ Endometriosis	☐ Oily Skin
☐ Anemia	☐ Epilepsy	☐ Ovarian Cysts
☐ Appendicitis	☐ Gallbladder	☐ Pelvic Infection
☐ Arthritis	☐ German Measles	☐ Seizures
☐ Blood Transfusions	☐ Gonorrhea	☐ Syphilis
☐ Breast Discharge	☐ Headaches/Migraines	☐ Thyroid Problems
☐ Breast Lump	☐ Heart Disease	☐ Tuberculosis
☐ Cancer	☐ Hepatitis	☐ Other…
☐ Chicken Pox	☐ Herpes	
☐ Chlamydia	☐ High Blood Pressure	
☐ Colitis	☐ Kidney Infection	
☐ Diabetes	☐ Liver Problems	
☐ Depression	☐ Mitral Valve Prolapse	

Do you drink alcohol? ☐ YES ☐ NO

If yes, how much? ______________________________

Have you been to alcohol treatment? ☐ YES ☐ NO

If yes, when? ______________________________

Do you smoke? ☐ YES ☐ NO

If yes, how many per day ____________

Do you use marijuana or any other street drugs? ☐ YES ☐ NO

Have you been to drug treatment? ☐ YES ☐ NO

If yes, explain:______________________________

Have you been immunized for Tetanus/Diphtheria/Pertussis? ☐ YES ☐ NO

Date: ________________

Have you had Cystic Fibrosis screening? ☐ YES ☐ NO

Result: ________________

Have you received Rubella immunization? ☐ YES ☐ NO

Date Received: ____________

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Have ever undergone surgery? ☐ YES ☐ NO

Date	Type	Hospital	Doctor

Were there?

Complications ☐ YES ☐ NO

Anesthesia problems ☐ YES ☐ NO

Bleeding problems ☐ YES ☐ NO

If yes, please explain: ____

____

Family History:

Mother Living ☐ Y ☐ N Diseases: ____________________________ ☐ None

If Yes, Age _____ If No, cause of death and age ____________________________

Father Living ☐ Y ☐ N Diseases: ____________________________ ☐ None

If Yes, Age _____ If No, cause of death and age ____________________________

Maternal Grandmother Living ☐ Y ☐ N Diseases: ____________________________ ☐ None

If Yes, Age ________ If No, cause of death and age ____________________________

Maternal Grandfather Living ☐ Y ☐ N Diseases: ____________________________ ☐ None

If Yes, Age _____ If No, cause of death and age ____________________________

Paternal Grandmother Living ☐ Y ☐ N Diseases: ____________________________ ☐ None

If Yes, Age _____ If No, cause of death and age ____________________________

Paternal Grandfather Living ☐ Y ☐ N Diseases: ____________________________ ☐ None

If Yes, Age _____ If No, cause of death and age ____________________________

Brother/Sister (circle one) Living ☐ Y ☐ N Diseases: ____________________________ ☐ None

If Yes, Age ________ If No, cause of death and age ____________________________

Brother/Sister (circle one) Living ☐ Y ☐ N Diseases: ____________________ ☐ None

If Yes, Age ____ If No, cause of death and age ____________________

Brother/Sister (circle one) Living ☐ Y ☐ N Diseases: ____________________ ☐ None

If Yes, Age ____ If No, cause of death and age ____________________

Brother/Sister (circle one) Living ☐ Y ☐ N Diseases: ____________________ ☐ None

If Yes, Age ____ If No, cause of death and age ____________________

Do any of your family members have the following?

Anemia	YES	NO	Who?
Diabetes	YES	NO	Who?
Cancer	YES	NO	Who?
Blood Disorders	YES	NO	Who?
Heart Defects	YES	NO	Who?
High Blood Pressure	YES	NO	Who?
Kidney Disease	YES	NO	Who?
Stroke	YES	NO	Who?
Blood Clots	YES	NO	Who?
Thyroid Disease	YES	NO	Who?
Excess Hair Growth	YES	NO	Who?
Muscular Dystrophy	YES	NO	Who?
Cystic Fibrosis	YES	NO	Who?
Mental Retardation	YES	NO	Who?
Birth Defects	YES	NO	Who?
Down Syndrome	YES	NO	Who?
Stillbirths	YES	NO	Who?
Twins	YES	NO	Who?
Early Menopause	YES	NO	Who?
Endometriosis	YES	NO	Who?
Infertility	YES	NO	Who?
Irregular Periods	YES	NO	Who?
Spina Bifida	YES	NO	Who?

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Additional Family History:

Has anyone in your family had a stillborn or newborn death?

You: ☐ YES ☐ NO

Partner: ☐ YES ☐ NO

If yes, explain: ____

____

Is there anybody who can't walk or needs crutches or braces to get around?

You: ☐ YES ☐ NO

Partner: ☐ YES ☐ NO

Is there anyone who was blind or deaf as a child?

You: ☐ YES ☐ NO

Partner: ☐ YES ☐ NO

Are you of Eastern European Jewish ancestry?

You: ☐ YES ☐ NO

Partner: ☐ YES ☐ NO

If the answer to the above question is yes, have you been screened for Tay-Sachs disease?

You: ☐ YES ☐ NO

Partner: ☐ YES ☐ NO

Are you of African American or Hispanic ancestry?

You: ☐ YES ☐ NO

Partner: ☐ YES ☐ NO

If the answer to the above is yes, have you been screened for sickle cell trait?

You: ☐ YES ☐ NO

Partner: ☐ YES ☐ NO

Are you of Italian, Greek or Mediterranean ancestry?

You: ☐ YES ☐ NO

Partner: ☐ YES ☐ NO

If the answer to the above is yes, have you been screened for beta thalassemia minor?

You: ☐ YES ☐ NO

Partner: ☐ YES ☐ NO

Are you of Philippine or South Asian ancestry?

You: ☐ YES ☐ NO

Partner: ☐ YES ☐ NO

If the answer to the above is yes, have you been screened for alpha thalassemia minor?

You: ☐ YES ☐ NO

Partner: ☐ YES ☐ NO

Do any hereditary diseases or abnormal conditions not previously mentioned run in your family?

You: ☐ YES ☐ NO

Partner: ☐ YES ☐ NO

If yes, explain: ____

____

Has anyone been diagnosed with Cystic Fibrosis in your family?

You: ☐ YES ☐ NO

Partner: ☐ YES ☐ NO

Occupational Reproductive Exposure:

Please check any of the following known chemicals or hazards that you are exposed to:

☐ Lead	☐ Styrene	☐ Arsenic
☐ Carbon Disulfide	☐ Nitrous	☐ DDT
☐ Hexachlorobenzene	☐ X-rays	☐ Toluene
☐ Trichloroethane	☐ Cadmium	☐ PCB
☐ Formaldehyde	☐ Benzene	☐ Vinyl Chloride
☐ Ionizing Radiation	☐ Solvents	☐ Anesthetic Gases
☐ Mercury	☐ Glycol Ethers	☐ Chloroprene
☐ Kepone	☐ Ethylene Oxide	☐ Xylene

Do you or your partner have any exposure to radiation, chemical or hazardous materials?

☐ YES ☐ NO

If yes, explain: ____