ASSOCIATES IN women's health

NEW PATIENT HISTORY QUESTIONNAIRE

Patient Information: Date: _____

Name: _____ Birthdate: _____

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
Date of Birth: _____

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? _____

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

Delivery Date or Date of Loss	Length of Pregnancy	How Long to Conceive	Complications	Infertility Therapy?
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: _____

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	RESULTS

Did you have any ultrasound monitoring when on medication? Yes No

Uterine, Tubal, Pelvic:

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: _____

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

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?

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: _____
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?
Ectopic/Tubal/Miscarriages (3 or more)	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?

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: _____

Patient Signature: _____ Date: _____

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