

NEW PATIENT QUESTIONNAIRE

Date: _____ Name: _____ Age/DOB _____

Marital Status: Single _____ Married _____ Prior Marriage: Wife _____ Husband _____

Referred by: _____

I. OBSTETRICAL HISTORY

Pregnancy Year	Length of Time to Conceive	Gestational Age	Miscarriage or abortion?	Current partner the father?	Complications
1.					
2.					
3.					
4.					
5.					

II. FERTILITY HISTORY

How many years have you been attempting pregnancy? _____

If married, how many years have you been married? _____

Have you ever been evaluated for infertility? Yes No

Who was your physician(s)? _____

What cause(s) of infertility was diagnosed? _____

Previous Fertility Treatment

Which drugs have you taken or treatments done for infertility? _____ None

- | | |
|--|--|
| _____ Clomiphene Citrate (Clomid, Serophene)
_____ Letrozole (Femara)
_____ Repronex, Menopur, or Bravelle
_____ Gonal-F, Follistim, or Luveris
_____ hCG (Ovidrel, Pregnyl, Novarel)
_____ Follicle monitoring with sonograms
_____ Artificial Insemination: # cycles _____ | _____ Progesterone supplements
_____ Acupuncture
_____ Prednisone or Dexamethasone
_____ Bromocriptine (Parlodel) or Dostinex
_____ Danazol (Danocrine)
_____ Lupron, Antagon/Cetrotide
_____ In Vitro Fertilization: # cycles _____ |
|--|--|

Ovulation Assessment

Age periods started _____ Date of last normal period _____

Do you have regular, cyclic, predictable, spontaneous periods? Yes No

If yes, at what interval (1st day to 1st day) _____

If no, explain: _____

How many days do your period last? _____

How many periods do you have in a year? _____

Do you ever "skip" periods? Explain: _____ Yes No

Do you experience mid-cycle or premenstrual spotting *on a regular basis*? Yes No

Explain: _____

Have you ever taken birth control pills? If yes, what ages? _____ Yes No

When (Month/Year) did you last take birth control pills? _____

Do you have any history of anorexia, bulimia (eating disorders)? _____ Yes No

Do you exercise? _____ hrs/week Activities _____ Yes No

Thyroid Disease

Do you have (or had) thyroid disease? Explain: _____ Yes No

Galactorrhea/Hyperprolactinemia

Do you have (or had) nipple discharge? Yes No

Milky or Watery (clear), spontaneous or manually expressed (only)

Explain: _____

Hirsutism

Do you have any hair growth you consider abnormal? (please circle) face, upper lip, chin, chest, nipples, or lower abdomen? Yes No

If yes, how long has this been present? _____ years

If yes, how often do you shave, use depilatory creams, pluck, or undergo electrolysis?

Explain: _____

Ovulation Monitoring/Testing

Can you tell when you are ovulating based on your physical symptoms? Yes No

Have you conducted any of the following tests?

___ Progesterone level (blood test) Results _____

___ Endometrial biopsy _____

___ Basal body temperature chart _____

Have you used any ovulation predictor kits? Yes No

If yes, which brands have you used? _____

If yes, which cycle days do you typically surge? _____

Do you find that the kits are reliable? Yes No

Uterotubal Assessment

Have you had a hysterosalpingogram or HSG (x-ray dye test of the uterus)? Yes No

When: _____

Results: _____

Have you had a sexually transmitted disease or an infection in your pelvis or fallopian tubes? Yes No

i.e., pelvic inflammatory disease, Chlamydia, Gonorrhea, Syphilis, or Herpes.

Explain: _____

Have you been diagnosed as having endometriosis? Yes No

Explain: _____

Have you been diagnosed as having uterine fibroids? Yes No

Explain: _____

Pelvic Pain

Do you suffer from pelvic pain? Yes No

Do you have painful cramps with your periods? Yes No

Are your cramps mild? moderate? severe?

Do you take pain medication for cramps? Which one (s) _____ Yes No

Does this medication provide adequate relief? Yes No

Do you experience painful intercourse? Yes No

Explain: _____

Cervical Assessment

Do you experience recurrent (> 2/year) yeast infections or bacterial vaginosis? Yes No

Have you had a postcoital test? Results: _____ Yes No

Have you had surgery on your cervix, i.e., biopsy or conization? Yes No

Explain: _____

Do you use lubricants for intercourse? Yes No

How many times per week do you and your partner have intercourse? _____

Male Factor Assessment

Husband's Name: _____ Age & Date of Birth: _____

Has your husband sired previous pregnancies (including miscarriages)? Yes No

Explain: _____

Does your husband have any health problems? Yes No

Explain: _____

Does your husband take any medications on a chronic basis? Yes No

Which medications? _____

Has your husband's sperm been tested? Yes No

Results: _____

Has your husband had genital surgery, or infections? Yes No

Explain: _____

Does your husband smoke? Yes No

Use alcohol? # drinks per week _____ Yes No

Use illicit drugs? Yes No

Current Occupation: _____ Previous: _____

III. CURRENT MEDICATIONS – Wife (include dosage, frequency, and any over-the-counter drugs)

IV. MEDICATION ALLERGIES – Wife only

Other allergies: _____

V. YOUR PAST MEDICAL HISTORY

Check any conditions that you had or currently have:

	Yes	No		Yes	No		Yes	No
Mitral Valve Prolapse	()	()	Diabetes	()	()	Stroke	()	()
Mental Disorder	()	()	Thyroid Disease	()	()	Liver or Gallbladder Disease	()	()
Arthritis	()	()	Heart Disease	()	()	High Blood Pressure	()	()
Asthma	()	()	Rheumatic Fever	()	()	Chronic Bronchitis	()	()
Ulcers	()	()	Phlebitis or Blood Clots	()	()	Blood Disorder	()	()
Crohn’s Disease	()	()	Seizures	()	()	Broken Bones	()	()
Ulcerative Colitis	()	()	Kidney Disease	()	()	Migraine Headaches	()	()

Explain: _____

Please list other physicians currently involved with your care: _____

VI. SURGICAL HISTORY

Surgeries/Hospitalization (dates): _____

VII. GYNECOLOGIC HISTORY:

Date of last pap smear _____ Normal Abnormal
 Date of last mammogram _____ Normal Abnormal Never done

Do you have a history of:

	Yes	No	Explain:
Abnormal pap smears	()	()	_____
Breast lump or mass	()	()	_____
Previous IUD use	()	()	_____
DES exposure in utero	()	()	_____

VIII.SOCIAL HISTORY

Current Occupation: _____ Previous: _____

Habits:

Tobacco: packs/day _____ Non-smoker _____ Previous smoker _____

Alcohol: (circle one) Drinks per: Day _____ Week _____ Month _____ Year _____ Non-drinker _____

Caffeine: Number of beverages per day _____ Illicit drugs: _____

IX. FAMILY HISTORY:

Check if any blood relative has had:

What is your ethnic background?

	Yes	No		Yes	No		
Down Syndrome	()	()	Heart Disease	()	()	English/Irish	()
Sickle Cell	()	()	High Blood Pressure	()	()	Greek/Italian	()
Thalassemia	()	()	Endometriosis	()	()	Ashkenazi Jewish	()
Tay Sachs	()	()	Kidney Disease	()	()	African Descent	()
Hemophilia	()	()	Diabetes	()	()	French Canadian	()
Cystic Fibrosis	()	()	Uterine Fibroids	()	()	Other: _____	
Muscular Dystrophy	()	()	Tuberculosis	()	()	_____	
Mental Retardation	()	()	Cancer	()	()		
Polycystic Kidney	()	()	Mental Disorder	()	()		
Hydrocephalus (water on the brain)	()	()	Seizures	()	()		
Spina Bifida (defect of spine)	()	()	Thyroid Disease	()	()		
Birth Defects	()	()					

	Age	Living	Deceased	Health or Cause of Death
Father				
Mother				
Siblings				

X. REVIEW OF SYSTEMS

Do you have (please circle):

Constitutional: fever, chills, sweats, loss of appetite, rapid weight loss, fatigue, or NONE

Eyes: vision loss, change in vision, or NONE

Ears/Nose: poor sense of smell, decreased hearing, or NONE

Throat: difficulty swallowing, chronic sore throat, hoarseness, or NONE

Cardiovascular: chest pains, palpitations, fainting spells, or NONE

Respiratory: chronic cough, shortness of breath, produce blood with coughing, wheezing, or NONE

GI: nausea, vomiting, abdominal pain, changes in stool, diarrhea, constipation, or NONE

GU: recurrent (>2/year) bladder infections, blood in urine, incontinence, or NONE

Psychiatric: depression, anxiety, or NONE

XI. COMMENTS:
