

Date of Initial Appointment: _____

Confidential Questionnaire

FEMALE HISTORY

NAME		AGE	DATE OF BIRTH
ADDRESS			
HOME PHONE	WORK PHONE	PLACE OF EMPLOYMENT	OCCUPATION
HOW WERE YOU REFERRED TO THE FERTILITY CENTER		DATE OF LAST PHYSICAL EXAMINATION: BY DOCTOR: _____/_____/_____	

MENSTRUAL HISTORY

AGE OF ONSET	REGULAR? <input type="checkbox"/> YES <input type="checkbox"/> NO	Monthly Cycle Length Day 1 to next Day 1	DURATION (DAYS) OF BLEEDING	FLOW <input type="checkbox"/> LIGHT <input type="checkbox"/> HEAVY <input type="checkbox"/> MEDIUM	CLOTS? <input type="checkbox"/> YES <input type="checkbox"/> NO	BLEEDING BETWEEN PERIODS? FREQUENCY <input type="checkbox"/> YES <input type="checkbox"/> NO
PAIN OR CRAMPING? SEVERE? <input type="checkbox"/> YES <input type="checkbox"/> NO / <input type="checkbox"/> YES <input type="checkbox"/> NO		PREMENSTRUAL SYMPTOMS? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE LIST SYMPTOMS		LAST MENSTRUAL PERIOD: ____/____/____	

MARITAL HISTORY

PRESENT MARRIAGE		PREVIOUS MARRIAGE	
YEARS MARRIED	YEARS ATTEMPTING PREGNANCY	YEARS MARRIED	YEARS ATTEMPTING PREGNANCY

GYNECOLOGICAL HISTORY

HAVE YOU EVER BEEN PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO				IF YES, PLEASE LIST COMPLETE THE FOLLOWING:							
Date	Current/Prior Partner	Live Birth (Y/N)	Miscarriage/Abortion/Ectopic	Weeks of Gestation	Fetal Heart (Y/N)	D & C (Y/N)	Delivery (Vag/C-sec)	Sex	Weight	Complications/Comments	

DATE OF LAST PAP SMEAR?	HISTORY OF ABNORMAL PAP? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, LIST DATE AND TREATMENT
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TYPES OF BIRTH CONTROL USED AND DATES OF USE

ANY HISTORY OF ANY SEXUALLY TRANSMITTED DISEASE? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, LIST DATE AND TREATMENT
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FREQUENCY OF INTERCOURSE PER WEEK	ANY PAIN WITH INTERCOURSE? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE DESCRIBE
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DO YOU USE ANY LUBRICANTS? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE LIST	DID YOUR MOTHER TAKE DES? <input type="checkbox"/> YES <input type="checkbox"/> NO
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PRIOR FERTILITY WORKUP

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HAVE YOU HAD ANY OF THE FOLLOWING? IF YES, PLEASE INDICATE THE DATE, THE PHYSICIAN WHO PERFORMED THE TEST, & RESULTS

	DATES	RESULTS	PHYSICIAN
Temperature Charts			
Post - Coital			
Endometrial Biopsy			
Hysterosalpingogram (X-RAY TUBES)			
HORMONE TESTS: (LIST SEPARATELY & DATES)			
MEDICATIONS: (PLEASE LIST NAME AND AMOUNT PRESCRIBED)			
INSEMINATIONS			
IVF / GIFT / ZIFT PROCEDURES			
SURGERIES			

MEDICAL HISTORY

DO YOU HAVE ANY SIGNIFICANT MEDICAL / HEALTH PROBLEMS? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE DESCRIBE
PAST SURGERIES	
HAVE ANY OF YOUR RELATIVES HAD ANY HEALTH PROBLEMS? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE DESCRIBE

MEDICAL HISTORY Continued

WHAT MEDICATIONS ARE YOU TAKING NOW, OR HAVE YOU TAKEN IN THE PAST?

ARE YOU ALLERGIC TO ANY MEDICATIONS?

YES NO

PLEASE LIST NAMES AND REACTION IT CAUSES

DO YOU HAVE ANY OTHER ALLERGIES?

YES NO

PLEASE LIST

HAVE YOU HAD	YES	NO	IF YES, DATES	TREATMENTS	BY WHOM
Rheumatic Fever	Y	N			
Rheumatic Heart Disease	Y	N			
German Measles	Y	N			
Pneumonia	Y	N			
High Blood Pressure	Y	N			
Diabetes	Y	N			
Tuberculosis	Y	N			
Chronic Kidney Disease	Y	N			
Anemia	Y	N			
Hepatitis	Y	N			
Phlebitis	Y	N			
Nervous Breakdown	Y	N			
Severe Depression	Y	N			
Epilepsy	Y	N			
Migraine Headaches	Y	N			
Bleeding Tendencies	Y	N			
Psychiatric Illness	Y	N			
Thyroid Disease	Y	N			
Congenital Heart Disease	Y	N			
Cancer	Y	N			
Radiation Therapy	Y	N			
Asthma	Y	N			
Heart Disease	Y	N			

MEDICAL HISTORY Continued

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HAVE YOU HAD ANY OTHER "SERIOUS" ILLNESS NOT LISTED ABOVE? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, DESCRIBE		
HAVE YOU HAD ANY HISTORY OF MISCARRIAGES? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, DESCRIBE (WHEN, HOW MANY)		
HAVE YOU HAD ANY AUTOIMMUNE STUDIES DONE? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, PLEASE LIST AND TREATMENT		
HAVE YOU HAD ANY ECTOPIC PREGNANCIES? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, PLEASE DESCRIBE (WHEN, HOW MANY, TREATMENT)		
DO YOU SMOKE? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, FOR HOW LONG AND HOW MUCH			
DO YOU DRINK ALCOHOL? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, HOW MANY DRINKS PER WEEK?			
DO YOU USE RECREATIONAL DRUGS NOW? IN THE PAST? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, PLEASE LIST PAST: _____ NOW: _____		
DO YOU USE ANY CAFFEINE? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE LIST			
DO YOU EXERCISE? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE LIST TYPE OF EXERCISE AND HOW OFTEN			
WEIGHT:	HEIGHT:	MAXIMUM WEIGHT WHEN?	MINIMUM WEIGHT WHEN?	DOES YOUR WEIGHT FLUCTUATE? <input type="checkbox"/> YES <input type="checkbox"/> NO
ANY RISK FACTORS FOR HIV? <input type="checkbox"/> YES <input type="checkbox"/> NO		HAVE YOU EVER USED DRUGS? <input type="checkbox"/> YES <input type="checkbox"/> NO	HAVE YOU EVER HAD HOMOSEXUAL RELATIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
HAVE YOU EVER HAD A BLOOD TRANSFUSION PRIOR TO 1985? <input type="checkbox"/> YES <input type="checkbox"/> NO		ARE YOU A HEMOPHILLIAC? <input type="checkbox"/> YES <input type="checkbox"/> NO		

FAMILY HISTORY

	AGE	HEALTH IF LIVING	CAUSE OF DEATH IF DECEASED
Father			
Mother			
Siblings / Names:			

Thank you for taking the time to fill out this questionnaire.
**PLEASE USE THE SPACE BELOW TO ADD ANYTHING (NOT MENTIONED ABOVE)
 THAT YOU FEEL IS IMPORTANT TO YOUR HISTORY AND CARE**

