

Confidential Questionnaire – FEMALE HISTORY

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NAME	AGE	DATE OF BIRTH	SSN
ADDRESS			
ETHNICITY: <input type="checkbox"/> ASIAN <input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> HISPANIC OR LATINO <input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER <input type="checkbox"/> WHITE <input type="checkbox"/> UNKNOWN			
REFERRED TO A FERTILITY CENTER BY:		MAIN REASON FOR THIS VISIT:	

MENSTRUAL HISTORY

AGE OF ONSET	REGULAR? <input type="checkbox"/> YES <input type="checkbox"/> NO	# OF DAYS FROM 1 ST DAY OF BLEED TO 1 ST DAY OF BLEED IN NEXT CYCLE	HOW MANY DAYS DO YOU BLEED?	FLOW <input type="checkbox"/> LIGHT <input type="checkbox"/> MEDIUM <input type="checkbox"/> HEAVY	CLOTS? <input type="checkbox"/> YES <input type="checkbox"/> NO	BLEEDING BETWEEN PERIODS? <input type="checkbox"/> YES <input type="checkbox"/> NO DESCRIBE? _____
PAIN OR CRAMPING? <input type="checkbox"/> YES <input type="checkbox"/> NO SEVERE? <input type="checkbox"/> YES <input type="checkbox"/> NO		DO YOU GET ANY SYMPTOMS BEFORE YOUR PERIOD STARTS? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, PLEASE LIST SYMPTOMS:		
HOT FLASHES? <input type="checkbox"/> YES <input type="checkbox"/> NO		VAGINAL DISCHARGE? <input type="checkbox"/> YES <input type="checkbox"/> NO		MIGRAINE HEADACHES? <input type="checkbox"/> YES <input type="checkbox"/> NO		WHEN DID YOUR LAST MENSTRUAL PERIOD START? _____/_____/_____

MARITAL/RELATIONSHIP HISTORY

PRESENT MARRIAGE / RELATIONSHIP		PREVIOUS MARRIAGE / RELATIONSHIP	
YEARS MARRIED/TOGETHER	YEARS ATTEMPTING PREGNANCY	YEARS MARRIED/TOGETHER	YEARS ATTEMPTING PREGNANCY

GYNECOLOGICAL HISTORY

HAVE YOU EVER BEEN PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO			NUMBER OF PREGNANCIES:				IF YES, PLEASE 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	
IF YOU HAD A D & C AFTER A PREGNANCY LOSS, WAS KARYOTYPING DONE ON THE FETUS? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, WERE THE RESULTS NORMAL OR ABNORMAL?											
DATE OF LAST PAP SMEAR? _____/_____/_____		HISTORY OF ABNORMAL PAP? <input type="checkbox"/> YES <input type="checkbox"/> NO			IF YES, LIST DATE AND TREATMENT:						
TYPES OF BIRTH CONTROL USED AND DATES OF USE:											
EVER USE ORAL CONTRACEPTIVES? <input type="checkbox"/> YES <input type="checkbox"/> NO BRAND NAME:						IF YES, ANY COMPLICATIONS: (e.g. blood clots, high blood pressure, allergies, other)					
HISTORY OF ANY SEXUALLY TRANSMITTED DISEASE? (e.g. chlamydia, gonorrhea, HPV, herpes, PID, other) <input type="checkbox"/> YES <input type="checkbox"/> NO				IF YES, LIST DATE, DIAGNOSIS AND TREATMENT:							
FREQUENCY OF INTERCOURSE PER WEEK			ANY PAIN WITH INTERCOURSE? <input type="checkbox"/> YES <input type="checkbox"/> NO			IF YES, PLEASE DESCRIBE					
DO YOU USE ANY LUBRICANTS? <input type="checkbox"/> YES <input type="checkbox"/> NO			IF YES, PLEASE LIST			HISTORY OF URINARY TRACT INFECTIONS? <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 BELOW

	Y	N	DATES	RESULTS	PHYSICIAN				
Temperature Charts									
Post – Coital									
Endometrial Biopsy									
Hysterosalpingogram (X-RAY OF TUBES)									
Hysterosonogram									
Hormone tests: Estradiol, FSH, LH (day 3)									
Immune Studies - APA - ATA - ANA - Thrombophilia - Embryo Toxicity - Natural Killer Cells									
Ovulation testing (urine)									
MEDICATIONS: (Please list number of cycles, amount prescribed and outcome)									
Clomid? <input type="checkbox"/> YES <input type="checkbox"/> NO									
Gonadotropins (shots)? <input type="checkbox"/> YES <input type="checkbox"/> NO									
INTRAUTERINE INSEMINATIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO		NUMBER OF INSEMINATIONS		PARTNER'S SPERM? <input type="checkbox"/> YES <input type="checkbox"/> NO					
DONOR SPERM? <input type="checkbox"/> YES <input type="checkbox"/> NO									
IVF PROCEDURES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE COMPLETE THE FOLLOWING:									
Date	Physician	Name of FSH used	Name of other drugs used	Daily Dose	# of eggs retrieved	# of embryo	# of embryo transferred	Pregnant Y/N	Outcome
GYNECOLOGICAL SURGERIES (if yes, add dates and outcome)									
Laparoscopy? <input type="checkbox"/> YES <input type="checkbox"/> NO									
Hysteroscopy? <input type="checkbox"/> YES <input type="checkbox"/> NO									
D & C? <input type="checkbox"/> YES <input type="checkbox"/> NO									
PRIOR FERTILITY DIAGNOSIS: (If you have been given a diagnosis or suspected diagnosis by another physician, please list here)									

MEDICATION HISTORY

WHAT MEDICATIONS ARE YOU TAKING NOW? (Please list all prescription, over-the-counter, herbal products, supplements and/or vitamins that you currently take. Include the amount and how often.)
WHAT MEDICATIONS HAVE YOU TAKEN IN THE PAST? (Please list all prescription, over-the-counter, herbal products, supplements and/or vitamins that you have taken. Include the amount and how often.)

MEDICAL HISTORY

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ARE YOU ALLERGIC TO ANY MEDICATIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE LIST NAMES AND REACTION IT CAUSES:	
DO YOU HAVE ANY ALLERGIES TO : PEANUTS <input type="checkbox"/> YES <input type="checkbox"/> NO SHELLFISH <input type="checkbox"/> YES <input type="checkbox"/> NO IODINE <input type="checkbox"/> YES <input type="checkbox"/> NO LATEX <input type="checkbox"/> YES <input type="checkbox"/> NO	
DO YOU HAVE ANY OTHER ALLERGIES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE LIST:	
DO YOU HAVE ANY SIGNIFICANT MEDICAL PROBLEMS OR SERIOUS ILLNESS? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE DESCRIBE:
ANY PAST SURGERIES? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE LIST WITH DATES:

HAVE YOU HAD	YES	NO	IF YES, DATES	TREATMENTS	PHYSICIAN
Rheumatic Fever / Heart Disease	Y	N			
Arthritis	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 / Blood Clots	Y	N			
Nervous Breakdown	Y	N			
Severe Depression	Y	N			
Epilepsy or Seizures	Y	N			
HIV or AIDS	Y	N			
Bleeding Tendencies	Y	N			
Mental Illness / Depression	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			
Mitral Valve Prolapse	Y	N			
Immune Disease	Y	N			

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MEDICAL HISTORY Continued

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WEIGHT:	HEIGHT:	MAXIMUM WEIGHT: WHEN?	MINIMUM WEIGHT: WHEN?	DOES YOUR WEIGHT FLUCTUATE? <input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU CURRENTLY SMOKE? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, HOW MUCH?	HAVE YOU SMOKED MORE THAN 100 CIGARETTES IN THE LAST 3 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO	HAVE YOU SMOKED MORE THAN 100 CIGARETTES IN YOUR LIFETIME? <input type="checkbox"/> YES <input type="checkbox"/> NO	
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? IF YES, PLEASE LIST: <input type="checkbox"/> YES <input type="checkbox"/> NO		DID YOU USE RECREATIONAL DRUGS IN THE PAST? IF YES, PLEASE LIST: <input type="checkbox"/> YES <input type="checkbox"/> NO		
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:			
ANY RISK FACTORS FOR HIV OR INFECTIOUS DISEASE? <input type="checkbox"/> YES <input type="checkbox"/> NO	HAVE YOU EVER USED INJECTABLE STREET DRUGS? <input type="checkbox"/> YES <input type="checkbox"/> NO	HAVE YOU EVER HAD SAME-SEX SEXUAL RELATIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO		
HAVE YOU EVER HAD A BLOOD TRANSFUSION? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, when?	ARE YOU A HEMOPHILIAC? <input type="checkbox"/> YES <input type="checkbox"/> NO	HAVE YOU LIVED OVERSEAS? <input type="checkbox"/> YES <input type="checkbox"/> NO Where? For how long?		

FAMILY HISTORY

HAVE ANY OF YOUR RELATIVES HAD ANY HEALTH PROBLEMS? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE DESCRIBE:
DID YOUR MOTHER OR SISTERS HAVE PROBLEMS WITH FERTILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE DESCRIBE:
ANY HISTORY OF BREAST CANCER? <input type="checkbox"/> YES <input type="checkbox"/> NO WHICH RELATIVE?	

	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