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	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 period started_____ Date of last normal period_____

How many days do your periods last? _____

How many periods do you have in a year? _____

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

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

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, 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 usually surge? _____

Do you find that the kits are reliable? Yes No

Uterotubal Assessment

Have you had a hysterosalpingogram or HSG (x-ray day 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

Do you experience painful intercourse? Yes No

Explain _____

Cervical Assessment

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 been responsible for previous pregnancies (including miscarriages)? 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

Does your husband have medical allergies? _____ Yes N

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	( )	( )	_____

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:

	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 the 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 with 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:

_____

_____

_____

_____

_____