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

Partner's Name: ________________________ Age & Date of Birth________________

Has your partner been responsible for previous pregnancies (including miscarriages)? Yes No

Explain ____

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

Which medications? ____

Has your partner's sperm been tested? Yes No

Results ____

____

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

Explain ____

Does your partner smoke? Yes No

Use alcohol? # drinks per week______ Yes No

Use illicit drugs? Yes No

Does your husband have medical allergies? ____

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. COMMENT

____

____

____

____

____