Please answer the questions to the best of your ability. Leave blank any questions to which you do not know the answer. If you are uncomfortable with any question, you may leave it blank.

IDENTIFYING INFORMATION

Date of initial appointment:_____

Name:_____Partner's Name: _____

Address: _____

Telephone Number -Day:_____Evening: _____

Current Age:____ Date of Birth:_____ Height:_____ Weight:_____ Partner's Date of Birth:_____

Reason for consultation: _____

EMPLOYMENT

Please describe all current employment including job title, description of responsibilities, duration of employment

GYNECOLOGICAL HISTORY

How old were you when you had your first period? _____

How frequently do your periods come? every_____days.

How long do your periods last?_____days. When did your last period start? _____

Do you experience cramping with your period? ❑ Yes ❑ No

If yes, when during your cycle does the pain occur? (circle all that apply) before during after

How would you describe the cramps? ❑ Mild ❑ Moderate ❑ Severe

Do you take pain medication for cramps? ❑ Yes ❑ No

If yes, specify medication_____

Do you bleed or spot between periods? ❑ Yes ❑ No If yes, please describe: _____

When was your last Pap smear?_____Was it normal? ❑ Yes ❑ No

Have you ever had an abnormal Pap smear result? ❑ Yes ❑ No If yes, what therapy was required?

❑ repeat Pap smear ❑ antibiotics ❑ colposcopy (microscope evaluation) ❑ biopsy

❑ cryotherapy (freezing of cervix) ❑ laser therapy ❑ cone biopsy ❑ loop excision (LEEP)

❑ other_____

Have you ever had any of the following infections involving any part of the reproductive tract (vagina, cervix, uterus, fallopian tubes, ovaries)? Check all that apply

❑ yeast ❑ chlamydia trichomonas ❑ gonorrhea ❑ herpes ❑ syphilis ❑ genital warts

Have you ever had a mammogram? ❑ Yes ❑ No If yes, when? _____

Result? ❑ normal ❑ abnormal

Please answer the questions to the best of your ability. Leave blank any questions to which you do not know the answer. If you are uncomfortable with any question, you may leave it blank.

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Name:_____Partner's Name: _____

Address: _____

Telephone Number -Day:_____Evening: _____

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Have you ever had a mammogram? ❑ Yes ❑ No If yes, when? _____

Result? ❑ normal ❑ abnormal

Do you have pain with intercourse? ❑ never ❑ sometimes ❑ frequently ❑ always

How frequently do you and your partner have intercourse?_____per week/month (circle)

How frequently do you and your partner have intercourse around ovulation?_____per week

Have you ever used contraception on the past? ❑ Yes ❑ No If yes, please check all that apply:
❑ contraceptive pills ❑ condoms ❑ diaphragm ❑ IUD ❑ foam/sponge ❑ rhythm
❑ withdrawal ❑ other

Do you use herbal medications? ❑ Yes ❑ No If yes, types of medications used _____

FERTILITY EVALUATION

1. How long have you and your partner been attempting to achieve pregnancy?_____
2. Have you ever conceived a pregnancy with a different partner? ❑ Yes ❑ No
3. Have you ever tried to achieve a pregnancy with a different partner? ❑ Yes ❑ No
4. Have you been treated for infertility previously? ❑ Yes ❑ No
   If yes, where/when?_____
   What was the cause of infertility?_____
5. Which of the following tests have been performed?

❑ Basal body temperature	❑ Infection test (mycoplasma, chlamydia)	❑ Laparoscopy
❑ Postcoital test	❑ Endometrial biopsy	❑ Hysteroscopy
❑ Hormonal tests	❑ Ultrasound	❑ Sonohysterogram
❑ Thyroid test	❑ Hysterosalpingogram (dye, x-ray test)	❑ Antibody tests

6. Have you ever taken any of the medications listed below:

❑ clomiphene citrate (Clomid, Serophene)	❑ hCG (Pregnyl) Novarel
❑ injectable gonadotropins (Bravelle, Menopur Luveris, Gonal-F, Follistim, Repronex)	❑ estrogens (Estrace, Estraderm)
❑ steroids (medrol, prednisone, dexamethasone)	❑ testosterone or male hormone
❑ bromocriptine (Parlodel or Dostinex)	❑ GnRH agonist (Lupron, Synarel, Zoladex)
❑ heparin	❑ progesterone (suppositories, injections, Crinone, Prometria)
❑ aspirin	❑ antibiotics
❑ danazol (Danocrine)	❑ progestins (Provera, Cycrin)

7. Have you ever had intrauterine inseminations? ❑ Yes ❑ No
   If yes, specimen was provided by: (check all that apply) ❑ Partner ❑ Donor
8. Have you ever attempted in vitro fertilization? ❑ Yes ❑ No
   If yes, please specify below (if known)

Date	Location	# Vials of meds/day	# Eggs retrieve	ICSI?* (Y/N)	# Eggs fertilized	# Embryo transferre	Pregnancy? (Y/N)	Outcome

* Intracytoplasmic sperm injection

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How frequently do you and your partner have intercourse?_____per week/month (circle)

How frequently do you and your partner have intercourse around ovulation?_____per week

Have you ever used contraception on the past? ❑ Yes ❑ No If yes, please check all that apply:
❑ contraceptive pills ❑ condoms ❑ diaphragm ❑ IUD ❑ foam/sponge ❑ rhythm
❑ withdrawal ❑ other

Do you use herbal medications? ❑ Yes ❑ No If yes, types of medications used _____

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❑ steroids (medrol, prednisone, dexamethasone)	❑ testosterone or male hormone
❑ bromocriptine (Parlodel or Dostinex)	❑ GnRH agonist (Lupron, Synarel, Zoladex)
❑ heparin	❑ progesterone (suppositories, injections, Crinone, Prometria)
❑ aspirin	❑ antibiotics
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* Intracytoplasmic sperm injection

OBSTETRICAL HISTORY

Have you ever been pregnant (including elective terminations, miscarriages, birth)? ❑ Yes ❑ No

Date	Outcome	How long to conceive?	Infertility therapy?	Complications w/ pregnancy?	Is current partner the father?

PAST MEDICAL HISTORY

Do you have or have you ever had (check all that apply):

❑ Acne
❑ Anemia
❑ Appendicitis
❑ Arthritis
❑ Autoimmune disease (eg. Lupus, rheumatoid arthritis)
❑ Blood transfusion
❑ Breast (nipple) discharge
❑ Breast disease
❑ Breast tenderness
❑ Chicken pox
❑ Chronic bronchitis
❑ Chronic headaches
❑ Cancer? (Specify)_____
_____
❑ Colitis
❑ Cystic fibrosis
❑ Color blindness
❑ Diabetes
❑ Dizziness
❑ Endometriosis
❑ Gallbladder disease
❑ Hair loss
❑ Heat/cold intolerance
❑ Heart disease
❑ Hepatitis
❑ Hirsutism (excess hair growth)
❑ High blood pressure
❑ Hot flashes
❑ Kidney problems
❑ Liver problems
❑ Loss of balance
❑ Measles: German
❑ Measles: regular
❑ Mumps
❑ Neurological problems
❑ Ovarian cysts
❑ Poor sense of smell
❑ Pneumonia
❑ Rheumatic fever
❑ Scarlet fever
❑ Seizures
❑ Thyroid problems
❑ Tuberculosis
❑ Ulcers
❑ Vision problems

Immunizations

Hepatitis B date(s)_____
❑ Tetanus
❑ German Measles (Rubella)
❑ Polio
❑ Mumps
❑ Tuberculosis
❑ Chicken pox

OBSTETRICAL HISTORY

Have you ever been pregnant (including elective terminations, miscarriages, birth)? ❑ Yes ❑ No

Date	Outcome	How long to conceive?	Infertility therapy?	Complications w/ pregnancy?	Is current partner the father?

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Hepatitis B date(s)_____
❑ Tetanus
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❑ Polio
❑ Mumps
❑ Tuberculosis
❑ Chicken pox

REVIEW OF SYSTEMS

Do you presently have any problems or symptoms in the following areas? Circle YES or NO below. If YES, please give explanation:

		Patient Comments:	Physician Comments:
Constitutional (good general health lately)	YES / NO		
Eyes	YES / NO		
Ears/Nose/Mouth/Throat	YES / NO		
Cardiovascular (heart/blood vessels/circulation)	YES / NO		
Respiratory (breathing difficulties)	YES / NO		
Gastrointestinal (stomach/intestines)	YES / NO		
Genitourinary (genitals/sexual function/kidney/bladder)	YES / NO		
Neurological (brain/nervous system)	YES / NO		
Integumentary (skin areas and/or breasts)	YES / NO		
Psychiatric (emotions/mood/memory)	YES / NO		
Musculoskeletal (bones/joints/muscles)	YES / NO		
Endocrine (hormones/metabolism/thyroid)	YES / NO		
Allergic/Immunologic (allergies/immune system)	YES / NO		
Hematologic/Lymphatic (blood or bleeding problems; lymph nodes or "swollen glands")	YES / NO		

PAST SURGICAL HISTORY

Have you ever had any surgeries in the past? ❑ Yes ❑ No

If yes, please indicate date, type, findings of surgery:

_____ _____

_____ _____

MEDICATIONS

Are you allergic to any medications? ❑ Yes ❑ No If yes, please indicate name of medication and type of reaction it causes:

Medications Reaction

_____ _____

_____ _____

Are your currently taking any prescription medications? ❑ Yes ❑ No If yes, please indicate below:

Medications Reaction

_____ _____

_____ _____

Are you currently taking any over-the-counter medications? ❑ Yes ❑ No

Medications Reaction

_____ _____

_____ _____

REVIEW OF SYSTEMS

Do you presently have any problems or symptoms in the following areas? Circle YES or NO below. If YES, please give explanation:

		Patient Comments:	Physician Comments:
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Psychiatric (emotions/mood/memory)	YES / NO		
Musculoskeletal (bones/joints/muscles)	YES / NO		
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Medications Reaction

_____ _____

_____ _____

SOCIAL HISTORY

Are you currently married/domestic partner?_____If so, how long? _____

Have you previously been married? _____

Do you smoke?_____If so, how many packs per day? _____

Do you drink alcohol?_____If so, how many alcoholic beverages per week? _____

Have you ever used illicit (Illegal) drugs?_____If so, please list _____

Do you exercise regularly?_____If so, please indicate type of exercise and estimate hrs/week spent in this activity.

Type	Hours/week	Type	Hours/week

Have you had a significant weight change in the last year? ❑ Yes ❑ No

If yes, please indicate: ❑ weight gain_____lbs ❑ weight loss_____lbs

Do you follow a particular food diet? ❑ Yes ❑ No

❑ vegetarian ❑ diet plan name: _____ ❑ other_____

FAMILY HISTORY

Have any of these illnesses occurred in your family? Check all that apply and indicate relationship to you:

Illness	Relationship to you:	Illness	Relationship to you:
❑ high blood pressure		❑ ovarian cancer	
❑ diabetes		❑ colon cancer	
❑ heart disease		❑ other	
❑ breast cancer			

Form completed by:_____Relationship to patient: _____

(please print) (write self if you are the patient)

Date Completed: _____

Instructions to Attending Physician:

Your signature below indicates that you have reviewed the information contained in the entire questionnaire and that you have reviewed the pertinent or key finding(s) with the patient and/or family. Key finding(s) must be summarized in your progress note, however, the questionnaire may be referenced for additional details.

Attending Physician Signature:_____Date: _____

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