

**NEW PATIENT QUESTIONNAIRE**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
Last First Middle

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apt. or POB #  
 \_\_\_\_\_  
City State Zip Code County

Marital Status:  Single  Married  Divorced  Separated  Committed Relationship

Phone: (H) (\_\_\_\_) \_\_\_\_\_ (W) (\_\_\_\_) \_\_\_\_\_ (C) (\_\_\_\_) \_\_\_\_\_  
 Okay to leave message?  Yes  No      Okay to leave message?  Yes  No      Okay to leave message?  Yes  No

E-Mail: \_\_\_\_\_ Pharmacy: (\_\_\_\_) \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Insurance Provider: \_\_\_\_\_ Do you need a referral?  Yes  No

Reason for Visit:  Infertility  Insemination  IVF  Congenital Genetic Abnormalities  
 Surgical  Endocrinology  Other \_\_\_\_\_

Primary Care Physician (PCP): \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Referred By: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Current Gynecologist: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

With which physician(s) would you like information shared?  PCP  Referring  OB/GYN  None

Partner Name: \_\_\_\_\_  
Last First Middle

Partner Social Security #: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Primary Care Physician (PCP): \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_



**MENSTRUAL HISTORY**

**YES NO**

Age at first period: _____	Date of first day of your last period: _____		
Are your periods regular? .....		<input type="checkbox"/>	<input type="checkbox"/>
If your cycles are regular, what is the usual # of days from the start of one to the start of another period?			
Usual _____	Minimum _____	Maximum _____	
Your periods usually last _____ days to _____ days			
Do you consider your flow abnormal? If yes, <input type="checkbox"/> Light <input type="checkbox"/> Heavy <input type="checkbox"/> Long <input type="checkbox"/> Short			
Do you experience any symptoms before menses starts? .....		<input type="checkbox"/>	<input type="checkbox"/>
If yes, what are they? _____			
If yes, <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe			
Are your periods now, or have they ever been irregular or unpredictable? .....		<input type="checkbox"/>	<input type="checkbox"/>
If yes: 1. When _____			
2. Average # of periods a year _____			
3. Shortest time in between periods _____			
4. Longest time spent without menstruating _____			
Has medication been prescribed for abnormal bleeding? .....		<input type="checkbox"/>	<input type="checkbox"/>
Have you required a D & C for abnormal bleeding? .....		<input type="checkbox"/>	<input type="checkbox"/>
(M.D. use only) _____			
_____			
_____			
Do you have painful menses? .....		<input type="checkbox"/>	<input type="checkbox"/>
If yes, <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe			
Do you have to take pain medication for cramps? .....		<input type="checkbox"/>	<input type="checkbox"/>
If yes, please specify med, dose, and frequency: _____			
How many days do you require pain medication? _____			
Do you miss school or work because of this pain? .....		<input type="checkbox"/>	<input type="checkbox"/>
Do you bleed or spot between periods? .....		<input type="checkbox"/>	<input type="checkbox"/>
If you've ever been on birth control pills, were your periods regular after stopping? .....		<input type="checkbox"/>	<input type="checkbox"/>
Do you have, or have you ever had, hot flashes / night sweats? .....		<input type="checkbox"/>	<input type="checkbox"/>
Did your mother have any difficulty with conception or pregnancy? .....		<input type="checkbox"/>	<input type="checkbox"/>
Did your mother take diethylstilbestrol (DES) or any other hormones when she was pregnant with you?		<input type="checkbox"/>	<input type="checkbox"/>
Is there a family history of infertility? .....		<input type="checkbox"/>	<input type="checkbox"/>
Is there any history of birth defects in your family? .....		<input type="checkbox"/>	<input type="checkbox"/>

	<b>YES</b>	<b>NO</b>
Is there any history of frequent miscarriage or a stillbirth in your family? .....	<input type="checkbox"/>	<input type="checkbox"/>
At what age did your mother begin menopause? _____		
Do you have acne or oily skin? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have or have you ever had breast discharge? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have extra body hair? .....	<input type="checkbox"/>	<input type="checkbox"/>
Does it run in your family? .....	<input type="checkbox"/>	<input type="checkbox"/>
Has this increased in the past 12 months? .....	<input type="checkbox"/>	<input type="checkbox"/>
What has been your maximum adult weight? _____ when? _____		
What has been your minimum adult weight? _____ when? _____		
Have you ever had a sudden weight change? .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how many pounds? _____ How many months? _____		
Do you feel that you are underweight? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel that you are overweight? .....	<input type="checkbox"/>	<input type="checkbox"/>

Please indicate the tests you have had to check for ovulation and a normal cycle. Also briefly indicate the test results. Answer the best you can recall as you understand the information given to you.

<u><b>Test</b></u>	<u><b>Results</b></u>
____ Basal Temperatures	_____
____ Urine L.H. Tests (ovulation predictor)	_____
____ Follicle Ultrasound	_____
____ Endometrial Biopsy	_____
____ Lab Work (blood tests)	_____

**UTERINE, TUBAL, PELVIC HISTORY**

Have you ever been surgically sterilized? .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, has it been reversed? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had an infection of your pelvis (uterus, fallopian tubes, or ovaries)? .....	<input type="checkbox"/>	<input type="checkbox"/>
Were you hospitalized? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been treated for a sexually transmitted disease? .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, <input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis <input type="checkbox"/> Genital Warts		

	YES	NO
Have you had your appendix removed? .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, <input type="checkbox"/> Uncomplicated <input type="checkbox"/> Ruptured <input type="checkbox"/> Complicated <input type="checkbox"/> Infection		
Have you ever used an I.U.D? .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, Name _____ : From _____ To _____		
Name _____ : From _____ To _____		
Did you note any problems? .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, <input type="checkbox"/> Pain <input type="checkbox"/> Bleeding <input type="checkbox"/> Fever <input type="checkbox"/> Infection		
Was it removed because of a problem? .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, explain: _____		
Have you ever had a D&C for an abortion, to end a miscarriage, following childbirth, or for abnormal bleeding? .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, explain: _____		
Have you had any of the following?		
<b>Hysterosalpingogram:</b> (HSG – x-ray of tubes and uterus) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure		
Date: _____		
Result: _____		
<b>Hysteroscopy:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure		
Date: _____		
Result: _____		
<b>Laparoscopy:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure		
Date: _____		
Result: _____		
<b>Laparotomy:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure		
Date: _____		
Result: _____		
<b>Cervical Cone Laser or LEEP procedure:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure		
Date: _____		
Result: _____		
Have you ever been diagnosed with endometriosis? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been treated for endometriosis? .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, Dates: _____ Treatment: _____ Problems: _____		
Dates: _____ Treatment: _____ Problems: _____		

**MEDICAL HISTORY AND REVIEW OF SYSTEMS**

**YES NO**

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Blood Type: \_\_\_\_\_  
 Lab documentation required

Have you lost greater than 20 lbs. of weight in the last year? .....  YES  NO

Do you follow a particular food diet or have any special dietary habits? .....  YES  NO  
 If yes, specify: \_\_\_\_\_

Do you have any allergies to medications? .....  YES  NO  
 If yes, please note: \_\_\_\_\_

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

**Physical Symptoms or Past History of Illness**

**General:**

- Recent Weight Gain/Loss
- Anorexia/Bulimia
- Lack of energy
- Fever / Chills
- Other \_\_\_\_\_
- None

**Head, Eyes, Ears, Nose and Throat:**

- Dizziness  Loss of sense of smell
- Headaches  Chronic nasal congestion
- Blurred vision  Ringing ears
- Hearing Loss / Deafness
- Other \_\_\_\_\_
- None

**Respiratory:**

- Shortness of breath
- Asthma  Bronchitis
- Pneumonia  Tuberculosis
- Bloody cough
- Other \_\_\_\_\_
- None

**Endocrine / Hormonal:**

- Diabetes  Hair Loss
- Thyroid gland problems
- Rapid weight gain or loss
- Excessive hunger/thirst
- Temperature intolerance - hot flashes or feeling cold
- Other \_\_\_\_\_
- None

**Breasts:**

- Discharge (clear? \_\_ bloody? \_\_ milky? \_\_)
- Lumps  Pain  Cancer
- Abnormal mammogram
- Reduction
- Augmentation / Breast implants (saline? \_\_\_\_ silicone? \_\_\_\_)
- Other \_\_\_\_\_
- None

**Neurological Problems:**

- Weakness / Loss of balance
- Seizures / Epilepsy
- Headaches
- Migraine Headaches
- Numbness
- Memory Loss
- Other \_\_\_\_\_
- None

**Gastrointestinal:**

- Nausea/vomiting  Ulcers
- Hepatitis  Diarrhea
- Blood in stool  Constipation
- Change in bowel habits
- Irritable Bowel Syndrome
- Colitis (ulcerative or Crohn's)
- Gallbladder or liver problems
- Other \_\_\_\_\_
- None

**Genito-Urinary:**

- Bladder Infections  Syphilis
- Kidney Infections  Gonorrhea
- Vaginal Infections  Pelvic Inflammation
- Frequent urination  Chlamydia
- Blood in the urine
- Herpes
- Other \_\_\_\_\_
- None

**Skin / Extremities:**

- Unexplained rash/inflammation
- Acne
- Skin cancer
- Burn injury
- Moles changing in appearance
- Excess hair growth
- Other \_\_\_\_\_
- None

**Musculoskeletal:**

- Unusual muscle weakness
- Decreased energy / stamina
- Arthritis
- Lupus Erythematosus
- Myasthenia gravis
- Other \_\_\_\_\_

**Hematologic:**

- Blood clotting disorder / Blood clot
- Sickle cell Anemia  Thrombophlebitis
- Easy bruising  Anemia
- Swollen glands / lymph nodes
- Blood transfusions (dates/reason \_\_\_\_\_)
- Other \_\_\_\_\_

**Cardiovascular:**

- Palpitations / Skipped beats
- Chest pain  Heart attacks
- Stroke  Murmurs
- High blood pressure
- Rheumatic fever / Scarlet fever
- Mitral valve prolapse (Need antibiotics Before dental procedure? \_\_ Yes \_\_ No)
- Other \_\_\_\_\_
- None

**Mental Health Problems:**

- Depression  Anxiety disorder
- Schizophrenia
- Other \_\_\_\_\_
- None

**Gynecology:**

- Ovarian cysts  Endometriosis
- Cervical cancer  Ovarian cancer
- Vaginitis: Trichomoniasis or yeast
- Bacterial Vaginosis (BVD)

**Allergies – List all known allergies:**

\_\_\_\_\_

\_\_\_\_\_



Please give approximate dates and outcomes of any pregnancies conceived with a previous partner:

Date of Pregnancy	Pregnancy Outcome		
	Delivered	Terminated	Miscarried

Are you or have you ever seen a urologist?  Yes  No

Urologist: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Have you ever had a semen analysis (sperm count) performed?  Yes  No If yes, please fill in below:

Date of Semen Analysis	Location of Semen Analysis	Count (Million/ml)	Motility	Grade	Morphology

Do you have any medical problems unrelated to your fertility?

Nature of Problem (Diagnosis)	Treatment	Physician

**MALE SURGICAL HISTORY**

Have you ever had surgery? If so, please indicate date and type of surgery.

Date	Type of Operation	Physician

Do you take any medication? Indicate medication, dosage, frequency and duration.

Medication	Diagnosis	Dosage/Frequency	Duration

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

Erection: if yes, please explain: \_\_\_\_\_

Ejaculation: if yes, please explain: \_\_\_\_\_

	YES	NO
Have your genitals ever been exposed to excessive heat? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any serious injuries to your genitals? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any infections of your penis, testicles or prostate gland? .....	<input type="checkbox"/>	<input type="checkbox"/>
Is there any history of birth defects in your family? .....	<input type="checkbox"/>	<input type="checkbox"/>
Is there any history of recurrent miscarriage in your family? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any allergies to medications? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you been exposed to any environmental hazardous chemicals at home or in your work area?	YES	NO

**COUPLE HISTORY**

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Is intercourse painful? .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe		
Do you use lubricants for intercourse? .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how often? _____      Which brand? _____		
Do you douche before or after intercourse? .....	<input type="checkbox"/>	<input type="checkbox"/>
How many times per week do you and your partner have intercourse? _____		
Have you had a post coital test (Huhner's)? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you and your partner try to "time" intercourse? .....	<input type="checkbox"/>	<input type="checkbox"/>
How do you and your partner try to "time" intercourse? .....	<input type="checkbox"/>	<input type="checkbox"/>

**HISTORY OF FERTILITY TESTING / TREATMENT**

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Have you been treated for infertility before? .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, who was your physician? _____		
Address: _____		

What was thought to be the cause of infertility? \_\_\_\_\_

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Have you taken any of the following medications? Check all that apply:

- Thyroid medication (e.g., Synthroid)    Bromocriptine (Parlodel)    Cabergoline (Dostinex)



Number of prior Gonadotropin Cycles: \_\_\_\_\_

**Gonadotropin Cycles (Injectable Medications)  
(Follistim, Gonal-F, etc.)**

Dates	# of Cycles	Max Starting Dose	Max Follicles	# with Insemination	# of Cycles Resulting in Pregnancy

Number of prior Fresh ART (IVF) cycles: \_\_\_\_\_

Number of prior Frozen ART (IVF) cycles: \_\_\_\_\_

**IVF History**

Cycle #	1	2	3	4	5	6
Date						
IVF Center						
Frozen Embryo Cycle	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Max Start Dose						
Max Estradiol						
# Eggs Retrieved						
# Eggs Fertilized						
ICSI	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
# of Embryo(s) Transferred						
Embryo Age (Day 2,3 or 5)						
Pregnancy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Delivered	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you have any personal, ethical, or religious objections to any test or treatment such as insemination, in vitro fertilization, egg donation, sperm donation, masturbation to collect a semen sample, etc.     Yes    No

**SOCIAL HISTORY**

Do you or your partner ever use or have used in the past:

- |   |         |     |    |
|---|---------|-----|----|
| 1. Alcohol, (# of glasses per week)         | You     | Yes | No |
| Wine _____ beer _____ cocktails _____       | Partner | Yes | No |
| 2. Cigarettes, (present _____ prior _____)  | You     | Yes | No |
| # of packs per day _____                    | Partner | Yes | No |
| # of years _____                            |         |     |    |
| 3. Illicit or recreational drugs (specify): | You     | Yes | No |
| _____                                       | Partner | Yes | No |

Have you or your partner ever been in a program for limiting or discontinuing use of drugs or alcohol?	You	Yes	No
	Partner	Yes	No

How many cups of coffee or caffeinated beverages do you drink each day?	You	_____
	Partner	_____

Do you take vitamins?  Yes  No

If yes, what kind and how much? \_\_\_\_\_

Have you or your partner been exposed to any environmental hazardous chemicals at home or in your work area?	You	Yes	No
	Partner	Yes	No

What is your ethnic origin?

You:            White non-Hispanic    White Hispanic    Black non-Hispanic    Black Hispanic  
 Asian non-Hispanic    Asian Hispanic    Native American    Other \_\_\_\_\_

Partner:        White non-Hispanic    White Hispanic    Black non-Hispanic    Black Hispanic  
 Asian non-Hispanic    Asian Hispanic    Native American    Other \_\_\_\_\_

Are you of: (check only if applies)

You:            Ashkenazi Jewish Descent    Italian/Greek/Mediterranean Ancestry    Philippine/South Asian Ancestry

Partner:        Ashkenazi Jewish Descent    Italian/Greek/Mediterranean Ancestry    Philippine/South Asian Ancestry

**FAMILY HISTORY**

<b>RELATIVE</b>	<b>ALIVE / DEAD</b>	<b>AGE</b>
Mother _____	A / D _____	_____
Father _____	A / D _____	_____
# of Sisters A _____ D _____	# of Brothers A _____ D _____	

Have you or your partners blood relatives ever had the diseases or conditions listed? (Put an X, O or both on the appropriate letter). **Patient = O Partner = X**

<u>Condition</u>	<u>Mother</u>	<u>Father</u>	<u>Brother/Sister</u>	<u>Other</u>
Alcoholism	M	F	S	O
Anemia	M	F	S	O
Diabetes	M	F	S	O
Cancer	M	F	S	O
Bleeding disorders	M	F	S	O
Heart disease	M	F	S	O
High blood pressure	M	F	S	O
Kidney disease	M	F	S	O
Stroke	M	F	S	O
Blood clots	M	F	S	O
Thyroid disease	M	F	S	O
Excess hair growth	M	F	S	O
Epilepsy	M	F	S	O
Muscular dystrophy	M	F	S	O
Cystic fibrosis	M	F	S	O
Mental retardation	M	F	S	O
Physical retardation	M	F	S	O
Downs syndrome	M	F	S	O
Frequent miscarriages	M	F	S	O
Stillbirths	M	F	S	O
Twins	M	F	S	O
Early menopause	M	F	S	O
Endometriosis	M	F	S	O
Infertility	M	F	S	O
Irregular periods	M	F	S	O
Fibroids (Myomas)	M	F	S	O
Other _____	M	F	S	O