Virginia Center for Reproductive Medicine

New Patient Questionnaire

Date: _____

Patient Name: _____

Date of Birth: _____ / _____ / _____ Age: _____

Social Security #: _____

Address: _____

_____ _____ _____

Phone: (H) ( ) **_____** (W) ( ) **_____**

Cell Phone: ( ) **_____ Pharmacy:** ( )**_____**

Partner Name: _____ _____

Partner's Social Security #: _____ DOB_____

Age: _____

Referred by: _____

Current Gynecologist: _____

Phone # _____

It is very important that you take the time to fill out the * questions accurately

MEDICAL HISTORY YES/NO

Weight _____ Height _____ Blood Type (if known)_____

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

Do you follow a particular food diet or have any special dietary habits? θ **YES** θ **NO**
If yes, specify: _____

Have you ever had an eating disorder (anorexia or bulimia)? θ **YES** θ **NO**
If yes, specify: _____

Do you have any allergies to medications? θ **YES** θ **NO**
If yes, please note:_____
_____

Exercise: _____ Hrs/Week _____ Exercise: _____ Hrs/Week _____

Do you or have you ever had (check **all** that apply):
θ Scarlet fever θ Kidney Infection θ Breast Tenderness
θ Rheumatic fever θ Heart Disease θ Breast Soreness
θ Tuberculosis θ Hirsutism (Excess Hair Growth)
θ Breast Milky Discharge θ Hepatitis θ High Blood Pressure
θ Neurologic Problems θ Syphilis θ Gallbladder Problems θ Seizures
θ Gonorrhea θ Liver Problems θ Epilepsy θ Pelvic Infection θ Ulcers
θ Visual Disturbances θ Chlamydia θ Appendicitis θ Poor Sense of Smell
θ Herpes θ Colitis θ Dizziness θ Chronic Bronchitis θ Diabetes
θ Loss of Balance θ Measles: Regular θ Anemia θ Chronic Headaches
θ Measles: German θ Arthritis θ Blood Transfusions θ Pneumonia θ Thyroid Problems θ Parasitic Infection θ Nongonococcal Urethritis θ Ovarian Cysts
θ Endometriosis θ Breast Cancer θ Cervical Cancer θ Ovarian cancer
θ **Other Cancer?**
Specify:_____

θ **Vaginitis:Trichomoniasis or Yeast**
 # per year:_____

List the forms and frequency of regular vigorous exercise (swimming, cycling, running, and age you began)

_____

Within the last year, have you taken any prescription medications? Please note in the chart below.

Medication	**Diagnosis**	**Dosage / Frequency**	**Duration**

Are you taking any over-the-counter meds on a regular basis? Please note in the chart below.

Medication	**Diagnosis**	**Dosage / Frequency**	**Duration**

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

θ Alcohol – How many glasses per week do you usually drink? Wine _____ Beer _____ Cocktails _____
θ Cigarettes- Number of packs / day _____ Number of years _____
θ Illicit or Recreational Drugs (Marijuana, Cocaine, etc.)

If you would feel more comfortable not writing anything down, please discuss this directly with your physician. Specify:

_____
_____

MENSTRUAL HISTORY YES/NO

Age at first period: _____ Date of **LAST** period: _____

Are your periods regular? θ **YES** θ **NO**

What is the usual # of days *between* periods? Minimum _____ Maximum _____

What is the usual duration of your bleeding? Minimum _____ Maximum _____

Do you have PMS? θ **YES** θ **NO**

If yes, …… θ MILD θ MODERATE θ SEVERE

Do you have painful menses? θ **YES** θ **NO**

If yes, …… θ MILD θ MODERATE θ SEVERE

Do you have to take pain medication for cramps? θ **YES** θ **NO**

If yes, please specify med: _____

Do you bleed or spot between periods? θ **YES** θ **NO**

If you've ever been on oral contraceptives,

Were your periods regular after stopping the pill? θ **YES** θ **NO**

Did your mother have any difficulty with conception or pregnancy? θ **YES** θ **NO**
Did your mother take diethylstilbestrol (DES) when she was pregnant with you? θ **YES** θ **NO**
At what age did your mother begin menopause? _____

Is there a family history of infertility? θ **YES** θ **NO**
If yes, who / relationship: _____

Is there a history of hormonal disorders in your family? θ **YES** θ **NO**
If yes, who / relationship/ type: _____

Is there a family history of birth defects? θ **YES** θ **NO**
If yes, who / relationship: _____

Is there a family history of habitual pregnancy loss? θ **YES** θ **NO**

If yes, who / relationship: _____

Have you ever used an intrauterine device (IUD)? θ **YES** θ **NO**
If yes, please specify type / # years: _____

Have you ever had pelvic inflammatory disease (PID)? θ **YES** θ **NO**
If yes, please describe: _____

Is intercourse painful? θ **YES** θ **NO**
If yes, …… θ MILD θ MODERATE θ SEVERE

Do you use lubricants for intercourse? θ **YES** θ **NO**
If yes, which brand? _____

Do you douche before or after intercourse? θ **YES** θ **NO**

How many times per week do you and your partner have intercourse?_____

***How many months have you had unprotected intercourse?**

_____

***How many months have you been trying to get pregnant?**

_____

Have you used Basal Body temperature (**BBT**)? θ **YES** θ **NO**
If yes, what day did you ovulate? _____

Have you used an ovulation predictor kit (**OPK**)? θ **YES** θ **NO**
If yes, what day did you ovulate? _____

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

Do you take vitamins? θ **YES** θ **NO**
If so, what kind and how much? _____

Have you been exposed to any toxins? θ **YES** θ **NO**

What is your ethnic origin?

_____

□ White non -Hispanic □ White Hispanic □ Black non -Hispanic □ Black Hispanic
□ Asian non- Hispanic □ Asian Hispanic □ Native American
□ Unknown /Not Stated please indicate

PREGNANCY DATA

***How many prior pre-term (< 37 weeks) births have you had?**

_____

***How many prior full-term (>37 weeks) births have you had**

_____

*****

How many pregnancies (including abortions) have you had?

_____

*****

How many spontaneous abortions have you had?

_____

Please fill in the chart below:

Pregnancy #	**Year**	**End in Abortion? Spontaneous or Induced Abortion? Or Ectopic Pregnancy?**	**Infertility therapy required to conceive?**	**How long to conceive?** (months)	**Greater than or equal to 37 weeks Yes/No**	**Baby born alive?**	**Is current partner the father?**
1st Pregnancy							
2nd Pregnancy							
3nd Pregnancy							
4th Pregnancy							
5th Pregnancy							

SURGICAL HISTORY

Have you ever been surgically sterilized? Yes_____ No_____

How many operations have you had? _____

If so, what type? _____

HISTORY OF FERTILITY THERAPY: YES/NO

Have you been treated for infertility before? θ **YES** θ **NO**

If yes, who was your physician? _____
Address: _____

What cause of infertility was diagnosed?

_____
_____
_____

Have you taken any of the following medications? Check all that apply:
θ Thyroid medication (e.g. Synthroid) θ bromocriptine (Parlodel)

Which of the following tests have you had performed?
Check all that apply and results if known.

θ Postcoital Test Date: ___/___ Results: _____
θ Day3 FSH, Estradiol, Date: ___/___ Results: _____
θ Endometrial Biopsy Date: ___/___ Results: _____
θ Hysterosalpingogram Date: ___/___ Results: _____
θ Antisperm Antibodies Date: ___/___ Results: _____
θ Laparoscopy Date: ___/___ Results: _____
θ Hysteroscopy Date: ___/___ Results: _____
θ Mycoplasma/Chlamydia Cultures Date: ___/___ Results: _____
θ Thyroid Tests Date: ___/___ Results: _____
θ Rubella Date: ___/___ Results: _____
θ HIV Date: ___/___ Results: _____
θ PAP Smear Date: ___/___ Results: _____
θ Mammogram Date: ___/___ Results: _____
θ Sickle Cell screen Date: ___/___ Results: _____
θ Tay Sachs Date: ___/___ Results: _____
θ Cystic Fibrosis Date: ___/___ Results: _____
θ Other-Specify: _____Date: ___/____ Results: _____

Infertility Treatment History

Clomiphene Citrate (Clomid, Serophene)

Dates	# Of Cycles	Max Starting Dose	Max Follicles	# With Insemination	# Of Cycles Resulting In Pregnancy

***Number of prior Gonadotropin Cycles _____**

Gonadotropin (Follistim, Gonal-F, Repronex, Bravelle, etc.)

Dates	# Of Cycles	Max Starting Dose	Max Estradiol	Max # Follicles	# With Insemination	# Of Cycles Resulting In Pregnancy

***Number of prior Fresh ART (IVF/ICSI) Cycles _____**

***Number of prior Frozen ART (IVF/ICSI) Cycles _____**

IVF HISTORY

Cycle#	**1**	**2**	**3**	**4**	**5**	**6**
Date						
IVF Center						
Frozen Embryo Cycle	θ Y θ N	θ Y θ N	θ Y θ N	θ Y θ N	θ Y θ N	θ Y θ N
Max. Start Dose						
Max. Estradiol						
# Eggs Retrieved						
# Eggs Fertilized						
ICSI: Y/N	θ Y θ N	θ Y θ N	θ Y θ N	θ Y θ N	θ Y θ N	θ Y θ N
# Embryo(s) Transferred						
Embryo Age at transfer (Day 2, 3 or 5)						
Pregnancy: Y/N	θ Y θ N	θ Y θ N	θ Y θ N	θ Y θ N	θ Y θ N	θ Y θ N
Delivered: Y/N	θ Y θ N	θ Y θ N	θ Y θ N	θ Y θ N	θ Y θ N	θ Y θ N

MALE DATA

Name: _____ _____

Marriage #: _____

Number of pregnancies conceived with current partner: _____

Number of pregnancies conceived with previous partners: _____

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

Date of Pregnancy	Delivered	Aborted	Miscarried

Urologist: _____

Address: _____
Phone: _____

Have you ever had a semen analysis (sperm count) performed? θ **YES** θ **NO**

Date of Semen Analysis	Location of 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 any surgery? If so, please indicate date and type of surgery. _____

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

Do you or have you ever used (check **all** that apply):
θ Alcohol – How many glasses per week do you usually drink? Wine _____ Beer _____ Cocktails _____
θ Cigarettes- Number of packs / day _____ Number of years _____
θ Illicit or Recreational Drugs (Marijuana, Cocaine, etc.) If you would feel more comfortable not writing anything down, please discuss this directly with your physician.
Specify: _____
_____

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

θ Erection: If yes, please explain:
_____

θ Ejaculation: If yes, please explain:
_____

Have your genitals ever been exposed to excessive heat? θ **YES** θ **NO**
Have you had any serious injuries to your genitals? θ **YES** θ **NO**
Have you had any infections of your penis, testicles or prostate gland? θ **YES** θ **NO**
Is there any history of birth defects in your family? θ **YES** θ **NO**

Is there any history of recurrent miscarriage in your family? θ **YES** θ **NO**

Do you have any allergies to medications? θ **YES** θ **NO**
If yes, please note:_____

PATIENT COMMENTS:

What do you understand about the cause of your infertility and possible treatment options?

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please use this space to add any additional comments or information you feel your physician should know.

_____

_____

_____

_____

_____

_____

_____

_____

_____