



FEMALE PRE-CONSULT QUESTIONNAIRE

1. IDENTIFYING INFORMATION

Name _____ DOB ____/____/____ Age _____
 Significant Other Name _____ DOB ____/____/____ Age _____
 Primary Language spoken: English Spanish Other: _____
 Date this form completed ____/____/____ Referred by: _____
 Primary GYN _____ Primary Care MD _____
 How long have you been attempting conception? _____ Number of years married/together _____
 Reasons you are coming to see us: _____

2. PREGNANCY HISTORY

Times Pregnant ____ Term births ____ Premature births ____ Miscarriages ____ Elective abortion ____ Adopted children ____

Date	Mis-carriage?	Elective Abortion?	Ectopic?	Months to conceive?	Infertility Treatment?	Weight and sex?	C-section?	Complications?	Is current partner the father?
1. _____	_____	_____	_____	_____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____	_____	_____	_____	_____

3. CONTRACEPTIVE USE

Type	From when to when	Reason discontinued
1. _____	_____	_____
2. _____	_____	_____

4. OPERATIONS AND HOSPITALIZATIONS

Date	Diagnosis	Operation	Where	Physician
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____

5. MEDICATIONS *List all prescriptions and over-the-counter drugs used during the past year*

Date	Dose and frequency	From when to when	Reason
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

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6. ALLERGIES

Drug or substance

Reaction

1. _____:

2. _____:

7. MENSTRUAL/HORMONAL

Are your periods regular? yes no Date of last two menstrual periods ____/____/____ and ____/____/____

Age at first period Do you bleed between periods? yes no

How many days from onset to onset? What is the usual duration of your periods?days

(Check all that apply).

Pelvic pain/cramps: none during menses before menses after menses at mid cycle during intercourse
 with bowel movements with urination cause you to miss work cause you to miss usual activities

Pelvic pain/cramps are: mild moderate severe worsening
 improving no change in midline on right side on left side

Do you have or have you had?

Hot flashes Increased facial or body hair Breast discharge Increased acne

Please explain a "Yes" answer: _____

8. GYNECOLOGIC / INFECTION

Last pap smear ____/____/____ Last mammogram ____/____/____

Do you have or have you had?

<input type="checkbox"/> Pelvic infection	<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Ovarian cysts
<input type="checkbox"/> Chlamydia	<input type="checkbox"/> Colitis or enteritis	<input type="checkbox"/> Syphilis	<input type="checkbox"/> Toxoplasmosis
<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Uterine fibroids or myomas	<input type="checkbox"/> Mycoplasma	<input type="checkbox"/> Cytomegalovirus (CMV)
<input type="checkbox"/> Pelvic adhesions	<input type="checkbox"/> Abnormal uterus shape	<input type="checkbox"/> Ureaplasma	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cervicitis	<input type="checkbox"/> Recurrent vaginitis	<input type="checkbox"/> Genital warts / condyloma	<input type="checkbox"/> Trichomonas
<input type="checkbox"/> Genital herpes	<input type="checkbox"/> Abnormal Pap smears	<input type="checkbox"/> Cryo (freezing) or surgery of the cervix	

9. OTHER HISTORY

Your occupation:.....

Alcohol - type and number of drinks per week:.....

Cigarettes - packs smoked per day:.....

Marijuana - frequency:.....

Other drugs - type and amount:

Caffeine drinks per day:.....

Ever used intravenous drugs? yes no

Radiation exposure? yes no

10. MEDICAL ILLNESSES

Do you have or have you had?

<input type="checkbox"/> Cancer	<input type="checkbox"/> Asthma	<input type="checkbox"/> Kidney disorder	<input type="checkbox"/> Psychiatric disorder
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Rubella	<input type="checkbox"/> Seizures
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Anesthetic complication	<input type="checkbox"/> Stroke
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Mumps	<input type="checkbox"/> Blood clots
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Hepatitis / liver disorder	<input type="checkbox"/> Chicken pox	<input type="checkbox"/> Anemia
<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Gall bladder problems	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Bleeding disorder
<input type="checkbox"/> Scarlet fever	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Serious injury / accident	<input type="checkbox"/> Thyroid disorder
<input type="checkbox"/> Mitral valve prolapse	<input type="checkbox"/> Colitis / enteritis	<input type="checkbox"/> Blood transfusion	<input type="checkbox"/> Recent immunization
<input type="checkbox"/> Heart murmur			

Please explain a "Yes" answer to any of the above _____

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11. SYSTEMIC REVIEW

Height _____ Weight _____ Maximum Weight _____ Minimum Weight _____ Weight change in last 2 yrs _____

Do/have you participated in any significant dietary changes over the past 3 years?.....

Do/have you participated in any vigorous exercise programs over the past 3 years?.....

If so please document : Vigorous exercise: type hrs/week

- The effect of being overweight on fertility therapies have been well documented.
- Please speak with your physician regarding weight loss attempts and ideal weight range for you height.
- Obesity does not usually cause infertility but obesity may have significant impact on treatment responses and may have multiple negative effects on both yourself and the fetus

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Wear glasses | <input type="checkbox"/> Bladder/kidney infections | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Acne |
| <input type="checkbox"/> Wear contact lenses | <input type="checkbox"/> Urgent / frequent / painful urination | <input type="checkbox"/> Nausea and vomiting | <input type="checkbox"/> Skin disorder |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Blood / abnormal color of urine | <input type="checkbox"/> Vomiting blood | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Hayfever | <input type="checkbox"/> Unable to control urination | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Abnormal urinary tract | <input type="checkbox"/> Food intolerance | <input type="checkbox"/> Skin cancer |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Kidney x-ray | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Recent anxiety increase |
| <input type="checkbox"/> Denture / bridges | <input type="checkbox"/> Bladder cystoscopy | <input type="checkbox"/> Jaundice / hepatitis | <input type="checkbox"/> Sensation loss / numbness |
| <input type="checkbox"/> Counseling | <input type="checkbox"/> Chronic constipation | <input type="checkbox"/> Recent stress increase | <input type="checkbox"/> Muscle control / weakness |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Heat or cold intolerance |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Blood in bowel movement | <input type="checkbox"/> Damp skin |
| <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Prolonged bleeding | <input type="checkbox"/> Irritable bowel | <input type="checkbox"/> Extraordinary fatigue |
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Bleeding from gums | <input type="checkbox"/> Hemorrhoids | |
| <input type="checkbox"/> Leg swelling | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Hernia | |
| <input type="checkbox"/> Calf pain | <input type="checkbox"/> Take aspirin/ibuprofen frequently | <input type="checkbox"/> Abnormal liver test | |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Unusual hair loss | <input type="checkbox"/> Back pain | |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Breast mass | Headaches: | |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Fibrocystic changes | Number per week _____ Medication used _____ | |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Breast implants | <input type="checkbox"/> mild | <input type="checkbox"/> moderate <input type="checkbox"/> severe <input type="checkbox"/> improving |
| <input type="checkbox"/> Cough up blood | <input type="checkbox"/> Do monthly breast self-exam | <input type="checkbox"/> worsening | <input type="checkbox"/> no change <input type="checkbox"/> with visual symptoms |
| <input type="checkbox"/> Chest x-ray/TB skin test | | <input type="checkbox"/> with vomiting | <input type="checkbox"/> stress related <input type="checkbox"/> migraines |

OTHER: _____

If yes, please comment: _____

12. FAMILY HISTORY / GENETIC HISTORY Adopted Adopted and unaware of Family-Genetic History

	Mother	Father	Brothers: #	Sisters: #	Children: #	Other
Cancer (type)						
Diabetes						
Hypertension						
High Cholesterol						
Heart Disease						
Stroke						
Uterine fibroids						
Endometriosis						
Premature Menopause						
Mental Retardation						

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Do you or anyone in either family have? *Information is used for genetic testing recommendation purposes*

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Neural tube defects/spina bifida/anencephaly | <input type="checkbox"/> Cystic fibrosis | <input type="checkbox"/> Tay-Sachs disease | <input type="checkbox"/> Chromosomal disorder |
| <input type="checkbox"/> Thalassaemia | <input type="checkbox"/> Muscular dystrophy | <input type="checkbox"/> Sickle cell disease or trait | <input type="checkbox"/> Genetic / inherited disorder |
| <input type="checkbox"/> Down syndrome | <input type="checkbox"/> Huntington chorea | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Baby with birth defects |
| <input type="checkbox"/> Hydrocephalus | <input type="checkbox"/> Mental retardation / fragileX | <input type="checkbox"/> Hormonal disorder | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Stillbirth | <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> 3 or more miscarriages | <input type="checkbox"/> Phenylketonuria | <input type="checkbox"/> Neurofibromatosis | <input type="checkbox"/> Myotonic dystrophy |
| | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Any birth defects? | <input type="checkbox"/> Any inherited disorders? |

Please explain a "Yes" answer to any of the above _____

13. GENETIC SCREENING:

It is recommended that **all couples** attempting conception be offered cystic fibrosis screening. Cystic Fibrosis is a pulmonary disease affecting children and is the most common genetic disease. The effectiveness of the test varies dependent on your ethnic background. You may be offered additional screening based on your ethnicity.

Are you: Caucasian Hispanic Asian African American Other (_____)
 Ashkenazi Jewish Yes No Mediterranean/Asian/French Canadian Yes No

If you answered YES to any of these, please let your physician know at the visit, so that the additional genetic screening can be offered to you. If you have any specific genetic concerns and desire to see a geneticist, please let the physician know.

- Down syndrome Mental retardation / Fragile X Hormonal disorder Infertility

14. SEXUAL PRACTISES

FEMALE: Frequency of Intercourse _____ Is this increased or decreased in past year? Yes No
 Are you able to achieve an orgasm Yes No Any changes in Sexual Spontaneity Yes No
 Painful intercourse with penile entry Yes No Painful intercourse with deep thrusting Yes No
 Any changes in Sexual Desire Yes No Any changes in sexual desirability-image-attractiveness? Yes No

MALE: N/A Ejaculation Issues Yes No
 Erectile Dysfunction Yes No
 Medications: _____

15. HISTORY OF FERTILITY THERAPY

Have you been treated for infertility previously? YES NO
 If yes, who was your physician?

What cause of infertility was diagnosed?

What drugs have you taken for infertility? Please check all that apply:

- | | | | | | |
|---|---------------------------------------|---------------------------------------|-----------------------------------|---|--|
| <input type="checkbox"/> Clomid (Serophene) | <input type="checkbox"/> hCG Profasi | <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Repronex | <input type="checkbox"/> Microdose Lupron | <input type="checkbox"/> Steroids |
| <input type="checkbox"/> Gonadotropin | <input type="checkbox"/> Progesterone | <input type="checkbox"/> Baby aspirin | <input type="checkbox"/> Pergonal | <input type="checkbox"/> Ganirelix or Cetrotide | <input type="checkbox"/> Oral Contraceptives |
| <input type="checkbox"/> Follistim | <input type="checkbox"/> Lupron | <input type="checkbox"/> Heparin | <input type="checkbox"/> Fertinex | <input type="checkbox"/> Parlodel | <input type="checkbox"/> Other |

Which of the following tests have you or your partner had performed? Please check all that apply and results, if known:

- | | | |
|--|---------------------|---------------|
| <input type="checkbox"/> Hysterosalpingogram | When ____/____/____ | Results |
| <input type="checkbox"/> Sonohystogram | When ____/____/____ | Results |
| <input type="checkbox"/> Laparoscopy, Hysteroscopy | When ____/____/____ | Results |
| <input type="checkbox"/> Thyroid tests | When ____/____/____ | Results |
| <input type="checkbox"/> Chromosomes | When ____/____/____ | Results |
| <input type="checkbox"/> Genetic screening | When ____/____/____ | Results |
| <input type="checkbox"/> OTHER _____ | | |

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Have you ever undergone Artificial Insemination (IUI) or In Vitro Fertilization (IVF)? Yes No

If yes, partner donor sperm #IUI's _____ #IVF cycles _____

We, at FSMG, understand that infertility can place a significant burden on the respective couple. This stress can have a profound impact on the reproductive system. Given these facts and our emphasis on treating the whole person, we would like to know your experience with / willingness to try alternative therapies. These include, but are not limited to:

- Acupuncture (if so, which acupuncturist) _____
Dates: + Current + Previous _____
- Herbal treatment _____
Dates: + Current + Previous _____
- Massage _____
Dates: + Current + Previous _____
- Psychological/group therapy _____
Dates: + Current + Previous _____
- Yoga / biofeedback / stress reduction techniques _____
Dates: + Current + Previous _____

Welcome, we look forward to working with you. Please write down any specific concerns you want to review at your visit.

-The FSMG Team