# New Patient Questionnaire - Female

Name ______________________________________________ DOB _____/_____/_____ Age _____________

☐ N/A Partner's Name _________________________________ DOB _____/_____/_____ Age _____________

Primary Language spoken ☐ English ☐ Spanish ☐ Other ______________________________________________

Date this form completed _____/_____/_____ Referred by ________________________________

OBGYN ________________________________________ Primary Care MD ____________________________________

Reason for consultation ☐ Infertility ☐ Recurrent Pregnancy Loss ☐ Use of donor sperm ☐ Recipient of Partner's Eggs

☐ Egg Freezing/Banking ☐ Hormonal Issues ☐ ________________________________________________________

_______________________________________________________________________________________________

Reproductive Goals (if applicable): Number of children desired? ________ Number of pregnancies desired? _________

## Pregnancy History ☐ None

Pregnancies_____ Term births ____ Preterm births ____ Miscarriages ____ Ectopics ____ Elective abortion ____ Adoptions ____

| Date or Year | Time to conceive | Spontaneous/ IUI/IVF | Outcome (Delivery, Loss, Ectopic, Abortion) | Weight/Sex (if delivery) | Complications (C-section, gestational diabetes, ↑ blood pressure) | Current ♂/ Different ♂/ Donor |
|---|---|---|---|---|---|---|
| | | | | | | |
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## Contraceptive Use ☐ None **(including condoms, IUD, oral contraceptive pills, withdrawal, natural family planning)**

| Type | Dates of Use | Reason Discontinued |
|---|---|---|
| | | |
| | | |

## Illnesses/Medical Conditions ☐ None **(include any recurrent reason you are seeing a physician)**

| Diagnosis | Active? | Name of Physician Following |
|---|---|---|
| | | |
| | | |
| | | |

## Operations and Hospitalizations ☐ None **(include any overnight stay in the hospital/anesthesia exposure/surgery)**

Anesthetic complication: ☐ none or____________________________________________________________

| Date | Diagnosis | Operation | Hospital/Clinic | Physician |
|---|---|---|---|---|
| | | | | |
| | | | | |
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## Medications ☐ None **(list prescriptions, over-the-counter medications, supplements used or using in the past year)**

| Medication/Supplement | Dose and Frequency | Dates of Use | Reason for Use |
|---|---|---|---|
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## Allergies ☐ None **(list all allergic reactions to medications and/or substances such as latex)**

| Medication or Substance | Reaction |
|---|---|
| | |
| | |
| | |
| | |

## Menstrual/Hormonal (1st day is defined as first day of full flow) Are your periods every 26-34 days? ☐ yes ☐ no

How many days from 1st day of period to the 1st day of the next period? ______ How many days of bleeding? _____

1st day of last three menses _____ / _____ /_____ _____ / _____ /_____ _____ / _____ /_____

Age at 1st period _____ Was this spontaneous? ☐ yes ☐ no Do you bleed between periods? ☐ yes ☐ no

**Pelvic pain:** ☐ none ☐ during menses ☐ before menses ☐ after menses ☐ at mid cycle

☐ during intercourse ☐ with bowel movements ☐ with urination ☐ cause you to miss work

**Pelvic pain is:** ☐ mild ☐ moderate ☐ severe ☐ in midline ☐ on left side ☐ on right side

**Do you have?** ☐ Hot flushes ☐ Increased facial /body hair ☐ Breast discharge ☐ Increased acne

**Please explain a "Yes" answer:** ______________________________________________________________

______________________________________________________________________________________

## Gynecology Last pap smear _____/_____/_____ Last mammogram _____/_____/_____ ☐ none

Do you have or have you had?

☐ Endometriosis ☐ Ovarian cysts ☐ Uterine fibroids/ myomas ☐ Appendicitis

☐ Abnormal uterus shape ☐ Abnormal Pap smears ☐ Cryo (freezing) or LEEP or surgery of the cervix

☐ Pelvic infection ☐ Gonorrhea ☐ Chlamydia ☐ Syphilis

☐ Myco/Ureaplasma ☐ Cytomegalovirus ☐ Genital warts/condyloma ☐ Trichomonas

☐ Pelvic adhesions ☐ Cervicitis/vaginitis ☐ Genital herpes ☐ Tuberculosis

## Medical Illnesses

Do you have or have you had?

☐ Mitral valve prolapse
☐ Hypertension
☐ Asthma
☐ Diabetes
☐ Rubella
☐ Blood clots
☐ Recent immunization
☐ Heart disease
☐ High cholesterol
☐ Pneumonia
☐ Kidney disorder
☐ Tuberculosis
☐ Anemia
☐ Cancer
☐ Rheumatic fever
☐ Stroke
☐ Heart murmur
☐ Colitis / enteritis
☐ Chicken pox
☐ Bleeding disorder
☐ Serious injury / accident
☐ Seizures
☐ Thyroid disorder
☐ Gall bladder problems
☐ Hepatitis
☐ Psychiatric disorder
☐ Blood transfusion

**Please explain a "Yes" answer:** ______________________________________________________________________

______________________________________________________________________________________

## Other History

Occupation ______________________________

Cigarettes ☐ In past ☐ Current packs/day_________

Caffeinated drinks/day ______________________

Alcohol ☐ no ☐ yes , #/week _____________

Radiation exposure? ☐ no ☐ yes ________________________

Marijuana ☐ no ☐ yes, frequency _________________________

Recreational Drugs (type/freq):___________________________

## Review of Systems

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? ________________________________

Vigorous exercise Type ________________________________________ hrs/week _______________________________

Do you have or have you had?

**Heart/Lungs**
☐ Sinus problems
☐ Wheezing
☐ Shortness of breath
☐ Persistent Cough
☐ Coughing up blood
☐ Chest pain
☐ Irregular heart beat

**Other**
☐ Back pain
☐ Muscle weakness
☐ Sensation loss/numbness
☐ Leg swelling
☐ Calf pain
☐ Fainting spells
☐ Extraordinary fatigue
☐ Heat or cold intolerance
☐ Fibrocystic breasts
☐ Breast mass

**GI**
☐ Abdominal pain
☐ Nausea/vomiting
☐ Chronic constipation
☐ Diarrhea
☐ Bloody stools
☐ Hemorrhoids
☐ Irritable bowel syndrome
☐ Vomiting blood
☐ Hernia
☐ Jaundice / hepatitis
☐ Gluten Sensitivity
☐ Abnormal liver test

**Urinary**
☐ Urgency
☐ Frequency
☐ Painful urination
☐ Bloody urine

**Skin**
☐ Acne
☐ Chronic Rash
☐ Skin cancer
☐ Unusual hair loss

**Mental Health**
☐ Anxiety
☐ Stress
☐ Counseling

**Headaches**
☐ None ☐ _____ per week
☐ Visual symptoms
☐ Stress related
☐ Related to menstrual cycle

**Other Medical Concerns** ____________________________________________________

__________________________________________________________________________

__________________________________________________________________________

## Family/Genetic History ☐ Adopted ☐ Adopted and unaware of family/genetic history

| | Mother | Father | Brothers: # | Sisters: # |
|---|---|---|---|---|
| Cancer (type) | | | | |
| Heart Disease | | | | |
| Stroke | | | | |
| Uterine fibroids | | | | |
| Intellectual Disability | | | | |
| Endometriosis | | | | |
| Early Menopause | | | | |

**Mother's age:** at time of last pregnancy___________ at menopause ____________ ☐ Unknown ☐ s/p hysterectomy

**Do you or anyone in either family have?** Information is used for purpose of making genetic testing and health screening recommendations.

☐ Neural tube defects/spina bifida/anencephaly
☐ Thalassemia
☐ Down syndrome
☐ Hydrocephalus
☐ Stillbirth
☐ 3 or more miscarriages
☐ Cystic fibrosis
☐ Muscular dystrophy
☐ Huntington chorea
☐ Mental retardation
☐ Epilepsy or seizures
☐ Phenylketonuria
☐ Diabetes
☐ Tay-Sachs disease
☐ Sickle cell disease or trait
☐ Hemophilia
☐ Fragile X
☐ Kidney disease
☐ Neurofibromatosis
☐ Any birth defects
☐ Chromosomal disorder
☐ Genetic / inherited disorder
☐ Infertility
☐ Mental illness
☐ Myotonic dystrophy

**Please explain a "Yes" answer to any of the above:** ____________________________________________

____________________________________________________________________________

## Genetic Screening

Have you had any genetic screening or testing? ☐ No ☐ Yes ________________________________________

It is recommended that **all couples/individuals** attempting conception be offered at a minimum cystic fibrosis screening. Additional testing may be recommended based on ethnicity and/or race. Genetic screening can be performed for a specific disease or in panels that look at a wide range of inherited disorders. Please ask your physician if you are interested in genetic screening.

Are you: ☐ Caucasian ☐ Hispanic ☐ Asian ☐ African American
☐ Ashkenazi Jewish ☐ Sephardic Jewish ☐ Mediterranean/French Canadian
☐ Other:_____________________________________________________________

## Sexual Practices

Sexually active ☐ Yes ☐ No

Frequency of vaginal intercourse ☐ _____ x week ☐ _____ x month ☐ only at time of ovulation ☐ N/A

Do you have pain with vaginal penetration? ☐ No ☐ Yes If yes, ☐ external ☐ with deep penetration ☐ both

Comments/Concerns ________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

## History of Evaluation/Treatment for Fertility or Recurrent Pregnancy Loss ☐ N/A

How long have you been having unprotected (no contraceptives/condoms) sex with your current partner? ___________ ☐ N/A

How long have you actively been attempting to conceive with your current partner? _______________________ ☐ N/A

Have you used? ☐ cycle tracking ☐ monitoring mucous changes ☐ temperature charting ☐ ovulation predictor kits

Have you previously been **evaluated** for infertility? ☐ No ☐ Yes If so, who was your physician? ____________________

**Were any of the following tests performed?**

☐ Hysterosalpingogram (HSG) _____ /_____/_____ Results ________________________________________

☐ Sonohystogram (SHG) _____ /_____/_____ Results ________________________________________

☐ Surgery _____ /_____/_____ Results ________________________________________

☐ Chromosomes _____ /_____/_____ Results ________________________________________

☐ Blood tests _____ /_____/_____ Results ________________________________________

Other ________________________________________________________________________________________

**Were any of the following diagnosed?** ☐ Ovulatory Dysfunction/Anovulation ☐ PCOS

☐ Hypothalamic Amenorrhea ☐ Decreased Ovarian Reserve (DOR) ☐ Tubal factor

☐ Male factor ☐ Uterine Abnormality ☐ Fibroids

☐ ______________________________________________________________________________________

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

☐ Clomid ☐ Letrozole ☐ Gonadotropin Injections (Follistim, Gonal-F, Bravelle, Menopur)

☐ Progesterone ☐ Baby aspirin ☐ Heparin/Lovenox

Other ________________________________________________________________________________

**Have you had any of the following treatments?** (TIC = timed intercourse, IUI = intra-uterine or artificial insemination)

Clomid/Letrozole – TIC ☐ No ☐ Yes # with LH kits ____ # using LH kits + ultrasound ____ # using hCG shot + ultrasound ____

Natural Cycle - IUI ☐ No ☐ Yes # with LH kits ____ # using LH kits + ultrasound ____ # using hCG shot + ultrasound ____

Clomid/Letrozole – IUI ☐ No ☐ Yes # with LH kits ____ # using LH kits + ultrasound ____ # using hCG shot + ultrasound ____

Gonadotropin – IUI ☐ No ☐ Yes # with LH kits ____ # using LH kits + ultrasound ____ # using hCG shot + ultrasound ____

IVF ☐ No ☐ Yes # Cycles ________ Did you have Preimpantation Genetic Screening/Diagnosis (PGS/PGD)? ☐ No ☐ Yes

Do you have cryopreserved embryos at another location? ☐ No ☐ Yes Clinic/Bank ____________________________

______________________________________________________________________________________________

**Have you had/used any of the following complimentary therapies**?

Acupuncture ☐ No ☐ Yes Practitioner ________________________________________ ☐ ongoing ☐ discontinued

Herbs/Teas ☐ No ☐ Yes Name(s) ________________________________________ ☐ ongoing ☐ discontinued

Therapy ☐ No ☐ Yes ☐ ongoing ☐ discontinued Yoga ☐ No ☐ Yes ☐ ongoing ☐ discontinued

**Is there anything else you would like us to know?** ________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________