The Center for Reproductive Health

Edwin D. Robins, MD

Patient Questionnaire

Date: _____ **Reason for Visit:** _____

Patient Name: _____
Last First Middle

Date of Birth: _____ **Age:**_____ **Social Security #:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone: (*Home)*_____*(Work)*_____*(Cell)* _____

E-Mail:_____**Pharmacy:** _____

Partner Name: _____

Date of Birth: _____ **Age:**_____ **Social Security #:** _____

Referred By: _____

Current Gynecologist: _____ **Phone:** _____

Address: _____

MEDICAL HISTORY (Please fill in blanks with N/A if question does not apply)

Weight: _____ Height: _____ Blood Type (if known) _____

	YES	NO
Have you lost greater than 20 lbs. of weight in the last year?…….……..	☐	☐
Do you follow a particular food diet or have any special dietary habits?…….	☐	☐
If yes, specify: _____		
Have you ever had an eating disorder (anorexia or bulimia)?…….……..	☐	☐
If yes, specify: _____		
Do you have any allergies to any medications?		☐
☐		
If yes, specify:_____		

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

Exercise: _____ Hrs/Week: _____ Age: _____

Exercise: _____ Hrs/Week: _____ Age: _____

Exercise: _____ Hrs/Week: _____ Age: _____

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

☐ Scarlet Fever
☐ Rheumatic Fever
☐ Tuberculosis
☐ Kidney Infection
☐ Heart Disease
☐ Hirsutism (Excess Hair Growth)
☐ Breast tenderness
☐ Breast soreness
☐ Breast Milky Discharge
☐ Hepatitis
☐ Syphilis
☐ Gonorrhea
☐ Pelvic Infection
☐ Chlamydia
☐ Herpes
☐ Chronic Bronchitis
☐ Measles: Regular
☐ Measles: German
☐ Pneumonia
☐ Nongonococcal Urethritis
☐ Breast Cancer
☐ Vaginitis: Trichomoniasis or Yeast
per year: _____
☐ High Blood Pressure
☐ Gallbladder Problems
☐ Liver Problems
☐ Ulcers
☐ Appendicitis
☐ Colitis
☐ Diabetes
☐ Anemia
☐ Arthritis
☐ Thyroid Problems
☐ Ovarian Cysts
☐ Cervical Cancer
☐ Other Cancer?
Specify: _____
☐ Neurologic Problems
☐ Seizures
☐ Epilepsy
☐ Visual Disturbances
☐ Poor Sense of Smell
☐ Dizziness
☐ Loss of Balance
☐ Chronic Headaches
☐ Blood Transfusions
☐ Parasitic Infection
☐ Endometriosis
☐ Ovarian Cancer

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

Medication	Diagnosis	Dosage/Frequency	Duration

Have you ever taken: ☐ Thyroid medication (e.g. Synthroid)? ☐ Bromocriptine (Parlodel)?

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

Medications	Diagnosis	Dosage/Frequency	Duration

Do you now or have you ever used (check for **all** that apply):
Alcohol ☐ Yes ☐ No If yes, how many glasses per week do you usually drink of the following:

Wine: _____ Beer: _____ Cocktails: _____

Illicit or Recreational Drugs (Marijuana, Cocaine, etc.) ☐ Yes ☐ No If yes, specify below:

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

_____

_____

Do you currently smoke? ☐ Yes ☐ No Total number of years: _____ Number of cigarettes per day: _____

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

What is the usual # of days *between* periods? Minimum_____ Maximum_____

What is the usual duration of your bleeding? Minimum_____ Maximum_____

	YES	NO
Are your periods regular? ……	☐	☐
Do you have PMS? ……...	☐	☐
If yes, is it: ☐ Mild ☐ Moderate ☐ Severe		
Do you have painful periods? ……...	☐	☐
If yes, is it: ☐ Mild ☐ Moderate ☐ Severe		
Do you have to take pain medication for cramps? ……	☐	☐
If yes, please specify medication: _____		
Do you bleed or spot between periods? ……... ……	☐	☐
If you've ever been on oral contraceptives, were your periods regular after you stopped taking the pill?.	☐	☐
Did your mother have any difficulty with conception or pregnancy?……...	☐	☐
Did your mother take diethylstilbestrol (DES) when she was pregnant with you?……..	☐	☐
At what age did your mother begin menopause? _____		
Have you ever used an intrauterine device (IUD)? ……	☐	☐
If yes, please specify type / # years: _____		
Have you ever had pelvic inflammatory disease (PID)? ……..……	☐	☐
If yes, please describe:_____		
Is intercourse painful? ……...	☐	☐
If yes, is the pain: ☐ Mild ☐ Moderate ☐ Severe		

Do you use lubricants for intercourse? …… ☐ ☐

If yes, which brand? _____

YES NO

Do you douche, before or after intercourse ? …… ☐ ☐

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**)?…… ☐ ☐

If yes, what day did you ovulate? _____

Have you used an ovulation predictor kit (**OPK**)?…… ☐ ☐

If yes, what day did you ovulate? _____

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

Have you been exposed to any toxins?…….. ☐ ☐

Do you take vitamins? …….. ☐ ☐

If yes, what kind and how much? _____

What is your ethnic origin (Asian, Hispanic, etc.)_____

Is there a family history of habitual pregnancy loss? …….. ☐ ☐

If yes, who / relationship: _____

Is there a family history of infertility? …… ☐ ☐

If yes, who / relationship:_____

Is there a history of hormonal disorders in your family? …… ☐ ☐

If yes, who / relationship: _____

Is there a family history of birth defects? …… ☐ ☐

If yes, who / relationship: _____

PREGNANCY HISTORY (Please do not leave empty blanks, use N/A when needed)

1. How many prior pre-term (less than 37 weeks) births have you had?_____.
2. How many full term (37 weeks or longer) births have you had? _____.
3. How many pregnancies (including abortions) have you had? _____.
4. How many spontaneous abortions have you had? _____.

Please fill in chart below:

Pregnancy #	Year	End in miscarriage or abortion? YES or NO	Ectopic Pregnancy?	Infertility therapy used to concieve? (IVF/IUI/clomid)	How long to conceive?	Baby born alive?	Vaginal delivery or C-Section?	Is current partner the father?
1st								
2nd								
3rd								
4th								
5th								

SURGICAL HISTORY (Please do not leave blanks empty, write N/A where necessary)

Have you ever been surgically sterilized? ☐ Yes ☐ No

How many operations have you had? _____

Date	Hospital	Procedure	Findings	Surgeon

OTHER TESTING

- ❑ Laparoscopy Date: _____ Results: _____
- ❑ Hysteroscopy Date: _____ Results: _____
- ❑ Thyroid Tests Date: _____ Results: _____
- ❑ Rubella Date: _____ Results: _____
- ❑ HIV Date: _____ Results: _____
- ❑ PAP Smear Date: _____ Results: _____
- ❑ Mammogram Date: _____ Results: _____
- ❑ Sickle Cell Date: _____ Results: _____
- ❑ Tay Sachs Date: _____ Results: _____
- ❑ Other-Specify: _____ Date: _____ Results: _____

HISTORY OF FERTILITY THERAPY (Please do not leave blanks empty, write N/A where necessary)

Have you been treated for infertility before?

- ❑ YES
- ❑ NO

If yes, who was your physician: _____

Physician's Address: _____

What cause of infertility was diagnosed? _____

Which of the following tests have you had performed? Check **all** that apply.

- ❑ Postcoital Test Date: _____ Results: _____
- ❑ Day 3, FSH, Estradiol Date: _____ Results: _____
- ❑ Endometrial Biopsy Date: _____ Results: _____
- ❑ Hysterosalpingogram Date: _____ Results: _____
- ❑ Antisperm Antibodies Date: _____ Results: _____
- ❑ Mycoplasma/Chlamydia Cultures Date: _____ Results: _____
- ❑ Sickle Cell Date: _____ Results: _____
- ❑ Tay Sachs Date: _____ Results: _____
- ❑ Other – Specify: _____ Date: _____ Results: _____

HISTORY OF FERTILITY CYCLES (Place N/A in non-applicable blanks)

Clomiphene (Clomid) Citrate

Dates	# of Cycles	Max Starting Dose	Max # Follicles	# with Inseminations	# of Cycles Resulting in pregnancy

Number of prior Gonadotropin cycles: _____.

Gonadotropin (Follistim, Gonal-F, etc.)

Dates	# of Cycles	Max Starting Dose	Max Estradiol	Max # Follicles	# with Inseminations	# of Cycles resulting in pregnancy

HISTORY OF IVF CYCLES (Place N/A in non-applicable blanks)

Number of prior fresh ART (IVF) cycles:_____. Number of prior frozen ART (IVF) cyles: _____.

Please Circle Y (Yes) or N (No), where indicated.

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

Comments:

_____

_____

_____

_____

MALE DATA (Please do not leave blanks empty, write N/A where necessary)

Name: _____
First M.I. Last

Have you had a vasectomy?_____ If yes, what year:_____ Physician:_____

Have you had a vasectomy reversal?_____ If yes, what year:_____ Physician:_____

Marriage #: _____

Number of pregnancies conceived with current partner: _____

Number of pregnancies conceived with previous partner(s): _____

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

Date of Pregnancy	Pregnancy Outcome		
	Delivered	Aborted	Miscarried

Urologist: _____

Address: _____ Phone: _____

Have you ever had a semen analysis (sperm count) performed? ☐ Yes ☐ No

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

Do you have any medical problems unrelated to your fertility?

Nature of Problem (Diagnosis)	Treatment	Physician

MALE HISTORY (Please do not leave blanks empty, write N/A where necessary)

Have you ever had any surgery? ☐ Yes ☐ No If yes, please complete chart below.

Date	Type of Operation	Physician

Do you take any medications? ☐ Yes ☐ No If yes, please complete chart below.

Medication	Diagnosis	Dosage/Frequency	Duration

Do you now or have you ever used (check **all** that apply):
Alcohol ☐ Yes ☐ No If yes, how many glasses per week do you usually drink of the following:
Wine: _____ Beer: _____ Cocktails: _____
Cigarettes ☐ Yes ☐ NoIf yes, how many packs per day: _____ Number of years total: _____
Illicit or Recreational Drugs (Marijuana, Cocaine, etc.) ☐ Yes ☐ No If yes, specify below:
If you would feel more comfortable not writing anything down please discuss this directly with your physician.

_____

_____

_____

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? ……	☐	☐
Have you had any serious injuries to your genitals? ……..……..	☐	☐
Have you had any infections of your penis, testicles or prostate gland? ……	☐	☐
Is there any history of birth defects in your family? ……...	☐	☐
Is there any history of recurrent miscarriage in your family? …….	☐	☐
Do you have any allergies to medications? ……..……	☐	☐

If yes, please specify medication: _____

What is your ethnic origin (Asian, Hispanic, etc.):_____

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:

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