



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

**New Patient Questionnaire**

Name: \_\_\_\_\_ Partner's Name: \_\_\_\_\_  
 Birthdate: \_\_\_\_\_ Partner's Birthdate: \_\_\_\_\_  
 Social Sec.#: \_\_\_\_\_ Social Sec.#: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Occupation: \_\_\_\_\_

Height: \_\_\_\_\_  
 Weight: \_\_\_\_\_

<b>Office Use Only</b>
BMI: _____
BP: _____

Reason for your visit: \_\_\_\_\_

If infertility, how long have you been trying? \_\_\_\_\_ Years \_\_\_\_\_ Months

How long have you and your partner (if applicable) been together? \_\_\_\_\_

**Reproductive History**

When was the first day of your most recent period?	
At what age did you begin having periods?	
Are your periods regular?	<input type="checkbox"/> Yes <input type="checkbox"/> No
How long is your menstrual cycle (the interval between the first day of one period and the first day of the next?) <i>(Please give range if cycles are irregular)</i>	
Do you currently take medicine to bring on a period?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have bleeding between periods?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have pain with your periods? If yes, is the pain: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you often have pelvic pain between periods?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have pain with intercourse?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had a pelvic infection (i.e. chlamydia, gonorrhea)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you ever have discharge from your breasts?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you currently have acne?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you have unwanted hair growth? If yes, where? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever used birth control? If yes, what type? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was your last pap smear normal? Date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been told you have endometriosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Fertility History**

**Please list all of your previous pregnancies below (include miscarriages, abortions and ectopics)**

	Year	How Long to Conceive?	Fertility Treatment (Y/N)	Outcome*	Current Partner (Y/N)
1.					
2.					
3.					
4.					
5.					

**\*Please indicate if vaginal delivery, C-section, ectopic, miscarriage, or termination of pregnancy**

**Previous Testing**

**Please check off which of the tests below you have had. Indicate result and date.**

Test	Result (normal/abnormal)	Date
Hysterosalpingogram	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Hysterosonogram	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Ultrasound of the uterus/ovaries	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Laparoscopy	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Laparotomy (open surgery)	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Hysteroscopy	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Semen Analysis	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Endometrial Biopsy	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Blood Tests (i.e. FSH, TSH)	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	

**Infertility Treatments**

**Please indicate which of the following treatments you have had, number of times, and outcome.**

<b><u>Treatment</u></b>	<b><u># of Times</u></b>	<b><u>Outcome</u></b>
Clomiphene Citrate		
Inseminations		
Injectible Fertility Medicines		
IVF		
IVF with ICSI		

**Personal Medical History**

Have you ever had surgery? (list type and dates)

\_\_\_\_\_

Do you have any medical problems?

\_\_\_\_\_

List all medications you take on a regular basis

\_\_\_\_\_

List all medical allergies

\_\_\_\_\_

Do you smoke?    Yes       No      If yes, how many packs/day: \_\_\_\_\_

Do you drink?     Yes       No      If yes, how many drinks/day: \_\_\_\_\_

Do you use recreational drugs?                       Yes       No

    If yes, which? \_\_\_\_\_

How much do you exercise? (please describe)

\_\_\_\_\_

**Genetic Risk Factors**

**Please indicate if you or your partner are members of any of the groups below, so that we may counsel you regarding recommended genetic tests.**

	<b>Self</b>	<b>Partner</b>
Mediterranean (i.e. Italian, Greek, Middle Eastern)	<input type="checkbox"/>	<input type="checkbox"/>
Southeast Asian (i.e. Indian, Chinese, Filipino)	<input type="checkbox"/>	<input type="checkbox"/>
Ashkenazi Jewish	<input type="checkbox"/>	<input type="checkbox"/>
French Canadian or Cajun	<input type="checkbox"/>	<input type="checkbox"/>
African American or African descent	<input type="checkbox"/>	<input type="checkbox"/>
Hispanic (please indicate country: _____)	<input type="checkbox"/>	<input type="checkbox"/>

**Please indicate if you or your partner have a family history of any of the following:**

	<b>Self</b>	<b>Partner</b>
Down Syndrome, Fragile X or mental retardation	<input type="checkbox"/>	<input type="checkbox"/>
Neural Tube defect	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Miscarriages	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (if yes, type:_____)	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>
Other genetic disorders or birth defects Please describe:_____	<input type="checkbox"/>	<input type="checkbox"/>

**Male Partner's Information**

Name: \_\_\_\_\_

Social Sec. #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

	<b>Yes</b>	<b>No</b>
Have you ever been involved in a pregnancy? If yes, how many? _____ If yes, was this/ were these with your current partner?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a sexually transmitted infection?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had the mumps?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever suffered from sexual/erectile dysfunction?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever suffered injury to your testicles?	<input type="checkbox"/>	<input type="checkbox"/>
Do you engage in body building?	<input type="checkbox"/>	<input type="checkbox"/>
Do you take hot baths, use hot tubs, or saunas?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been exposed to toxic substances? If yes, describe: _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any medical conditions? If yes, describe: _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently taking any medicines on a regular basis? If yes, list: _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke? If yes, how many packs/day? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink? If yes, how many drinks/week? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you use recreational drugs? If yes, which ones? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had abdominal or genital surgery? If yes, describe: _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any infertility tests? If yes, which ones? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a Semen Analysis? If yes, was it normal? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been seen by a urologist?	<input type="checkbox"/>	<input type="checkbox"/>