

New Patient Questionnaire



Name _____ Home Phone _____

Address _____ Work Phone _____

DOB _____ Age _____ Occupation _____

SS# _____ Married _____ Single _____ Divorced _____ Widowed _____

Spouse/Partner Name _____

Referred by _____ Referring physician address _____

Primary Care M.D. _____

I am here today for the following reason(s):

- _____ menstrual problems
- _____ unable to conceive
- _____ prior miscarriages
- _____ reversal of tubal ligation
- _____ menopause (hormonal therapy)
- _____ excess hair growth
- _____ breast problems
- _____ other (explain below):

For Those Couples Seeking Infertility Services

How long have you been attempting to become pregnancy? _____ years.

Please circle prior testing you may have had done:

- a. Basal body temperature charts
- e. hysterosalpingogram
- b. blood hormone tests
- c. postcoital test
- d. endometrial biopsy
- g. laparoscopy
- d. semen analysis
- h. hysteroscopy

What infertility diagnosis have you been given by your prior physician as to why pregnancy has not occurred? _____

Are you interested in information about adoption? _____

Are you interested in counseling services or infertility/miscarriage support group? _____

Clinician Use only Signature _____ Date _____

New Patient Questionnaire

Menstrual History

Approximate age of 1st menstrual period _____

Starting date of last period _____

Starting date of period before that _____

Number of days that bleeding lasts _____

Number of days from day 1 of period to day 1 of next period _____

Amount of menstrual bleeding (number of pads/tampons per day) _____

Do you ever have bleeding after intercourse? _____

Do you spot or stain before your period flow starts? _____

Do you have cramps with your period? YES NO

If yes, are your cramps getting worse? _____

Is intercourse painful? _____

Do you have pelvic pain when not menstruating? _____

If you have had menopause, at what age? _____

Gynecologic History

Date of: Last pelvic exam _____

Last Pap Smear _____, Was it normal? _____

Have you ever had a mammogram? YES NO. If so, when and was it normal? _____

Have you ever had and abnormal of the following: (If yes, when? _____)

Hair growth pattern Yes _____ No _____

Breast discharge Yes _____ No _____

Pap smear Yes _____ No _____

If yes, did you have your cervix frozen, cone resected, or lasered, or LEEP resected?

Have you ever been treated for: (If yes, when? _____)

Gonorrhea Yes _____ No _____

Syphilis Yes _____ No _____

Herpes Yes _____ No _____

Chlamydia Yes _____ No _____

Have you been tested for the AIDS virus? _____ If so, when? _____

Have you ever used: Birth Control Pills Yes _____ No _____

Intrauterine device Yes _____ No _____

Diaphragm Yes _____ No _____

Please list dates and name of birth control pill or IUD used if you can: _____

Clinician Use only Signature _____ Date _____

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Obstetrics History

Please list all your pregnancies including miscarriages or abortions:

Date	# weeks pregnant	Miscarriage	Abortion	Type of Delivery, vaginal or C/S	Living	Complications

What is your blood type if known? _____ If you are Rh negative, did you have Rhogam with prior pregnancies? _____ Husbands blood type? _____

Medical History

Do you have any medication or food allergies? If so, please list _____

Please list any medications you currently or intermittently take including dosage: _____

Do you usually take antibiotics before surgeries or dental procedures? YES NO

Have you ever had?

Rubella (German measles)	YES	NO	Measles	YES	NO
Chicken Pox	YES	NO	Hepatitis	YES	NO

Do you have a history of (please check):

Stroke	_____	Gall bladder disease	_____
Seizure disorder	_____	Bowel problems	_____
Emotional problems	_____	Kidney infections	_____
High blood pressure	_____	Kidney stones	_____
Diabetes	_____	Bladder infections	_____
Heart disease	_____	Loss of urine	_____
Heart murmur	_____	Liver problems	_____
Asthma	_____	Arthritis	_____
Tuberculosis	_____	Easy bruising	_____
Thyroid disease	_____	Cancer	_____
Hepatitis	_____	Rheumatic fever	_____
Ulcers	_____	Other	_____

For any diseases checked, please list treatments and dates: _____

Clinician Use only Signature _____ Date _____

New Patient Questionnaire

Surgical History

Have you had any surgery specifically on the uterus, fallopian tubes, ovaries, or bowels?

Type	Year	Reason for surgery

Have you had any other types of surgery?

Type	Year	Reason for surgery

Other hospitalizations or serious illness? _____

Family History and Genetic Screening

My ethnic background is:

- African American _____
- Italian, Greek, or Mediterranean _____
- Eastern European Jewish _____
- Philippine or Southeast Asian _____
- Northern European/Caucasian _____

Have you been tested for:

- Tay-Sachs _____
- Sickle Cell Trait _____
- Alpha-thalassemia minor _____
- Beta-thalassemia minor _____

Does anyone in your family have the following problems?

Infertility _____	Any birth defect _____
Recurrent miscarriage _____	Adult cystic kidney disease _____
Cystic Fibrosis _____	Adult neurologic disease _____
Sickle cell trait/dis. _____	Muscular dystrophy _____
Tay-Sachs _____	Spina bifida _____
Thalassemia _____	Neural tube defects _____

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Club foot _____ Brain or leg blood clots _____

Cleft lip or palate _____ Heart birth defects _____

Mental illness _____ Mental retardation _____

If answered yes to any of the above, how are you related to the person? _____

Is there a family history of cancer of the cervix, uterus, ovary, or breast? _____

If yes, please list the type of cancer, relationship to you, treatment, and whether living or deceased

Did your mother take Diethylstilbesterol (DES) while pregnant with you? _____

Have you or anyone in your family had an adverse reaction to anesthesia? _____

Social History

Do you now or have you ever smoked cigarettes? _____

If yes, how many packs per day and for how many years? _____

Do you drink alcohol? _____ If so, how many drinks per week? _____

Do you now or have you ever used recreational drugs? _____

If yes, what drug, when, and how much? _____

Have you ever worked with toxic chemicals, heavy metals, or ionizing radiation? When, which, and how long? _____

Do you exercise? _____ If so, how many hours per week? _____

Are you married? _____ If so, how long? _____

If not married, are you sexually active? _____ Contraceptive type? _____

Primary Care Surveillance

Are your childhood immunizations up to date? YES NO DON'T KNOW

Last cholesterol test: _____

Last fecal blood test: _____

Last tetanus shot: _____

Domestic safety screening:

1. Do you feel safe in your home? _____ yes _____ no.

2. Are you now or have you been a victim of abuse? _____ yes _____ no

3. Are there issues you or your partner would like to discuss alone with a clinician?

_____ yes _____ no

Clinician Use only Signature _____ Date _____

New Patient Questionnaire

General health screening questions:

1. Has your weight changed by more than 10 pounds in the last 30 days? ___yes ___no

2. If yes, were you attempting to lose weight? _____ yes _____no

3. Do you suffer from any of the following problems?

Chronic nausea and/or vomiting? _____ yes _____no

Chronic constipation? _____ yes _____no

Chronic diarrhea? _____ yes _____no

4. Do you have difficulty performing activities of daily living such as:

Dressing yourself? _____ yes _____no

Walking? _____ yes _____no

Eating? _____ yes _____no

Feeding yourself? _____ yes _____no

5. Are there any health problems that you would like to discuss with our physician or nurse today that you have not addressed with your primary care physician?

Clinician Use only Signature _____ Date _____

New Patient Questionnaire

Male's History

Name _____ Home Phone _____

Address _____ Work Phone _____

DOB _____ Age _____ Occupation _____ SS# _____

Have you ever had:	YES	NO
Mumps involving the testicles	_____	_____
Injury to the testicles	_____	_____
Birth defects involving the penis or testicles	_____	_____
Prostate trouble	_____	_____
Diabetes or other endocrine disorder	_____	_____
Gonorrhea or syphilis	_____	_____
Surgery of the pelvis, testes, or hernia repair	_____	_____

If yes to any above, please list and explain including dates _____

Have you ever fathered a pregnancy (including elective abortions or miscarriages)? _____

If yes, when and time to conceive _____

Have you tried to achieve a pregnancy with a prior partner? _____ For how long? _____

Frequency of intercourse per week? _____

How often does intercourse result in ejaculation?

0% _____ 25% _____ 50% _____ 75% _____ > 90% of the time _____

Have you had a sperm count? _____ When? _____

Did it show: normal results _____ decreased sperm numbers _____
abnormal sperm motility _____ dead sperm _____ abnormal sperm shape _____

Do you have difficulty with?

Premature ejaculations YES NO

Difficulty maintaining an erection YES NO

Difficulty penetrating the vagina YES NO

Male Social History

Do you now or have you ever smoked cigarettes? _____

If yes, how many packs per day and for how many years? _____

Do you drink alcohol? _____ If so, how many drinks per week? _____

Clinician Use only Signature _____ Date _____

New Patient Questionnaire

Do you now or have you ever used recreational drugs? _____

If yes, what drug, when, and how much? _____

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Do you exercise? _____ If so, how many hours per week? _____

Male Family History and Genetic Screening

My ethnic background is? African American _____

Italian, Greek, or Mediterranean _____

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Philippine or Southeast Asian _____

Northern European/Caucasian _____

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Cystic Fibrosis _____ Adult neurologic disease _____

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Tay-Sachs _____ Spina bifida _____

Thalassemia _____ Neural tube defects _____

Club foot _____ Brain or leg blood clots _____

Cleft lip or palate _____ Heart birth defects _____

Mental illness _____ Mental retardation _____

If answering yes to any of the above, how are you related to the person? _____

Did your mother take Diethylstilbesterol (DES) while pregnant with you? _____

List any significant illnesses you have had _____

List any medications taken in the last year _____

Clinician Use only Signature _____ Date _____