Palo Alto Medical Foundation
A Sutter Health Affiliate

Reproductive Endocrinology & Fertility Female Patient Questionnaire

Please answer the questions to the best of your ability. Leave blank any questions to which you do not know the answer. If you are uncomfortable with any question, you may leave it blank.

IDENTIFYING INFORMATION

Date of initial appointment: ______________________ SSN: ______________________

Name: ______________________ Partner's Name: ______________________

Address: ______________________

Telephone Number – Day: ______________________ Evening: ______________________

Current Age: ________ Date of Birth: ________ Height: ________ Weight: ________ Partner's Date of Birth: ________

E-mail address: ______________________

Have you heard of PAMFOnline: ❑ Yes ❑ No Are you registered with them: ❑ Yes ❑ No

Would you like more information on it? ❑ Yes ❑ No

EMPLOYMENT

Please describe all current employment including job title, description of responsibilities, duration of employment.

____

____

____

____

GYNECOLOGICAL HISTORY

How old were you when you had your first period? ________ How frequently do your periods come? every ________ days.

How long do your periods last? ________ days. When did your last period start? ________

Do you experience cramping with your period? ❑ Yes ❑ No

If yes, when during your cycle does the pain occur? (circle all that apply) Before During After

How would you describe the cramps? ❑ Mild ❑ Moderate ❑ Severe

Do you take pain medication for cramps? ❑ Yes ❑ No

If yes, please specify medication ______________________

Do you bleed or spot between periods? ❑ Yes ❑ No If yes, please describe ______________________

When was your last Pap smear? ________ Was it normal? ❑ Yes ❑ No

Have you ever had an abnormal Pap smear result? ❑ Yes ❑ No If yes, what therapy was required?

❑ repeat Pap smear ❑ antibiotics ❑ colposcopy (microscope evaluation) ❑ biopsy

❑ cryotherapy (freezing of cervix) ❑ laser therapy ❑ cone biopsy ❑ loop excision (LEEP)

❑ other ______________________

FORM n0434 (November 2004)

Have you ever had any of the following infections involving any part of the reproductive tract (vagina, cervix, uterus, fallopian tubes, ovaries)? Check all that apply

❑ yeast ❑ Chlamydia ❑ trichomonas ❑ gonorrhea ❑ herpes ❑ syphilis ❑ genital warts

Have you ever had a mammogram? ❑ Yes ❑ No If yes, when? ____________ Result? ❑ normal ❑ abnormal

Do you have pain with intercourse? ❑ never ❑ sometimes ❑ frequently ❑ always

How frequently do you and your partner have intercourse? ______________ per week/month (circle)

How frequently do you and your partner have intercourse around ovulation? ______________ per week.

Have you ever used contraception in the past? ❑ Yes ❑ No If yes, please check all that apply below

❑ contraceptive pills ❑ condoms ❑ diaphragm ❑ IUD ❑ foam/sponge ❑ rhythm ❑ withdrawal ❑ other

Do you use herbal medications? ❑ Yes ❑ No If yes, please specify types of medications used ____________________

FERTILITY EVALUATION

1. How long have you and your partner been attempting to achieve pregnancy? ______________________________

2. Have you ever conceived a pregnancy with a different partner? ❑ Yes ❑ No

3. Have you ever *tried* to achieve a pregnancy with a different partner? ❑ Yes ❑ No

4. Have you been treated for infertility previously? ❑ Yes ❑ No

   If yes, where/when? ______________________________

   What was the cause of infertility? ______________________________

5. Have you ever had any of the following tests performed?

   ❑ Basal body temperature
   ❑ Postcoital test
   ❑ Hormonal test
   ❑ Thyroid test
   ❑ Infection test (mycoplasma, chalmydia)
   ❑ Endometrial biopsy
   ❑ Ultrasound
   ❑ Hysterosalpingogram (dye, x-ray test)
   ❑ Laparoscopy
   ❑ Hysteroscopy
   ❑ Sonohysterogram
   ❑ Antibody tests

6. Have you ever taken any of the medications listed below

   ❑ clomiphene citrate (Clomid, Serophene)
   ❑ injectable gonadotropins (Pergonal, Humegon, Metrodin, Fertinex, Gonal-F, Follistim, Repronex)
   ❑ steroids (medrol, prednisone, dexamethasone)
   ❑ bromocriptine (Parlodel or Dostinex)
   ❑ heparin
   ❑ aspirin (baby)
   ❑ hCG
   ❑ estrogens (Estrace, Estraderm)
   ❑ testosterone or male hormone
   ❑ GnRH agonist (Lupron, Synarel, Zoladex)
   ❑ progesterone (suppositories, injections, Crinone, Prometria)
   ❑ progestins (Provera, Cycrin)
   ❑ danazol (Danocrine)
   ❑ Metformin (Glucophage)

7. Have you ever had intrauterine inseminations? ❑ Yes ❑ No

   If yes, specimen was provided by (check all that apply) ❑ Partner ❑ Donor

8. Have you ever attempted in vitro fertilization? ❑ Yes ❑ No

   If yes, please specify below (if known)

Date	Location	# Vials of meds/day	# Eggs retrieved	ICSI?* (Y/N)	# Eggs fertilized	# Embryo transferred	Pregnancy? (Y/N)	Outcome

*Intracytoplasmic sperm injection

OBSTETRICAL HISTORY

Have you ever been pregnant (including elective terminations, miscarriages, births)? ❑Yes ❑No

Date	Outcome	How long to conceive?	Infertility therapy?	Complications with pregnancy?	Is current partner the father?

PAST MEDICAL HISTORY

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

- ❑ Acne
- ❑ Anemia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Autoimmune disease (eg. Lupus, rheumatoid arthritis)
- ❑ Blood transfusion
- ❑ Breast (nipple) discharge
- ❑ Breast disease
- ❑ Breast tenderness
- ❑ Chicken pox
- ❑ Chronic bronchiti
- ❑ Chronic headaches
- ❑ Cancer? (Specify) ______________
- ❑ Colitis
- ❑ Cystic fibrosis
- ❑ Color blindness
- ❑ Diabetes
- ❑ Dizziness
- ❑ Endometriosis
- ❑ Gallbladder disease
- ❑ Hair loss
- ❑ Heat/cold intolerance
- ❑ Heart disease
- ❑ Hepatitis
- ❑ Hirsutism (excess hair growth)
- ❑ High blood pressure
- ❑ Hot flashes
- ❑ Kidney problems
- ❑ Liver problems
- ❑ Loss of balance
- ❑ Measles: German
- ❑ Measles: regular
- ❑ Mumps
- ❑ Neurological problems
- ❑ Ovarian cysts
- ❑ Poor sense of smell
- ❑ Pneumonia
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ Seizures
- ❑ Thyroid problems
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Vision problems

Immunizations

- ❑ Tetanus
- ❑ Hepatitis B
- ❑ German Measles (rubella)
- ❑ Polio
- ❑ Mumps
- ❑ Tuberculosis
- ❑ Chicken pox

REVIEW OF SYSTEMS

Do you presently have any problems or symptoms in the following areas? Circle YES or NO below. If YES, please give explanation

		Patient Comments:	Physician Comments
Constitutional (good general health lately)	YES/NO		
Eyes	YES/NO		
Ears/Nose/Mouth/Throat	YES/NO		
Cardiovascular (heart/blood vessels/circulation)	YES/NO		
Gastrointestinal (stomach/intestines)	YES/NO		
Genitourinary (genitals/sexual functions/kidney/bladder)	YES/NO		
Neurological (brain/nervous system)	YES/NO		
Integumentary (skin areas and/or breasts)	YES/NO		
Psychiatric (emotions/mood/memory)	YES/NO		
Musculoskeletal (bones/joints/muscles)	YES/NO		
Endocrine (hormones/metabolism/thyroid)	YES/NO		
Allergic/immunological (allergies/immune system)	YES/NO		
Hematologic/Lymphatic (blood or bleeding problems; lymph nodes or "swollen glands")	YES/NO		

PAST SURGICAL HISTORY

Have you ever had any surgeries in the past? ❑Yes ❑No

If yes, please indicate date, type, findings of surgery below

______________________ ____

______________________ ____

MEDICATIONS

Are you allergic to any medications? ❑Yes ❑No If yes, please indicate name of medication and type of reaction it causes below Medications Reaction

______________________ ____

______________________ ____

Are you currently taking any prescription medications? ❑Yes ❑No If yes, please indicate below

Medications Reason

______________________ ____

______________________ ____

Are you currently taking any over-the-counter medications? ❑Yes ❑No If yes, please indicate below

Medications Reason

______________________ ____

______________________ ____

SOCIAL HISTORY

Are you currently married/domestic partner?______________ If so, how long?______________

Have you previously been married?______________

Do you smoke?__________ If so, how many packs per day? __________

Do you drink alcohol?__________ If so, how many alcoholic beverages per week? __________

Do you use illicit (illegal) drugs?__________ If so, please list ______________________

Do you exercise regularly?__________ If so, please indicate type of exercise and estimate hrs/week spent in this activity.

Type	Hours/week	Type	Hours/week

Have you had a significant weight change in the last year? ❑Yes ❑No

If yes, please indicate ❑weight gain __________ lbs ❑weight loss __________ lbs

Do you follow a particular food diet? ❑Yes ❑No

❑vegetarian ❑diet plan name ______________________ ❑other ______________________

FAMILY HISTORY

Have any of these illnesses occurred in your family? Check all that apply and indicate relationship to you:

Illness	Relationship to you	Illness	Relationship to you
❑ high blood pressure		❑ ovarian cancer	
❑ diabetes		❑ colon cancer	
❑ heart disease		❑ other	
❑ breast cancer			

Form completed by ______________________ Relationship to patient ______________________

(please print) (write self if you are the patient)