New Patient Questionnaire

PART I: CONTACT INFORMATION

First Name_____**Middle Initial** _____ **Last Name**_____ Age_____

Date of Birth (MM/DD/YY) _____/_____/_____ Occupation _____

Home Street Address _____

City _____State_____ Zip/Postal Code_____ Country_____

Indicate which number to call or leave messages.

☐ Home Phone ( )_____ ☐ Work Phone ( )_____ ☐ Cell Phone ( ) _____

Are you married? ☐ Yes ☐ No ☐ Divorced ☐ Other

Spouse/Partner's First Name_____**Middle Initial** __ **Last Name**_____ Age_____

☐ Not Applicable

Date of Birth (MM/DD/YY) _____/_____/_____ Occupation _____

Home Street Address _____

City _____State_____ Zip/Postal Code_____ Country_____

Indicate which number to call or leave messages.

☐ Home Phone ( )_____ ☐ Work Phone ( )_____ ☐ Cell Phone ( ) _____

Who referred you?

☐ Physician Name_____ Phone ( ) _____

Address_____

☐ Former Patient/Friend _____

☐ Web Site _____

☐ Insurance (Name of Insurance) _____

Who is your Ob/Gyn?

Name _____Phone ( ) _____

Address_____

Who is your Primary Care Physician?

Name _____Phone ( ) _____

Address_____

Physician Notes
(for office use only)

_____

_____

_____

_____

_____

_____

_____

2828 Chicago Avenue South #400
Minneapolis, MN 55407
p. 612.863.5390 f. 612.863.2697

991 Sibley Memorial Highway #100
Saint Paul, MN 55118
p. 651.379.3110 f. 651.379.3111

PART II: FEMALE MEDICAL HISTORY AND INFORMATION

Reason for Visit: ☐ InfertilityEvaluation ☐ Insemination ☐ Other _____

What are your expectations for this visit? _____

What questions do you want answered at this visit? _____

_____

Do you have any personal, ethical, or religious objections to any of our tests or treatments such as insemination, in vitro fertilization, egg donation, sperm donation, masturbation to collect a semen sample, etc.? ☐ Yes_____☐ No ☐ NA

How many months have you been having intercourse without using any form of birth control?_____☐ NA

Pregnancy Summary

• Total Number of ALL Pregnancies:_____ • Number of Miscarriages (less than 20 weeks):_____

• Number of Ectopic/Tubal Pregnancies: _____ • Number of Elective Terminations (Abortions): _____

• Number of Full Term Deliveries: _____ Of these, how many were live births?____How many were stillborn?____

• Number of Premature (less than 37 weeks) Deliveries: _____Of these, how many were live births?___

How many were stillborn?___ • Any Pregnancies with Birth Defects? ☐ Yes-explain_____ ☐ No

	Date Pregnancy Ended or Delivered	Months to Conception	Treatments to Conceive	Delivery Type/D&C/ Complications	Current Partner?
1.	_____	_____	_____	_____	☐ Y ☐ N
2.	_____	_____	_____	_____	☐ Y ☐ N
3.	_____	_____	_____	_____	☐ Y ☐ N
4.	_____	_____	_____	_____	☐ Y ☐ N
5.	_____	_____	_____	_____	☐ Y ☐ N
6.	_____	_____	_____	_____	☐ Y ☐ N

Menstrual History

• Menstrual cycle pattern (check all that apply): ☐ Regular periods ☐ Irregular periods ☐ Spotting before periods ☐ No periods ☐ Heavy periods ☐ Light periods ☐ Bleeding between periods

• Number of days between the start of one period to the start of the next period: _____ days

• How many days of bleeding do you have? _____ days

• Do you need medication to bring on a period? ☐ Yes-what type? _____ ☐ No

• Do you have severe cramping or pelvic pain with your periods? ☐ Yes: __Always __Sometimes __Recently __In the past ☐ No

• Have you used over-the-counter ovulation kits to time intercourse? ☐ Yes ☐ No

SexualHistory

• Are you sexually active? ☐ Yes ☐ No

• How many times do you have intercourse per week? _____Times per week ☐ None ☐ Not applicable

• Do you have pain with intercourse? ☐ Yes ☐ No

• Do you use lubricants (K-Y Jelly®, etc.) during intercourse? ☐ Yes-what types?_____ ☐ No

• Have you had any of the following sexually transmitted diseases or pelvic infections? ☐ Yes (check all that apply) ☐ No

☐ Chlamydia-date_____ ☐ Gonorrhea-date_____ ☐ Syphilis-date_____

☐ HIV/AIDS-date_____ ☐ Hepatitis-date_____ ☐ Other-date_____

Pap Smear History

Have you undergone any procedures as a result of an abnormal pap smear?

☐ Yes (check all that apply) ☐ No

☐ Colposcopy ☐ Cryosurgery (Freezing) ☐ Laser treatment ☐ Conization ☐ LEEP procedure

Breast Screening History

Have you ever had a mammogram? ☐ Yes-date_____ Result: ☐ normal ☐ abnormal-explain _____ ☐ No

Medical History

Are you allergic to any medications? ☐ Yes ☐ No

If yes, please list and describe reactions: _____

_____

Are you allergic to any foods (peanuts, eggs, etc.)? ☐ Yes ☐ No

If yes, please list and describe reactions: _____

_____

List any medications you are currently taking, including over-the-counter medicines. _____

_____

Do you take any herbal medicines/vitamins or health food store supplements? ☐ Yes ☐ No

If yes, please list : _____

_____

Do you have any medical problem(s)? ☐ Yes (Please list type, dates, and treatments.) ☐ No

Surgical History

Have you had any surgeries? ☐ Yes (List all surgeries in chronologic order.) ☐ No

Year	Reason and Type of Surgery
(l)_____	(1) _____
(2) _____	(2) _____
(3) _____	(3) _____
(4) _____	(4) _____
(5) _____	(5) _____

Social History

How many caffeinated beverages (coffee, tea, soda) do you drink per day? _____ ☐ None

Do you smoke cigarettes? ☐ Yes How many/day?_____ How many years?_____ ☐ Quit-when?_____ ☐ No

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per week? _____ _____

Have you casually used marijuana, cocaine, or any other similar drug? ☐ Yes-describe_____ ☐ No

Do you exercise? ☐ Yes (describe) ☐ No

FamilyHistory

	Living	Cause of Death/Age at Death
Mother	☐ Yes - age___ ☐ No	_____
Father	☐ Yes - age___ ☐ No	_____
Brother(s)	☐ Yes - age___ ☐ No	_____
Sister(s)	☐ Yes - age___ ☐ No	_____
Maternal Grandmother	☐ Yes - age___ ☐ No	_____
Maternal Grandfather	☐ Yes - age___ ☐ No	_____
Paternal Grandmother	☐ Yes - age___ ☐ No	_____
Paternal Grandfather	☐ Yes - age___ ☐ No	_____

Disorders in You/Your Family

	Self or Relationship to You		
Birth defects	☐ Yes _____	☐ No	☐ Don't Know
Blood clots	☐ Yes _____	☐ No	☐ Don't Know
Bone/Skeletal Defects	☐ Yes _____	☐ No	☐ Don't Know
Breast cancer	☐ Yes _____	☐ No	☐ Don't Know
Colon cancer	☐ Yes _____	☐ No	☐ Don't Know
Ovarian cancer	☐ Yes _____	☐ No	☐ Don't Know
Other cancer	☐ Yes _____	☐ No	☐ Don't Know
Cystic Fibrosis	☐ Yes _____	☐ No	☐ Don't Know
Deafness/Blindness	☐ Yes _____	☐ No	☐ Don't Know
Developmental delay	☐ Yes _____	☐ No	☐ Don't Know
Diabetes	☐ Yes _____	☐ No	☐ Don't Know
Down syndrome	☐ Yes _____	☐ No	☐ Don't Know
Other chromosome defects	☐ Yes _____	☐ No	☐ Don't Know
Endometriosis	☐ Yes _____	☐ No	☐ Don't Know
Heart disease	☐ Yes _____	☐ No	☐ Don't Know
Hemochromatosis	☐ Yes _____	☐ No	☐ Don't Know
Hemophilia	☐ Yes _____	☐ No	☐ Don't Know
Infertility	☐ Yes _____	☐ No	☐ Don't Know
Leaming problems	☐ Yes _____	☐ No	☐ Don't Know
Marfan syndrome	☐ Yes _____	☐ No	☐ Don't Know
Menopause before age 40	☐ Yes _____	☐ No	☐ Don't Know
Muscular Dystrophy	☐ Yes _____	☐ No	☐ Don't Know
Neural Tube Defects	☐ Yes _____	☐ No	☐ Don't Know
Polycystic kidney disease	☐ Yes _____	☐ No	☐ Don't Know
Psychiatric problems	☐ Yes _____	☐ No	☐ Don't Know
Sickle Cell Anemia	☐ Yes _____	☐ No	☐ Don't Know
Tay-Sachs disease	☐ Yes _____	☐ No	☐ Don't Know
Thalassemia	☐ Yes _____	☐ No	☐ Don't Know
Thyroid problems	☐ Yes _____	☐ No	☐ Don't Know
High blood pressure	☐ Yes _____	☐ No	☐ Don't Know
Glaucoma	☐ Yes _____	☐ No	☐ Don't Know

What is your Ancestry?

- ☐ African-American
- ☐ American Indian/Native American
- ☐ Ashkenazi Jewish
- ☐ Asian-American
- ☐ Cajun/French Canadian
- ☐ Caucasian
- ☐ Eastern European
- ☐ Hispanic/Caribbean
- ☐ Northern European
- ☐ Southern European
- ☐ Other (Specify_____)

Would you like to be screened for:

- Cystic Fibrosis: ___Yes ___No
- Sickle Cell Anemia: ___Yes ___No
- Tay-Sachs Disease: ___Yes ___No
- Thalasemia: ___Yes ___No
- SMA: ___Yes ___No
- Fragile X: ___Yes ___No

PRIOR INFERTILITY TESTING AND TREATMENT

Have you had prior infertility testing or treatment elsewhere? ☐ Yes ☐ No

PriorTests (check all that apply): ☐ Basal body temperature chart date_____/results_____
☐ Thyroid test (date_____/results_____) ☐ Ovulation test kit (date_____/results_____)
☐ Day 3 blood test for FSH level (date_____/results_____)
☐ Hysterosalpingogram (HSG) (date_____/results_____)
☐ Laparoscopy surgery (date_____/results_____) ☐ Hysteroscopy surgery(date_____/results_____)
☐ Progesterone blood test (date_____/results_____) ☐ Prolactin blood test (date_____/results_____)

Prior Treatment(check all that apply:

	# of cycles	Dates(mo/)year) (mo/year)	Outcome
☐ Intrauterine insemination:	___	From__ /__to__/__	__Pregnant: __Delivered __Ectopic__Miscarriage: __Not Pregnant
☐ Clomiphene citrate (Clomid): maximum # tablets per day?_____	___	From__ /__to__/__	__Pregnant: __Delivered __Ectopic__Miscarriage: __Not Pregnant
☐ Letrozole (Femara): maximum # tablets per day?_____	___	From__ /__to__/__	__Pregnant: __Delivered __Ectopic__Miscarriage: __Not Pregnant
☐ Daily fertility drug injections: maximum # vials per day?_____	___	From__ /__to__/__	__Pregnant: __Delivered __Ectopic__Miscarriage: __Not Pregnant
☐ Completed in vitro fertilization cycle(s):	___		
1. # eggs___ # embryos transferred___ # frozen___		From__ /__to__/__	__Pregnant: __Delivered __Ectopic__Miscarriage: __Not Pregnant
2. # eggs___ # embryos transferred___ # frozen___		From__ /__to__/__	__Pregnant: __Delivered __Ectopic__Miscarriage: __Not Pregnant
3. # eggs___ # embryos transferred___ # frozen___		From__ /__to__/__	__Pregnant: __Delivered __Ectopic__Miscarriage: __Not Pregnant
4. # eggs___ # embryos transferred___ # frozen___		From__ /__to__/__	__Pregnant: __Delivered __Ectopic__Miscarriage: __Not Pregnant
☐ Frozen embryo transfers:	___		
1. # embryos transferred_____		From__ /__to__/__	__Pregnant: __Delivered __Ectopic__Miscarriage: __Not Pregnant
2. # embryos transferred_____		From__ /__to__/__	__Pregnant: __Delivered __Ectopic__Miscarriage: __Not Pregnant
3. # embryos transferred_____		From__ /__to__/__	__Pregnant: __Delivered __Ectopic__Miscarriage: __Not Pregnant
4. # embryos transferred_____		From__ /__to__/__	__Pregnant: __Delivered __Ectopic__Miscarriage: __Not Pregnant
Canceled in vitro fertilization attempt(s):	___		
☐ Any other prior treatment (describe):_____			

EMOTIONAL STATUS

On a scale of 1-10 (10 being the worst), estimate the level of stress you feel due to infertility and other pressures.
Do you see a counselor? ☐ Yes-For how long?_____ How often?_____ ☐ No
List any antidepressant/antianxiety medications you are currently taking._____
Describe any emotional, marital, or sexual problems caused by your infertility. _____
_____
_____
_____
_____

PART Ill: MALE MEDICAL HISTORY AND INFORMATION

Complete with your male partner if applicable.

Have you been evaluated by a urologist? ☐ Yes ☐ No
Have you previously conceived with another woman? ☐ Yes: How many times?_____ ☐ No
Have you had a semen analysis? ☐ Yes ☐ No

Date	Volume	Count	Motility	Morphology
1.				
2.				
3.				

Do you have difficulty with erections? ☐ Yes ☐ No
Are you able to ejaculate inside your partner's vagina? ☐ Yes ☐ No
Have you had any of the following sexually transmitted diseases or severe testicular pain? ☐ No

☐ Chlamydia-date_____ ☐ Syphilis-date_____
☐ Gonorrhea-date_____ ☐ HIV/AIDS -date_____
☐ Hepatitis-date_____ ☐ Other_____

Have you had a history of undescended testicles? ☐ Yes - One side___Both___ ☐ No
Have you ever had torsion/twisting of the testicles? ☐ Yes ☐ No
Did you have mumps after puberty? ☐ Yes ☐ No
Have you had injury to your testicles requiring an ER visit or hospitalization? ☐ Yes ☐ No

Have you been diagnosed with any of the following diseases? ☐ No

☐ Diabetes Mellitus ☐ Cancer
☐ Multiple Sclerosis ☐ Other neurologic problems
☐ Prostatic infections ☐ Urinary infections
☐ High Blood Pressure ☐ _____

Have you had a vasectomy? ☐ Yes (date_____) ☐ No
If yes, have you had a vasectomy reversal? ☐ Yes (date_____) ☐ No
Have you had varicocele surgery? ☐ Yes ☐ No
Have you had hernia surgery? ☐ Yes ☐ No
Have you had other surgery to the scrotum or groin area? ☐ Yes ☐ No

Are you exposed to any radiation or harmful chemicals in the workplace? ☐ Yes ☐ No
Have you had chemotherapy or radiation for cancer? ☐ Yes ☐ No
Are you allergic to any medications? ☐ Yes ☐ No
If yes, please list and describe reactions: _____
List your current medications: _____
List any current medical problem(s): _____
_____

Do you smoke cigarettes? ☐ Yes How many/day?_____How many years?_____ ☐ Quit-when?_____ ☐ No
Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per week?_____
Have you casually used marijuana, cocaine, or any other similar drug? ☐ Yes (describe_____☐ No
Do you use herbal medicines/vitamins or health food store supplements? ☐ Yes(describe)_____
Are you aware of any solvents/toxic materials exposure? ☐ Yes ☐ No_____
Do you use hot tubs regularly? ☐ Yes ☐ No

Have any of your immediate family members had difficulty conceiving a child? ☐ Yes ☐ No
If yes, please describe _____

Male Family History

	Living	Cause of Death/Age at Death
Mother	☐ Yes - age___ ☐ No	_____
Father	☐ Yes - age___ ☐ No	_____
Brother(s)	☐ Yes - age___ ☐ No	_____
Sister(s)	☐ Yes - age___ ☐ No	_____
Maternal Grandmother	☐ Yes - age___ ☐ No	_____
Maternal Grandfather	☐ Yes - age___ ☐ No	_____
Paternal Grandmother	☐ Yes - age___ ☐ No	_____
Paternal Grandfather	☐ Yes - age___ ☐ No	_____

Disorders in Your Family

		Relationship to You		
Bone/Skeletal Defects	☐ Yes	_____	☐ No	☐ Don't Know
Cancer				
Cystic Fibrosis	☐ Yes	_____	☐ No	☐ Don't Know
Deafness/Blindness	☐ Yes	_____	☐ No	☐ Don't Know
Developmental delay	☐ Yes	_____	☐ No	☐ Don't Know
Diabetes	☐ Yes	_____	☐ No	☐ Don't Know
Down syndrome	☐ Yes	_____	☐ No	☐ Don't Know
Other chromosome defects	☐ Yes	_____	☐ No	☐ Don't Know
Heart defect from birth	☐ Yes	_____	☐ No	☐ Don't Know
Hemochromatosis	☐ Yes	_____	☐ No	☐ Don't Know
Hemophilia	☐ Yes	_____	☐ No	☐ Don't Know
Infertility	☐ Yes	_____	☐ No	☐ Don't Know
Leaming problems	☐ Yes	_____	☐ No	☐ Don't Know
Marfan syndrome	☐ Yes	_____	☐ No	☐ Don't Know
Muscular Dystrophy	☐ Yes	_____	☐ No	☐ Don't Know
Neural Tube Defects	☐ Yes	_____	☐ No	☐ Don't Know
Polycystic kidney disease	☐ Yes	_____	☐ No	☐ Don't Know
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Thalassemia	☐ Yes	_____	☐ No	☐ Don't Know
High blood pressure	☐ Yes	_____	☐ No	☐ Don't Know
Glaucoma	☐ Yes	_____	☐ No	☐ Don't Know
High cholesterol	☐ Yes	_____	☐ No	☐ Don't Know

What is your Ancestry?

- ☐ African-American
- ☐ American Indian/Native American
- ☐ Ashkenazi Jewish
- ☐ Asian-American
- ☐ Cajun/French Canadian
- ☐ Caucasian
- ☐ Eastern European
- ☐ Hispanic/Caribbean
- ☐ Northern European
- ☐ Southern European
- ☐ Other (Specify_____)

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- SMA: ___Yes ___No
- Fragile X: ___Yes ___No