Center for Reproductive Medicine • Advanced Reproductive Technologies

www.ivfminnesota.com

New Patient Questionnaire

Name _____ DOB _____ Age _____

Marital Status: ○ Single ○ Married ○ Partnered ○ Separated ○ Divorced ○ Remarried Occupation _____

Home Address _____

Partner's name_____ DOB_____ Age_____Occupation_____

Partner Address _____

What is your travel time/distance to the Center for Reproductive Medicine?_____

Phone # Home_____ Work_____ Cell_____

Prior Physician History

Dates	MD	Clinic Address

Referring Doctor:_____ Do you want a letter sent to your referring physician? ○ Yes ○ No

Reason for today's visit? ○ Infertility ○ Recurrent Pregnancy Loss ○ Other_____

When did you begin attempting pregnancy? Months: _____

Pregnancy History

Biochemical:_____ Ectopic:_____ Stillborn:_____

Term Pregnancy: _____ Preterm: _____SAB: _____ Living:_____

PAST PREGNANCIES (include miscarriages and abortions)

Date Mo/Yr	Weeks of Gestation At Delivery	Infertility Treatment	How Long to Conceive	Sex M/F	Type of Delivery	Current Partner	ART Live Birth	Comments/Complications
						Y / N	Y / N	
						Y / N	Y / N	
						Y / N	Y / N	
						Y / N	Y / N	
						Y / N	Y / N	

Surgical History (List all prior surgeries in chronological order)

Date	Procedure	Comments
○ None		

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

PATIENT PAST MEDICAL HISTORY

	No	Yes		No	Yes
1. Hospitalizations	○	○	16. Genetic Abnormalities	○	○
2. Anesthesia Complications	○	○	17. Congenital Abnormalities	○	○
3. Diabetes	○	○	18. Bleeding disorder	○	○
4. Heart Disease (MVP) (Arrhythmias)	○	○	19. Clotting disorder	○	○
5. Autoimmune Disorder (Lupus)	○	○	20. Pulmonary Embolism	○	○
6. Kidney Disease	○	○	21. Hypertension	○	○
7. Neurological Disease	○	○	22. AIDS	○	○
8. Depression	○	○	23. Irritable Bowel Syndrome	○	○
9. Eating Disorder	○	○	24. Ulcerative Colitis	○	○
10. Hepatitis/Liver Disease	○	○	25. Crohns Disease	○	○
11. Thyroid Dysfunction	○	○	26. Chemotherapy	○	○
12. History of blood transfusions	○	○	27. Radiation Therapy	○	○
13. Pulmonary Disease (Asthma)	○	○	28. Seizures	○	○
14. Exposed to TB	○	○	29. Other	○	○
15. Cancer	○	○	30. Tubal /Pelvic Disease	○	○

Family History (include Parents, Siblings, Grandparents, Aunts, Uncles and Cousins)

	No	Yes	COMMENTS:
1. Infertility	○	○	
2. Recurrent Pregnancy Loss	○	○	
3. Genetic Abnormalities	○	○	
4. Birth Defects	○	○	
5. Bleeding or Clotting Disorders	○	○	
6. Mental Retardation	○	○	
7. Prior Genetic Testing	○	○	
8. Breast Cancer	○	○	
9. Ovarian Cancer	○	○	
10. Cystic Fibrosis	○	○	
11. Other	○	○	

Ancestry

○ African-American	○ Caucasian	○ Pacific Islander
○ American Indian/Native American	○ Eastern European	○ Unknown / Not Observed
○ Ashkenazi Jewish	○ Hispanic/Caribbean	○ Refused
○ Asian	○ Northern European	
○ Cajun/French Canadian	○ Southern European	
○ Other	○ Native Hawaiian	

Social History

	No	Yes			
			COMMENTS:		
1. Exposure to chemicals	○	○	List:		
2. Smoking	○	○	How many packs per day?	For how many years?	Quit?
3. Alcohol	○	○	How much?		
4. Recreational Drugs	○	○			
5. Chemical Dependency	○	○	When Treatment?		
6. Caffeine	○	○	How much?		
7. Exercise Regularly	○	○	Type?	Frequency?	
8. Recent Piercing	○	○			
9. Recent Tattoo	○	○			

CURRENT MEDICATIONS

Name	Dose

ALLERGIES

- ◯ None
- ◯ Drug
- ◯ Food
- ◯ Environmental
- ◯ Latex
- ◯ Iodine
- ◯ Shell Fish
- ◯ Other_____

Menstrual History

Age at first period: _____ Interval between periods:_____Length of flow:_____ ◯ Regular ◯ Irregular

First day of last period:_____ Height:_____ Weight:_____

Have you ever used any of the following birth control: ◯ Pill ◯ Depo Provera ◯ Implants ◯ IUD ◯ Tubal Ligation ◯ Vasectomy

GYN Review of Systems / History

	No	Yes		No	Yes
1. Bleeding between periods	◯	◯	14. Uterine malformation	◯	◯
2. Bleeding after intercourse	◯	◯	15. Pelvic surgery	◯	◯
3. Unusually heavy periods	◯	◯	16. Cervical surgery	◯	◯
4. Significant pain with periods	◯	◯	17. PID (Pelvic Inflammatory Disease)	◯	◯
5. Abnormal hair growth	◯	◯	18. Condyloma (HPV)	◯	◯
6. Breast Discharge	◯	◯	19. STD (GC, Chlamydia, Syphilis)	◯	◯
7. Hot flashes	◯	◯	20. Herpes virus	◯	◯
8. Pelvic pain	◯	◯	21. Ectopic pregnancy	◯	◯
9. Significant weight change	◯	◯	22. Pelvic adhesions	◯	◯
10. DES exposure	◯	◯	23. Endometriosis	◯	◯
11. Ovarian cyst	◯	◯	24. Tubal blockage	◯	◯
12. Uterine Fibroid	◯	◯	25. Do you use lubricants?	◯	◯
13. Uterine Polyp	◯	◯	If yes, what type?		

COMMENTS:

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

Describe any emotional, marital, or sexual problems caused by your infertility. _____

MALE PARTNER INFORMATION

Name: _____ Age:_____

Have you seen an Urologist for evaluation? ◯ No ◯ Yes When:_____

Physician name: _____

Have you ever fathered any prior pregnancies? ◯ No ◯ Yes

Outcome:_____

Review of Systems

	No	Yes	COMMENTS:
Testicular swelling	◯	◯	
Testicular pain	◯	◯	
Difficulty with vaginal penetration	◯	◯	
Inability to obtain an erection	◯	◯	
Inability to maintain an erection	◯	◯	
Problems with ejaculation	◯	◯	

Urologic History

	No	Yes	COMMENTS:
1. Undescended testicle	◯	◯	
2. Prostate infection	◯	◯	
3. Varicocele	◯	◯	
4. Vasectomy	◯	◯	
5. Sperm Antibodies	◯	◯	
6. Congenital abnormalities	◯	◯	
7. Genetic abnormalities	◯	◯	
8. Sexually transmitted disease	◯	◯	
9. Testicular abnormalities	◯	◯	
10. Spinal injury	◯	◯	
11. Other medical problems	◯	◯	

Surgical History (List all prior surgeries in chronological order)

Date	Procedure	None ◯	Comments

Medications (List current medications)

Name of Medication	None ◯	Dose

MALE PARTNER INFORMATION

Allergies (List allergies to medication or environmental allergies)

Type of Allergy | None ○ | Reaction

Past Medical History (List illnesses or hospitalizations) ○ None

1. _____
2. _____
3. _____

Social History

	No	Yes	COMMENTS:		
1. Exposure to chemicals	○	○	List:		
2. Smoking	○	○	How many packs per day?	For how many years?	Quit?
3. Alcohol	○	○	How Much?		
4. Recreational drugs	○	○			
5. Chemical Dependency	○	○	When Treatment?		
6. Excess heat exposure	○	○			
7. Recent Piercing	○	○			
8. Recent Tattoo	○	○			

Male Partner's Family History (Include parents, siblings, grandparents, aunts, uncles & cousins)

	No	Yes	COMMENTS:
1. Infertility	○	○	
2. Recurrent Pregnancy Loss	○	○	
3. Genetic Abnormalities	○	○	
4. Birth Defects	○	○	
5. Mental Retardation	○	○	
6. Prior Genetic Testing	○	○	
7. Cystic Fibrosis	○	○	
8. Bleeding or Clotting Disorder	○	○	
9. Other	○	○	

Ancestry

○ African-American	○ Caucasian	○ Pacific Islander
○ American Indian/Native American	○ Eastern European	○ Unknown / Not Observed
○ Ashkenazi Jewish	○ Hispanic/Caribbean	○ Refused
○ Asian	○ Northern European	
○ Cajun/French Canadian	○ Southern European	
○ Other	○ Native Hawaiian	