Patient Name:_____

Medical Record Number:_____

Date of Birth:_____

WAYNE STATE UNIVERSITY PHYSICIAN GROUP

FERTILITY CENTER QUESTIONNAIRE

Date: _____

Name of Patient: _____ DOB _____ Age _____
Patient preferred name _____

Name of Partner _____ DOB _____ Age _____
Partner preferred name: _____

Gynecologist _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____
May we contact you at work? ☐ Yes ☐ No
May we leave a message on your voicemail:
At home? ☐ Yes ☐ No At work? ☐ Yes ☐ No On cell? ☐ Yes ☐ No
To whom may we thank for referring you or if not referred, where did you hear about us?
_____

AT MY FIRST VISIT I WOULD LIKE TO DISCUSS (check all that apply)

_____ Infertility
_____ Endometriosis
_____ Pelvic pain
_____ Ovarian cyst(s)
_____ Abnormal uterine bleeding
_____ Other: _____
_____ Polycystic ovary syndrome
_____ No periods
_____ Fibroids
_____ Abnormal hair growth
_____ Recurrent pregnancy loss

Have you ever seen someone about your problem(s)? Yes _____ No _____
Who? _____
Where? _____
Diagnosis? _____

Concerning your problem(s), have you had any of the following: (If yes, please comment.)

Blood Tests?	Yes _____	No _____	How many _____
X-rays?	Yes _____	No _____	How many _____
Ultrasounds?	Yes _____	No _____	How many _____
Surgery?	Yes _____	No _____	How many _____
Medications?	Yes _____	No _____	How many _____
Tubal Ligation?	Yes _____	No _____	How many _____
Clomid Cycles?	Yes _____	No _____	How many _____
Letrozole Cycles?	Yes _____	No _____	How many _____
Injectable Cycles?	Yes _____	No _____	How many _____
Timed Intercourse?	Yes _____	No _____	How many _____
Intrauterine Insemination (IUI)?	Yes _____	No _____	How many _____
IVF?	Yes _____	No _____	How many _____
Other treatments?	Yes _____	No _____	How many _____

FEMALE MEDICAL HISTORY

(Please have all medical records from these tests and treatments sent to the Fertility Center at Gundersen Lutheran.)

DRUG ALLERGIES Check here if no known allergies: ☐

Medication/Allergen	Reaction

Do you have a latex allergy? Yes _____ No _____

CURRENT MEDICATIONS, VITAMINS AND SUPPLEMENTS Check here if not taking any: ☐

Please include over the counter medications.

Medication	Dose	Frequency

PREVIOUS SURGERIES (especially important are pelvic and abdominal surgeries)

Check here if none: ☐

Procedure	Date	Problem/Indication	Results/Outcome

Have you ever been hospitalized (for something other than surgery)?

_____

_____

OBSTETRICAL HISTORY

How long have you been trying to have a baby? _____ years

Have you ever been pregnant before? Yes _____ No _____

Date	Current/ Prior Partner	Live Birth (Y/N)	Miscarriage / Abortion/ Ectopic	Wks	Fetal Heart (Y/N)	D&C (Y/N)	Mode of Delivery	Sex	Wt.	Complications

GYNECOLOGIC HISTORY

1. When was the first day of your last 3 periods? _____ _____ _____
2. Are your periods regular? Yes _____ No _____
3. Amount of bleeding: Light _____ Medium _____ Heavy _____
4. How many pads/tampons on heaviest days? _____
5. Age at first period? _____
   Number of days between periods? _____ Number of days of bleeding? _____ Spotting? _____
6. Have you ever needed medication to bring on your period? Yes _____ No _____
7. Do you have pain with your period? Yes _____ No _____
   a. Degree of pain: Mild ____ Moderate ____ Severe ____
   b. Pain relieved by over the counter medications? Yes _____ No _____
      - Name of over the counter medication: _____
   c. Prescription medication used? Yes _____ No _____
      - Name of prescription medication used: _____
   d. Does pain start with the onset of bleeding? Yes _____ No _____
   e. Does pain begin a few days prior to the onset of bleeding? Yes _____ No _____
   f. Does pain persist more than 48 hours? Yes _____ No _____
8. Do you have pain with ovulation/midcycle pain? Yes _____ No _____
9. Do you experience pain with sexual intercourse? Yes _____ No _____
   a. Is the pain mostly on the exterior? Yes _____ No _____
   b. Is the pain mostly internal? Yes _____ No _____
   c. Is the pain mostly with deep penetration? Yes _____ No _____
10. Do you experience pain at other times in your cycle? Yes _____ No _____
11. Are you experiencing any vaginal discharge? Yes _____ No _____
    a. Associated with itching or burning? Yes _____ No _____
    b. Associated with an unusual odor? Yes _____ No _____
12. When was your last Pap Smear? _____
    a. Results? _____
13. Have you ever had an abnormal Pap Smear? Yes _____ No _____
    a. If yes, what follow up was needed: _____
14. Have you ever had a Mammogram? Yes _____ No _____
15. Have you ever tested positive for HIV? Yes _____ No_____
    If yes, when: _____
16. Have you ever had a sexually transmitted disease? Yes _____ No _____
    (ie Chlamydia, Gonorrhea, Syphilis, Herpes)
    a. When? _____ Was it treated? _____
17. Have you ever had Pelvic Inflammatory Disease (PID)/
    a pelvic infection? Yes _____ No _____
    a. When? _____
    b. Were you hospitalized? _____
18. Do you experience milk or discharge from your breasts? Yes _____ No _____
19. Have you ever used an IUD? Yes _____ No _____
    a. Any complications? _____
20. Have you ever used Oral Contraceptives, Nuva Ring
    or OrthoEvra? Yes _____ No _____
    a. How many years? _____
    b. When did you last use it? _____
    c. Any problems? _____
21. Do you have a history of past physical, sexual or
    psychological abuse? Yes _____ No _____
22. Are you currently experiencing physical, sexual, or
    psychological abuse? Yes _____ No _____

MEDICAL CONDITIONS

Do you have a history of any of the following? If so, check box and include frequency, dates, or other comments.

_____ German measles (Rubella) _____
_____ Glasses/contact lenses _____
_____ Thyroid problems _____
_____ Pneumonia _____
_____ Tuberculosis _____
_____ Asthma _____
_____ Bronchitis _____
_____ Other lung conditions _____
_____ Heart attack _____
_____ Heart murmur _____
_____ Rheumatic fever _____
_____ Other heart conditions _____
_____ High blood pressure _____
_____ Gastric/duodenal ulcer _____
_____ Hepatitis _____
_____ Cirrhosis _____
_____ Irritable bowel syndrome _____
_____ Intestinal bleeding _____
_____ Other bowel problems _____
_____ Bleeding tendency _____
_____ Anemia _____
_____ Problems with anesthesia _____
_____ Diabetes _____
_____ Kidney stones _____
_____ Kidney infection _____
_____ Other kidney disorders _____
_____ Bladder infection _____
_____ Other bladder problems _____
_____ Rheumatoid arthritis _____
_____ Other forms of arthritis _____
_____ Lupus erythematosus _____
_____ Migraine _____
_____ Prolonged dizziness _____
_____ Paralysis _____
_____ Other neurologic disorders _____
_____ Thrombophlebitis _____
_____ Varicose veins _____
_____ Breast tumor (benign) _____
_____ Breast cancer _____
_____ Ovarian cancer _____
_____ Uterine cancer _____
_____ Cervical cancer _____
_____ Other cancer _____
_____ Depression or Anxiety _____
_____ Psychiatric treatment _____
_____ Blood transfusion _____
_____ Tattoos, body piercings, _____
_____ Acupuncture, electrolysis _____

IMMUNIZATIONS

Tetanus: _____ Hepatitis: _____ Rubella: _____

FAMILY HISTORY

	Age	Alive?	Deceased? (age at death)	If Deceased, when	Health Problems
Mother					
Father					
Sister					
Sister					
Sister					
Sister					
Brother					
Brother					
Brother					
Brother					
Maternal Grandmother					
Maternal Grandfather					
Paternal Grandmother					
Paternal Grandfather					

Is there a history of any of the following conditions in the family?

Condition	Yes/ No	Mother's Side	Father's Side	Comments
Diabetes				
Heart disease				
High blood pressure				
Kidney disease				
Liver disease				
Multiple births				
Mental retardation				
Birth defects				
Inherited diseases				
Rheumatoid arthritis				
Thyroid disease				
Lupus erythematosis				
Blood disorders				
Breast cancer				
Ovarian cancer				
Uterine cancer				
Other cancer				
Infertility				
Endometriosis				
Fibroids				
Polycystic ovary syndrome				
Sickle cell disease				
Cystic fibrosis				
Tay Sachs				
Thalassemia				
Other				

SOCIAL HISTORY

1. Occupation: _____
2. Do you currently use tobacco products? Yes _____ No _____
   a. Smoke? ____ (#Packs/day _____)
   b. Chew?_____
3. Have you ever used tobacco products? Yes _____ No _____
   a. If yes, how long ago? _____
4. Do you drink alcohol? Yes _____ No _____
   #Drinks/wk _____
5. Was there ever a time when you drank more? Yes _____ No _____
   a. If yes, how much? _____ When (give years) _____ How long _____
6. Do you drink beverages with caffeine? Yes _____ No _____
   a. #Drinks/day ____
7. Have you ever used illicit drugs (marijuana, cocaine, etc.) Yes _____ No _____
8. Did you ever inject illicit drugs Yes _____ No _____
9. Are you currently using any illicit drugs? Yes _____ No _____
10. Are you currently married or in a relationship? Yes _____ No _____
    a. Number of years _____
11. Have you been married or in a relationship before? Yes _____ No _____
12. If yes, any problems conceiving in that relationship? Yes _____ No _____
13. How frequently do you have intercourse? _____ per wk/month
14. Do you use a lubricant? Yes _____ No _____
    a. If yes, what kind? _____

MALE MEDICAL HISTORY

(Please have all medical records from these tests and treatments sent to the Fertility Center at Gundersen Lutheran.)

DRUG ALLERGIES Check here if no known allergies: ☐

Medication/Allergen	Reaction

Do you have a latex allergy? Yes _____ No _____

CURRENT MEDICATIONS, VITAMINS AND SUPPLEMENTS Check here if not taking any: ☐

Please include over the counter medications.

Medication	Dose	Frequency

PREVIOUS SURGERIES (especially important are pelvic and abdominal surgeries)

Check here if none: ☐

Procedure	Date	Problem/Indication	Results/Outcome

Have you had any of the following procedures?

Surgery	Date	Result	Comment
Vasectomy			
Vasectomy reversal			
Testicular biopsy			
Varicocele ligation			
Hernia repair			
Undescended testicle			
Removal of testicle(s)			

Have you ever been hospitalized (for something other than surgery)?

_____

_____

Have you ever been exposed to the following:

Exposed to	Yes/No	When	How Often
Toxic chemicals, solvents or their fumes			
Agent Orange			
Pesticides/Herbicides			
Radiation (x-rays or radioisotopes)			
Chemotherapeutics			

MALE FAMILY HISTORY

	Age	Alive?	Deceased? (age at death)	If Deceased, when	Health Problems
Mother					
Father					
Sister					
Sister					
Sister					
Sister					
Brother					
Brother					
Brother					
Brother					
Maternal Grandmother					
Maternal Grandfather					
Paternal Grandmother					
Paternal Grandfather					

Is there a history of any of the following conditions in the family?

Condition	Yes/ No	Mother's Side	Father's Side	Comments
Diabetes				
Heart disease				
High blood pressure				
Kidney disease				
Liver disease				
Multiple births				
Mental retardation				
Birth defects				
Inherited diseases				
Rheumatoid arthritis				
Thyroid disease				
Lupus erythematosis				
Blood disorders				
Prostate cancer				
Testicular cancer				
Other cancer				
Sperm issues				
Infertility				
Endometriosis				
Fibroids				
Polycystic ovary syndrome				
Sickle cell disease				
Cystic fibrosis				
Tay Sachs				
Thalassemia				
Other				

MALE SOCIAL HISTORY

1. Occupation: _____
2. Have you initiated any pregnancies in the past? Yes _____ No _____
   a. Number of pregnancies? _____
   b. Number with current partner? _____
   c. When was the most recent pregnancy? _____
3. Have you ever been evaluated by a Urologist? Yes _____ No _____
   a. Diagnosis: _____
4. Have you ever had a semen analysis? Yes _____ No _____

Result:			
	Date	_____	_____
	Count (Million cell/ml)	_____	_____
	Motility (%)	_____	_____
	Morphology (% normal forms)	_____	_____
	Other	_____	_____

5. Have you ever tested positive for HIV? Yes_____ No_____
   a. If yes, when: _____
6. Have you ever had a sexually transmitted disease such as Gonorrhea or Chlamydia? Yes _____ No _____
7. Have you ever had a genital injury? Yes _____ No _____
   a. If yes, please describe: _____
   _____
8. Do you currently use tobacco products? Yes _____ No _____
   a. Smoke? ____ (Number of packs/day _____)
   b. Chew?_____
9. Have you ever used tobacco products? Yes _____ No _____
   a. If yes, how long ago? _____
10. Do you drink alcohol? Yes _____ No _____
    Number of drinks/wk _____
11. Was there ever a time when you drank more? Yes _____ No _____
    a. If yes, how much? _____ When (give years) _____ How long _____
12. Do you drink beverages with caffeine? Yes _____ No _____
    a. Number of drinks/day _____
13. Have you ever used illicit drugs (marijuana, cocaine, etc.)? Yes _____ No _____
14. Did you ever inject illicit drugs? Yes _____ No _____
15. Are you currently using any illicit drugs? Yes _____ No _____
16. Do you use a hot tub or sauna? Yes _____ No _____
    a. Number of times per week _____
17. Are you an avid bicyclist? Yes _____ No _____
18. Have you had any tattooing, piercing, acupuncture or electrolysis? Yes _____ No _____
19. Have you ever had a blood transfusion? Yes _____ No _____
20. Have you ever had difficulty with intercourse or ejaculation? Yes _____ No _____
21. Are you currently married or in a relationship? Yes _____ No _____
    a. Number of years _____
22. Have you been married or in a relationship before? Yes _____ No _____
23. If yes, any problems conceiving in that relationship? Yes _____ No _____
24. How frequently do you have intercourse? _____ per wk/month
25. Do you use a lubricant? Yes _____ No _____
    a. If yes, what kind? _____

Patient Signature Date

Partner Signature Date