

Reproductive Medicine Associates of Connecticut

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Patient Questionnaire

Date _____

Patient Name _____
Last First Middle

Date of Birth ____ / ____ / ____ Age _____

Last 4 digits of Social Security # _____

Address _____
Street Apt. or POB#

City State Zip Code

Phone (H) (____) _____ (W) (____) _____
(C) (____) _____

Email _____ Pharmacy (____) _____

Partner Name _____
Last First Middle

Partner Social Security Last 4 # _____ DOB ____ / ____ / ____ Age _____

Referred By _____

Current Gynecologist _____

Gynecologist's Phone # _____

It is very important that you take the time to fill out the * questions accurately

Medical History

Weight: _____ Height: _____ Blood Type (if known): _____

Do you have any allergies or sensitivities to medications?

_____ Any other known allergies or sensitivities (environmental, food, latex, etc.) _____

Have you lost greater than 20 pounds of weight in the last year? YES NO

Do you follow a particular food diet or have any special dietary habits? YES NO

If yes, please specify _____

Have you ever had an eating disorder (anorexia or bulima)? YES NO

List the forms and frequency of regular vigorous exercise (swimming, cycling, running, etc. and the age you began) _____

Exercise: _____ Hrs/Wk _____ Exercise: _____ Hrs/Wk _____

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

- | | | |
|--|--|---|
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> Breast Tenderness |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Heart Disease/Disorder | <input type="checkbox"/> Breast Soreness |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Excessive Hair Growth | <input type="checkbox"/> Breast Milky Discharge |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Neurological Problems |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Gall Bladder Problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Pelvic Infection | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Visual Disturbances |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Poor sense of smell |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> Colitis | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Measles: Regular | <input type="checkbox"/> Anemia | <input type="checkbox"/> Chronic Headaches |
| <input type="checkbox"/> Measles: German | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Blood Transfusions |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Parasitic Infection |
| <input type="checkbox"/> Nongonococcal Ureth. | <input type="checkbox"/> Ovarian Cysts | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Cervical Cancer | <input type="checkbox"/> Ovarian Cancer |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Blood/bleeding Disorder | <input type="checkbox"/> Muscle Aches/Joint Pains |
| <input type="checkbox"/> Vaginitis, Trichomoniasis | <input type="checkbox"/> Other Cancer? | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Or yeast? # per year: _____ | <input type="checkbox"/> Specify: _____ | |

Within the last year, have you taken any prescription medications? Please note in the chart below.

Medication	Diagnosis	Dosage/Frequency	Duration

Are you taking any over-the-counter meds on a regular basis? Please note in the chart below.

Medication	Diagnosis	Dosage/Frequency	Duration

Do you use or have you ever used (Check all that apply):

Alcohol-How many glasses per week do you usually drink? Wine ___ Beer ___ Cocktails ___

Cigarettes-Number of packs per day? _____ Number of years _____?

Illicit or Recreational Drugs (Marijuana, Cocaine, etc.) If you would feel more comfortable not writing anything down, please discuss this directly with your physician. Specify _____

Menstrual History

Age at first period _____ Date of last period _____

Are your periods regular?..... YES NO

What is usual # of days between periods? Minimum _____ Maximum _____

What is the usual duration of your bleeding? Minimum _____ Maximum _____

Do you have PMS?..... YES NO

If yes, MILD MODERATE SEVERE

Do you have painful menses? YES NO

If yes, MILD MODERATE SEVERE

Do you take pain medication for cramps? YES NO

If yes, please specify what medication(s) _____

Do you bleed or spot between periods?..... YES NO

If you've ever been on oral contraceptives?..... YES NO

Were your periods regular after stopping the pill? YES NO

Did your mother have any difficulty with conception or pregnancy? YES NO

Did your mother take diethylstilbestrol (DES) when she was pregnant with you? YES NO

At what age did your mother begin menopause? _____

Is there a family history of infertility? YES NO

If yes, who/relationship _____

Is there a history of hormonal disorders in your family?..... YES NO

If yes, who/relationship/type _____

Is there a family history of birth defects? YES NO

If yes, who/relationship _____

Is there a family history of habitual pregnancy loss? YES NO
If yes, who/relationship _____

Have you ever used an intrauterine device (IUD)? YES NO
If yes, please specify type/# years _____

Have you ever had pelvic inflammatory disease (PID)? YES NO

Is intercourse painful? YES NO
If yes, MILD MODERATE SEVERE

Do you use lubricants for intercourse? YES NO
If yes, which brand? _____

Do you douche before, or after intercourse? YES NO

How many times per week do you and your partner have intercourse? _____

***How many months have you had unprotected intercourse? _____**

***How many months have you been trying to get pregnant? _____**

Have you used Basal Body temperature (BBT)? YES NO
If yes, what day did you ovulate? _____

Have you ever used an ovulation predictor kit (OPK)? YES NO
If yes, what day did you ovulate? _____

How many cups of coffee or caffeinated beverages do you drink each day? _____

Do you take vitamins? YES NO
If yes, what kind and how much? _____

Have you been exposed to any toxins? YES NO

Do you have:

<input type="checkbox"/> Jewish Ancestry	<input type="checkbox"/> African Ancestry	<input type="checkbox"/> Mediterranean Ancestry	<input type="checkbox"/> Asian Ancestry
<input type="checkbox"/> French-Canadian Ancestry			

Pregnancy Data

*How many prior pre-term (<37 weeks) births have you had? _____

*How many prior full-term (>37 weeks) births have you had? _____

*How many pregnancies (including abortions) have you had? _____

*How many spontaneous abortions have you had? _____

Pregnancy Data (continued)

Please fill in the chart below:

Pregnancy #	Year	End in abortion? Spontaneous or Induced abortion? Or ectopic pregnancy?	Infertility therapy required to conceive?	How long to conceive? (months)	Greater than or equal to 37 weeks Yes/No	Baby born alive?	Is current partner the father?
1 st Pregnancy							
2 nd Pregnancy							
3 rd Pregnancy							
4 th Pregnancy							
5 th Pregnancy							

Surgical History

Have you ever been surgically sterilized? YES NO

How many operations have you had? _____

Surgical History

Date	Hospital	Procedure	Findings	Surgeon

History of Fertility Therapy

Have you been treated for infertility before? YES NO

If yes, who was your physician? _____

Address: _____

What cause of infertility was diagnosed? _____

Have you taken any of the following medications? Check all that apply:

Thyroid medication (e.g. Synthroid)

Bromocriptine (Parlodel)

Which of the following tests have you had performed?

Check all that apply and results if known.

Postcoital Test Date: ____/____ Results: _____

Day 3 FSH, Estradiol Date: ____/____ Results: _____

Endometrial Biopsy Date: ____/____ Results: _____

Hysterosalpingogram Date: ____/____ Results: _____

Antisperm Antibodies Date: ____/____ Results: _____

Laparoscopy Date: ____/____ Results: _____

Hysteroscopy Date: ____/____ Results: _____

Mycoplasma/
Chlamydia Cultures Date: ____/____ Results: _____

Thyroid Tests Date: ____/____ Results: _____

Rubella Date: ____/____ Results: _____

HIV Date: ____/____ Results: _____

Pap Smear Date: ____/____ Results: _____

Mammogram Date: ____/____ Results: _____

Sickle Cell Date: ____/____ Results: _____

Tay Sachs Date: ____/____ Results: _____

Other/specify: _____ Date: ____/____ Results: _____

Infertility Cycle History

Clomiphene Citrate

Dates	# of cycles	Max. starting dose	Max. follicles	# with insemination	# of cycles resulting in pregnancy

*Number of prior Gonadotropin cycles _____

Gonadotropin (Follistim, Gonal-F, etc.)

Dates	# of cycles	Max. starting dose	Max. Estradiol	Max. # follicles	# with insemination	# of cycles resulting in pregnancy

*Number of prior Fresh ART (IVF) Cycles _____

*Number of prior Frozen ART (IVF) Cycles _____

IVF History

Cycle #	1	2	3	4	5	6
Date						
IVF Center						
Frozen Embryo Cycle	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Max. Start Dose						
Max. Estradiol						
# Eggs Retrieved						
# Eggs Fertilized						
ICSI: Y/N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
# Embryo(s) Transferred						
Embryo Age (Day 2, 3, or 5)						
Pregnancy: Y/N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Delivered: Y/N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N

Psychological Assessment

Fertility treatment has been described, very accurately, as “an emotional roller coaster.” Most fertility patients report that it is one of the most emotionally difficult experiences of their lives. In order for us to provide you with the best possible care, it is very important for us to have an understanding of any emotional or psychiatric issues that you may be dealing with currently, or have struggled with in the past.

Please fill out the following questions in as much detail as possible. It will be a helpful reference for us throughout your treatment.

Psychological History and Management

<u>Psychiatric Issue</u>	<u>Dates</u>	<u>Medication</u>	<u>Treatment</u>
Depression	_____	_____	_____
Anxiety (Panic,OCD)	_____	_____	_____
Bipolar Disorder	_____	_____	_____
Eating Disorder	_____	_____	_____
Alcohol Abuse	_____	_____	_____
Drug Abuse	_____	_____	_____
Other	_____	_____	_____

For Current Psychiatric/Psychological Issues:

Psychiatrist: _____ Phone: _____

Therapist: _____ Phone: _____

1. Is Psychiatrist/Therapist aware that you are seeking fertility treatment? YES NO
2. Do you plan to modify your psychiatric medication before starting treatment?
YES NO
3. If you are planning to modify or wean off of your psychiatric medications, are you doing this under the guidance of a psychiatrist? YES NO
4. What is the plan for modifying or weaning off of medication? _____

Male Data (if applicable)

Name: _____
First Last

Marriage #: _____

Number of pregnancies conceived with current partner: _____

Number of pregnancies conceived with previous partners: _____

Please give approximate dates and outcomes of any pregnancies conceived with a previous partner:

Date of Pregnancy	Pregnancy Outcome		
	Delivered	Aborted	Miscarried

Urologist: _____

Address: _____ Phone: _____

Have you ever had a semen analysis (sperm count) performed? YES NO

Date of semen analysis	Location of analysis	Count (million/ml)	Motility	Grade	Morphology

Do you have any medical problems unrelated to your fertility?

Nature of Problem (Diagnosis)	Treatment	Physician

Male Surgical History

Have you ever had any surgery? If so, please indicate date and type of surgery.

Date	Type of Operation	Physician

Do you take any medications? Indicate medication, dosage, frequency and duration.

Medication	Diagnosis	Dosage/Frequency	Duration

Do you or have you ever used (check **all** that apply):

Alcohol-How many glasses per week do you usually drink? Wine ___ Beer ___ Cocktails ____

Cigarettes-Number of packs per day? _____ Number of years _____?

Illicit or Recreational Drugs (Marijuana, Cocaine, etc.)? If you would feel more comfortable not writing anything down, please discuss this directly with your physician. Specify _____

Do you or have you ever had any difficulties with (check **all** that apply):

Erection: If yes, please explain _____

Ejaculation: If yes, please explain _____

Have your genitals ever been exposed to excessive heat? YES NO

Have you had any serious injuries to your genitals? YES NO

Have you had any infections of your penis, testicles or prostate gland? YES NO

Is there any history of birth defects in your family? YES NO

Is there any history of recurrent miscarriage in your family? YES NO

Do you have any allergies to medications? YES NO

If yes, please note: _____

