FAMILY FERTILITY CENTER **www.familyfertility.com**
H. Christina Lee, M.D., J.D., H.C.L.D., F.A.C.O.G. **Medical and Laboratory Director**
95 Highland Avenue, #100 Telephone (610) 868-8600
Bethlehem, PA 18017 Fax (610) 868-8700

Questionnaire for Women

General Information

Referred by: Dr___________ Word of mouth [ ] Web Search [ ] Insurance [ ] Other [ ]

Name ____ **Today's Date** ______________________

Address ____

Telephone: Home: _______________________ Work: ______________________________ Cell: ____________________

Birth date _______________________ Age __________ Ethnic Background ____

Height _______________ Weight ______________ Highest Education ____

Partner's Name _____________________________________ How long in this relationship? ____________________________

Work History: Please list all recent employment, titles, brief description, and years employed:

_______________________ _______________________ ____ _____

_______________________ _______________________ ____ _____

Gynecologic History

Age of first period _____ Date of first day of last period _____

Usual cycle length _____________ days _____________ range

(interval from start of one period to start of next)

Usual duration of bleeding ______________________________

Do you have any symptoms at time of ovulation (i.e., pain)?

Yes___ No____ ___________________________________

Amount of flow: Light ______ Moderate ______ Heavy______

Cramping: None____ Minimal ____ Moderate ____ Severe_____

What do you do to relieve menstrual symptoms? _____________

____

Circle symptoms preceding period: None Breast soreness Irritability Cramping Other:____________________

History of: Pelvic Pain _________________________________

Endometriosis ____

Gynecologic surgery ________________________________

____

Last PAP _______ Results _____________________________

History of Abnormal PAP?______________________________

Last Mammogram _______ Results ______________________

Have you ever been treated for: Dates

HPV Human Papilloma Virus ____________________

Syphilis ____________________

Gonorrhea ____________________

Chlamydia ____________________

Genital / anal warts ____________________

Pelvic inflammatory disease ____________________

Do you have a history of genital herpes? Yes______ No_______

Did your mother take any medications while pregnant with you?

Yes _____ No_____ Don't know _____ What?_______________

Was DES taken? Yes_____ No_____

Sexual History

Frequency of sexual intercourse per week __________________

Use of lubricants ___ yes ___ no ___________

Name of lubricants ____________________________________

Does husband ejaculate in the vagina during intercourse__ yes__no

Is intercourse painful to you? ________ yes ________no

Is intercourse painful to your partner? ________ yes ________ no

Contraceptive History

Birth control pills ______ yes ______ no # of years taken _____

Date stopped birth control pills ___________________________

Were menses regular before birth control pills ____ yes ____ no

Were menses regular after stopping the pills ____ yes ____ no

How long after stopping the pills did menses start ___________

Previous use of IUD (intrauterine device) __ yes __ no __ # years

When was IUD removed (date) _________ reason __________

____

Circle previous use of:

Diaphragm Condom Foam Rhythm Sponge

Sterilization (date) ________________

By Whom: ____

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RECORD ALL PREGNANCIES									
	Year	End in Abortion	End in Miscarriage	Ectopic Pregnancy	Infertility Treatment To Conceive?	How Long to Conceive?	Baby born Alive?	Method of Delivery?	Is current Partner the Father?
1st									
2nd									
3rd									
4th									
5th									

Occupation/Leisure History

	Yes	No	Dates/Comments
Exposed to chemical or x-rays in work or hobby	_____	_____	________________________
Please list current or past history:	**Yes**	**No**	**Amounts per day or week**
Caffeine	_____	_____	________________________
Smoking	_____	_____	________________________
Alcohol	_____	_____	________________________
Marijuana	_____	_____	________________________
Nutritional supplements, herbs, etc.	_____	_____	________________________
Drugs (not prescribed)	_____	_____	________________________

Please describe recreational/sports activities (frequency, length of time, etc.) ______________________________

Family History

Father's age if alive _____ If no longer living, cause of death and age______________________________

Medical problems: ______________________________ # of biologic children:____________

Mother's age if alive _____ If no longer living, cause of death and age______________________________

Medical problems: ______________________________ # of biologic children: ___________

Sister(s): Age: __________ Medical problems: ______________________________

Age: __________ Medical problems: ______________________________

Age: __________ Medical problems: ______________________________

Brother(s): Age: __________ Medical problems: ______________________________

Age: __________ Medical problems: ______________________________

Age: __________ Medical problems: ______________________________

Is there a family history of:	Yes	No	Comments
Birth defect	_____	_____	________________________
Mental Retardation	_____	_____	________________________
Genetic diseases	_____	_____	________________________
Infertility	_____	_____	________________________
Hormone problems	_____	_____	________________________
Miscarriages/stillbirths	_____	_____	________________________
Pregnancy problems	_____	_____	________________________
Cancer: Breast Prostate Ovarian Colon	_____	_____	________________________
Stroke	_____	_____	________________________
Heart disease	_____	_____	________________________

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Is there a family history of: (cont'd)	Yes	No	Comments
Lung disease	_____	_____	______________________________
Diabetes	_____	_____	______________________________
Thyroid/endocrine problems	_____	_____	______________________________
High blood pressure	_____	_____	______________________________
Any women who have never menstruated	_____	_____	______________________________
Any men who have never had to shave	_____	_____	______________________________

Medical/Surgery History	**Yes**	**No**	**Dates/Comments**
Mumps	_____	_____	______________________________
Measles	_____	_____	______________________________
Chicken Pox	_____	_____	______________________________
Rubella (German Measles)	_____	_____	______________________________
Rheumatic fever	_____	_____	______________________________
Elevated Blood pressure	_____	_____	______________________________
Heart murmur	_____	_____	______________________________
Heart disease	_____	_____	______________________________
Diabetes	_____	_____	______________________________
Lung disease	_____	_____	______________________________
Liver or gall bladder disease	_____	_____	______________________________
Jaundice	_____	_____	______________________________
Kidney infections	_____	_____	______________________________
Hepatitis	_____	_____	______________________________
Kidney stones	_____	_____	______________________________
Gout	______	_____	______________________________
Urinary tract abnormalities	_____	_____	______________________________
Thyroid disease	_____	_____	______________________________
Arthritis	_____	_____	______________________________
Auto immune diseases (lupus, rheumatoid arthritis, etc.)	_____	_____	______________________________

Other serious or chronic diseases ____

Any surgery (list type and year) ____
____

Do you have any adverse reactions to food/medications/other? Yes ________ No_________
If yes, name and type of reaction: ____

Please list any medications you are now taking or have taken in the past. Current: ______________________ Past: ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________

Any history of therapeutic x-ray treatment or anti-cancer drugs? Current: ______________________ Past: ______________________
______________________ ______________________
______________________ ______________________

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Please fill in a review of any current or recent symptoms:

	Yes	No		Yes	No		Yes	No
Chronic headaches	____	____	Increased thirst	____	____	Excessive Fatigue	____	____
History of head injury	____	____	Increased sweating	____	____	Tremors	____	____
Convulsion history	____	____	Intolerance to heat	____	____	Desire for extra salt	____	____
Visual problems	____	____	Intolerance to cold	____	____	Excess Loss of scalp hair	____	____
Dizziness	____	____	Difficulty swallowing	____	____	Growth of hair on face or body in new places	____	____
Rapid weight change	____	____	Change in voice or hoarseness	____	____	Change in size of clitoris	____	____
Acne	____	____	Difficulty sleeping	____	____	Discharge from nipples	____	____
Change of appetite	____	____						

Please include any other information which you believe may be pertinent to your infertility problem ________________________
____
____
____
____

Pre-conceptual Health Screening

Have you ever been tested for:	**Yes**	**No**	**If yes, give dates/results**
Hepatitis B	☐	☐	____________________
HIV (AIDS)	☐	☐	____________________
Rubella	☐	☐	____________________
TB (Tuberculosis)	☐	☐	____________________
Blood Type	☐	☐	____________________
Tay-Sachs	☐	☐	____________________
Gaucher Disease	☐	☐	____________________
Canavan Disease	☐	☐	____________________
Cystic Fibrosis	☐	☐	____________________
Sickle cell	☐	☐	____________________
Diabetes	☐	☐	____________________
Anemia or Thalassemia	☐	☐	____________________

Previous Infertility Testing

Length of time currently attempting pregnancy _____ Years ___ Months
Length of time not using any method to avoid pregnancy __________________

	No	**Yes**	**If yes, give dates/results**
Temperature charts	☐	☐	____________________
Hysterosalpingogram (x-ray of tubes and uterus)	☐	☐	____________________
Hysteroscopy (looking inside uterus)	☐	☐	____________________
Endometrial biopsy (taking tissue from inside uterus)	☐	☐	____________________

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Post-coital test ☐ ☐ ______________________________
(to test sperm in cervical mucus)
____

Semen Analysis ☐ ☐ ______________________________
____

Laparoscopy ☐ ☐ ______________________________
____
____

Hormone Tests

Day 3 FSH ☐ ☐ ______________________________

Day 3 Estradiol ☐ ☐ ______________________________

Clomid Challenge Test ☐ ☐ ______________________________

Anti-Mullerian Hormone ☐ ☐ ______________________________

Thyroid tests ☐ ☐ ______________________________

Chromosome tests ☐ ☐ ______________________________

Genetic tests ☐ ☐ ______________________________

Previous Infertility Treatment

Treatment with Clomiphene (Clomid, Serophene) ☐ No ☐ Yes

If Yes:

Cycles **without** Intrauterine Insemination (IUI) ☐ No ☐ Yes #Cycles / Dates ______________________

Cycles **with** Intrauterine Insemination (IUI) ☐ No ☐ Yes #Cycles / Dates ______________________

Pregnant ☐ No ☐ Yes Dates ______________________________

Treatment with Gonadotropins (e.g., Follistim, Gonal-F, Bravelle, Menopur) ☐ No ☐ Yes

If Yes:

Cycles **without** Intrauterine Insemination (IUI) ☐ No ☐ Yes #Cycles / Dates ______________________

Cycles **with** Intrauterine Insemination (IUI) ☐ No ☐ Yes #Cycles / Dates ______________________

Pregnant ☐ No ☐ Yes Dates ______________________________

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Treatment with IVF or other Assisted Reproductive Technologies (ICSI, GIFT, ZIFT)

Cycle #	Stimulation Protocol (if known)	Dose of FSH or LH	Peak Estrogen Level	# Eggs Retrieved	# Eggs Fertilized	# Embryos Transferred	# Embryos Frozen	Outcome: +Preg, -Preg SAB, etc	Birth Outcome

Other comments on Infertility treatments:

____
____
____
____
____
____

Patient Signature:____ **Date:**____________________