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 ☐None ☐Breast soreness ☐Irritability

preceding period: ☐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	☐	☐
Rapid weight change	☐	☐	Change in voice or			or body in new places	☐	☐
Acne	☐	☐	hoarseness	☐	☐	Change in size of		
Change of appetite	☐	☐	Difficulty sleeping	☐	☐	clitoris	☐	☐
						Discharge from nipples	☐	☐

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:**_____