Tripler Army Medical Center REI Clinic New Patient Information Questionnaire

For us to best assist you, it is important that we understand your health history. Please fill out this form as best you can. This will be held in strictest confidence, but if there are certain responses you would rather provide privately, leave them blank and inform us during your appointment. If any portions are not applicable, please mark them as such.

Date: _____

Name: _____

Date of Birth: _____

Occupation: _____

Spouse/Partner (if applicable): _____

Date of Birth: _____

Occupation: _____

What issues do you want help with?

_____

Age:

Are you married/ with a partner: YES ❒ NO ❒

Duration of Relationship: _____

Menstrual History

Age of first period: _____ Date of last period: _____

Are your periods regular? YES ❒ NO ❒

Typical Number of days between periods: _____

Do you skip periods? YES ❒ NO ❒

Typical length of bleeding: _____

Estimated number of periods per year: _____

Do you have bleeding between periods? YES ❒NO ❒

Do you have pain during periods? YES ❒ NO ❒ Severe? _____

Have you ever had pelvic inflammatory disease YES ❒ NO ❒

Do you have painful menses YES ❒ NO ❒ MILD ❒ MODERATE ❒ SEVERE ❒

Have you used birth control to control menstrual pain or bleeding YES ❒ NO ❒

Does your mother, sister, maternal or paternal grandmother have history of :

Breast ❒ Ovarian ❒ Colon ❒ Uterine Cancer ❒ Who: _____

Fertility History:

How long have you been trying to conceive? _____

How many times a week are to you trying to conceive? _____

Is intercourse painful? YES ❒ NO ❒ MILD ❒ MODERATE ❒ SEVERE ❒ DO YOU HAVE TO STOP ❒ AVOID INTERCORSE DUE TO PAIN ❒

Do you use lubricants? YES ❒ NO ❒ BRAND_____

Do you use ovulation predictor kits (OPK?) YES ❒ NO ❒ BRAND _____
Are they positive YES ❒ NO ❒

Have you had a tubal ligation or other surgical sterilization procedure YES ❒ NO ❒

Fertility History

Have you had prior evaluation and treatment for fertility before? YES ❒ NO ❒

If yes, who was your physician? _____

What was your diagnosis? _____

Which tests did you have performed? Check all that apply and provide results if known.

Day 3 labs ❒ FSH ❒ Date (s) _____ Results _____
LH ❒ Date (s)_____ Results _____
Estradiol ❒ Date (s) _____ Results _____

AMH ❒ Date (s) _____ Results _____

Hysterosalpingogram ❒ Date (s) _____ Results _____

Saline sonogram ❒ Date (s) _____ Results _____

Laparoscopy ❒ Date (s) _____ Results _____

Hysteroscopy ❒ Date (s)_____ Results _____

Prior Fertility Treatment

Have you had any prior fertility treatment? YES ❒ NO ❒ If yes, please fill in chart below
Number of prior Clomiphene (Serophine/Clomid) cycles: _____/Letrozole(Femara) cycles:_____

Date	Drug(Clomid/Letrozole)hCG trigger/Dose	Number follicles	Received IUI? Yes or No	Pregnancy? Yes or No If yes, what was the outcome
			YES ❒NO❒	YES ❒NO❒
			YES ❒NO❒	YES ❒NO❒
			YES ❒NO❒	YES ❒NO❒
			YES ❒NO❒	YES ❒NO❒
			YES ❒NO❒	YES ❒NO❒
			YES ❒NO❒	YES ❒NO❒

IUI= Intrauterine insemiations

Number of prior Gonadotropin(injectable) Cycles:_____ (Gonal F, Menopur, Follistim, Bravelle, Repronex)

Date	Injectable Drug dose/hCG trigger?	Number follicles	Received IUI? Yes or No	Pregnancy? Yes or No If yes, what was the outcome
			YES ❒NO❒	YES ❒NO❒
			YES ❒NO❒	YES ❒NO❒
			YES ❒NO❒	YES ❒NO❒
			YES ❒NO❒	YES ❒NO❒
			YES ❒NO❒	YES ❒NO❒
			YES ❒NO❒	YES ❒NO❒

Number of prior Fresh In Vitro Fertilization(IVF) cycles: _____ Frozen Transfers:_____

Date				
IVF Center				
Fresh or Frozen?				
# eggs retrieved				
# eggs fertilized				
ICSI?	YES ❒NO❒	YES ❒NO❒	YES ❒NO❒	YES ❒NO❒
# embryos transferred				
Embryo age (day 3 or 5)				
Pregnancy?	YES ❒NO❒	YES ❒NO❒	YES ❒NO❒	YES ❒NO❒
Pregnancy outcome?				
Extra embryos for freezing? How many	YES ❒NO❒	YES ❒NO❒	YES ❒NO❒	YES ❒NO❒
Embryo Genetic Testing (PGS/PGD)?	YES ❒NO❒	YES ❒NO❒	YES ❒NO❒	YES ❒NO❒

Pregnancy History?

Have you ever been pregnant? YES ❒ NO ❒
How may total pregnancies have you had? _____
How many full term births (>37 weeks)? _____
How many pre term (<37 weeks) births? _____
How many biochemical pregnancies (positive pregnancy test, nothing on ultrasound)?_____
How many spontaneous miscarriages before 20 weeks?_____
How many ectopic pregnancies?_____ If any how were they treated? Surgery or Methotrexate? _____

Pregnancy	Outcome -chemical -miscarriage -abortion -ectopic -delivery	Any fertility therapy and type	Time to pregnancy after starting to try	Delivery method -vaginal -c-section -forceps	Gestational age at delivery	Conceived with current partner?
1						
2						
3						
4						
5						

Medical History

Height: _____ Weight: _____ Age:_____
When was your last well woman exam? _____
If > 40 have you had a mammogram in the last 12 months? _____
Do you have or have you ever had (check all that apply)
Diabetes ❒ High Blood Pressure ❒ Thyroid problems ❒ Endometriosis ❒ Uterine Fibroids ❒ Pelvic infection ❒ Delayed or early puberty ❒ Anorexia ❒ Bulimia ❒ Cancer ❒ Chemotherapy ❒ Blood Clots ❒ Sickle Cell disease ❒ Gonorrhea ❒ Chlamydia ❒ Hepatitis ❒ A ❒ B ❒ C ❒ HIV/AIDS ❒ Syphilis ❒ Heart Disease ❒ Stroke ❒ Have you ever been told you can't take birth control ❒ Have you ever been treated for depression ❒ Substance abuse ❒ Describe: _____
Other: _____

Do you have any allergies? YES ❒ NO ❒
List_____

Within the last 12 months, what medications/prescription or over the counter have you taken?

Medication	Reason/Diagnosis	Dosage	Frequency	Duration

Surgical History

Have you ever had surgery YES ❒ NO ❒

Have you ever been hospitalized other than surgery YES ❒ NO ❒

Describe: _____

Describe surgeries/Hospitalizations

Year	Surgery/Hospitalization	Reason	Outcome

Male Partner History (If applicable)

Height: _____ Weight :_____ Occupation:_____
Number of pregnancies conceived with partner: _____
Number of pregnancies conceived with prior partners: _____
Have you had a semen analysis performed YES ❒ NO ❒
List results of Semen analysis if known with date:

_____

Do you have any medical problems unrelated to fertility? YES ❒ NO ❒

List any medical problems and treatment:

_____

List any surgeries you may have had:

_____

Have you had a vasectomy? YES ❒ NO ❒

What medications do you take?

_____

Have you been prescribed testosterone or are you taking testosterone YES ❒ NO ❒ If yes, How long? _____

Do you drink more that 6 alcoholic drinks/week? YES ❒ NO ❒

Do you use cigarettes or smokeless tobacco? YES ❒ NO ❒

Do you have any sexual dysfunction YES ❒ NO ❒ Explain: _____

Have you had any infection of the genitals YES ❒ NO ❒
Explain: _____

Have you or are you seeing a urologist YES ❒ NO ❒
if yes what is the reason: _____