

# Hudson Valley Fertility

## Clinical Questionnaire

Name \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_

Partner \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_

Telephone(H) \_\_\_\_\_ (W) \_\_\_\_\_

Cell \_\_\_\_\_ Email \_\_\_\_\_

Social # Self \_\_\_\_\_ Spouse \_\_\_\_\_

Referred by:  
Physician \_\_\_\_\_

Insurance \_\_ Internet \_\_ Seminar \_\_ Ad \_\_ Other \_\_\_\_\_

Health Insurance \_\_\_\_\_ Policy Number \_\_\_\_\_

Date of consultation: \_\_\_\_\_

### 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/ comments

**Gynecologic History**

Date of Last Menstrual Period \_\_\_\_\_ Periods regular? Y/N  
Age at first period \_\_\_\_\_ Days between Periods \_\_\_\_\_  
# Days of bleeding \_\_\_\_\_ Any bleeding between the periods? Y/N  
Amount of bleeding: Light/Medium/Heavy  
Other bleeding issues \_\_\_\_\_  
Need medication to induce period Yes \_\_\_\_\_ No \_\_\_\_\_  
Pain with periods? Yes \_\_\_\_\_ No \_\_\_\_\_  
Pain with intercourse? Yes \_\_\_\_\_ No \_\_\_\_\_  
Mid-cycle pain? Yes \_\_\_\_\_ No \_\_\_\_\_  
Vaginal discharge? Yes \_\_\_\_\_ No \_\_\_\_\_  
Do you have a Gynecologist? Yes \_\_\_\_\_ No \_\_\_\_\_  
Name of Gynecologist \_\_\_\_\_  
Date of last Pap Smear \_\_\_\_\_  
Any abnormal Pap Smears? Yes \_\_\_\_\_ No \_\_\_\_\_  
Prior freezing/LEEP/cone biopsy Yes \_\_\_\_\_ No \_\_\_\_\_  
Have you ever had a mammogram? Yes \_\_\_\_\_ No \_\_\_\_\_  
Date of Last Mammogram \_\_\_\_\_  
Have you ever had a Sexually Transmitted Disease? Yes \_\_\_\_\_ No \_\_\_\_\_  
(Syphilis, Gonorrhea, Chlamydia, Herpes)  
Was this treated? Yes/No Date of last treatment \_\_\_\_\_  
Have you ever had Pelvic Inflammatory Disease (PID?)  
Yes \_\_\_\_\_ Was this treated with medication? \_\_\_\_\_  
Have you ever had breast discharge Yes \_\_\_\_\_ No \_\_\_\_\_  
Have you ever used an IUD? Yes \_\_\_\_\_ No \_\_\_\_\_  
Have you ever used the oral contraceptive Pill Yes \_\_\_\_\_ No \_\_\_\_\_  
How many years? \_\_\_\_\_ When did you last use it?  
Have you ever experienced excessive facial hair? Yes \_\_\_\_\_ No \_\_\_\_\_  
Do you need to shave/pluck/ use creams? Yes \_\_\_\_\_ No \_\_\_\_\_

**Past Medical History**

Hypertension Yes \_\_\_\_\_ No \_\_\_\_\_  
Diabetes Yes \_\_\_\_\_ No \_\_\_\_\_  
Asthma/Bronchits/Pneumonia Yes \_\_\_\_\_ No \_\_\_\_\_  
Heart Disease Yes \_\_\_\_\_ No \_\_\_\_\_  
Kidney Disease Yes \_\_\_\_\_ No \_\_\_\_\_  
Bleeding Tendency Yes \_\_\_\_\_ No \_\_\_\_\_  
Headaches/Migraines Yes \_\_\_\_\_ No \_\_\_\_\_  
Cancer Yes \_\_\_\_\_ No \_\_\_\_\_  
Breast Cysts Yes \_\_\_\_\_ No \_\_\_\_\_  
Gastric/Duodenal Ulcers Yes \_\_\_\_\_ No \_\_\_\_\_  
Neurologic Disorder Yes \_\_\_\_\_ No \_\_\_\_\_  
Thyroid Disorder Yes \_\_\_\_\_ No \_\_\_\_\_  
Varicose Veins Yes \_\_\_\_\_ No \_\_\_\_\_

Rheumatoid Arthritis Yes \_\_\_\_\_ No \_\_\_\_\_  
 Problems with Anesthesia Yes \_\_\_\_\_ No \_\_\_\_\_  
 DES or other exposure Yes \_\_\_\_\_ No \_\_\_\_\_

Other: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Surgeries**

Procedure	Date	Indication	Outcome	Complications

**Medications**

Medication	Dose	Frequency

**ALLERGIES**

Do you have any known drug allergies? Yes \_\_\_\_\_ No \_\_\_\_\_

**Medication**

**Reaction**

\_\_\_\_\_

**Other allergies? Please list:**

\_\_\_\_\_

\_\_\_\_\_

**Family History**

<b>Condition</b>	<b>Yes</b>	<b>No</b>	<b>Comments</b>
Infertility			
Pregnancy Losses			
Heart Disease			
Cancers			
Thyroid Disease			
Endometriosis			
Birth Defects			
Bleeding Issues			
Multiple Births			
Genetic Issues			
Rheumatoid Arthritis			
Blood Disorders			
Celiac Disease			
Lupus			
Immune Disorders			
Mental Retardation			
Other			

**Social History**

Occupation \_\_\_\_\_  
 Tobacco use: none/past/present                      Packs/day \_\_\_\_\_  
 Alcohol use: none/rare/mild/moderate              Drinks/week \_\_\_\_\_  
 Recreational Drug use: Yes/No \_\_\_ Type and amount \_\_\_\_\_  
 Prior marriage: Yes/No              Prior conception problems Y/N  
 Frequency of intercourse: \_\_\_\_\_ per week/month  
 Any intercourse issues?: Yes/No \_\_\_\_\_

**Male History**

Occupation \_\_\_\_\_  
 Prior Pregnancies                      Yes \_\_\_ NO \_\_\_\_\_  
     Number of Pregnancies \_\_\_\_\_  
     Number with current partner \_\_\_\_\_  
 Have you been seen by a Urologist? Yes \_\_\_ No \_\_\_\_\_  
 Diagnosis and  
 Treatment \_\_\_\_\_  
 \_\_\_\_\_

Results of Last Semen Analysis:

Count \_\_\_\_\_ Motility \_\_\_\_\_ Morphology \_\_\_\_\_

Any Allergies? Yes \_\_\_\_\_ No \_\_\_\_\_

Medical Problems \_\_\_\_\_  
 \_\_\_\_\_

Prior Surgeries \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Medications \_\_\_\_\_  
 \_\_\_\_\_

Tobacco Use Y/N \_\_\_\_\_ Packs/day \_\_\_\_\_  
 Alcohol Use Y/N \_\_\_\_\_ Drinks/week \_\_\_\_\_  
 Recreational drug use Yes \_\_\_\_\_ No \_\_\_\_\_

**Prior Fertility Evaluation**

Test/Procedure	Date	Results
FSH- day 3		
Estradiol- day 3		
LH-day 3		
Progesterone- day 21		
TSH		
Prolactin		
DHEAS		
Testosterone		
Blood Type		
Rubella		
HIV		
Hepatitis		
RPR/VDRL		
Other		
<b>Immune Testing</b>		
ANA		
APA		
NKA		
Immunophenotype		
ATA		
Antisperm antibodies		
DQ alpha		

Thrombophilia Screen		
Other		
<b>Cervical Cultures</b>		
Chlamydia		
Gonorrhea		
Mycoplasma		
Other		

**Procedures**

<b>Procedure</b>	<b>Date</b>	<b>Result</b>
Pap Smear		
Endometrial Biopsy		
Mammogram		
Basal Body Temperature (BBT)		
Ovulation Kits		
Post Coital Test		
Semen Analysis		
Vaginal Ultrasound		
Hysterosalpingogram/ X-ray dye test		
Fluid Ultrasound		
Laparoscopy		
Hysteroscopy		
Other		

**Prior Fertility Treatments**

<b>Treatment</b>	<b>Dates</b>	<b>Dose</b>	<b># cycles</b>	<b>Comment</b>
Timed Intercourse				
Clomiphene (Clomid)				
Intrauterine Insemination (IUI)				
Metformin				
Injectible Gonadotropins (Gonal-F, Follistim, Bravelle, Repronex, Pergonal)				
Heparin				
Aspirin				

Intravenous Immunoglobulin (IVIG)				
Leukocyte Immunization Therapy (LIT)				

**In-Vitro Fertilization**

Have you ever done an IVF cycle? Yes \_\_\_ No \_\_\_

Number of Fresh IVF cycles \_\_\_ Dates \_\_\_\_\_

Numbers of Frozen cycles \_\_\_ Dates \_\_\_\_\_

Number of Donor cycles \_\_\_\_\_

Outcomes of IVF cycles:

	Date	Fresh/Frozen	Outcome
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

**Most recent fresh IVF cycle**

Dose and type of stimulation \_\_\_\_\_

Own eggs \_\_\_\_\_ Donor \_\_\_\_\_ Surrogate \_\_\_\_\_

Number of follicle seen on ultrasound \_\_\_\_\_

Highest Estradiol (E2) level prior to HCG \_\_\_\_\_

Endometrial Thickness on day of hCG \_\_\_\_\_ mm

Was lupron used? Yes \_\_\_ No \_\_\_

Was Lupron used as part of flare protocol? Yes \_\_\_ No \_\_\_

Micro Lupron or micro dose hCG? Yes \_\_\_ No \_\_\_

Was a GnRH antagonist used (ex: Ganirelix) Yes \_\_\_ No \_\_\_

How many eggs were retrieved? \_\_\_\_\_

Was ICSI used? \_\_\_\_\_

What was the egg quality? \_\_\_\_\_

How many embryos were produced? \_\_\_\_\_

Was this a day 3 or day 5 transfer? \_\_\_\_\_

Was assisted hatching performed? \_\_\_\_\_

How many embryos were transferred? \_\_\_\_\_

What was the quality of the embryos? \_\_\_\_\_

Outcome of cycle? \_\_\_\_\_

