

ADVANCED REPRODUCTIVE CARE CENTER

NEW PATIENT MEDICAL QUESTIONNAIRE

Date: _____ Name: _____ Date of birth: _____

Age: _____ Marital Status: Married Separated Single

Partner's name: _____ His age: _____

Your occupation: _____ Spouse's occupation: _____

Your home phone: _____ Cell phone: _____

Your ethnic background is: Caucasian African descent Hispanic Asian Ashkenazi Jew
Native American Other _____

A. Medical History

1. Medication(s) you are taking: _____

2. Allergy: No known allergy Iodine Shellfish Peanut

Drugs: _____

3. Do you use Tobacco /how much? _____ Alcohol _____

Recreational drugs (cocaine, marijuana, etc) _____

4. Please indicate any significant illness you have had:

- Anorexia, bulimia Hepatitis ____B or ____C Seizure disorder
Asthma Other liver disease Stroke
Clots in lungs or legs High blood pressure Hypothyroidism
Crohn's or Ulcerative Colitis Kidney disease Hyperthyroidism
Diabetes Mitral valve prolapse GI ulcers
Heart disease Rheumatic fever Other _____

B. Surgical History (including cryosurgery and LEEP)

Year

- 1. _____
2. _____
3. _____
4. _____
5. _____

C. Menstrual History

- At what age did you first have your period? _____
• How often do you have your periods? _____
• Do you have spotting before the start of menses? Yes No
• Do you pass clots of quarter size or larger during menses? Yes No
• Do you have painful cramps with your periods? Yes No
• Do you have pelvic pain at other times besides your periods? Yes No
• At what age did your mother undergo menopause? _____

D. Sexual History

- How often do you have intercourse? _____
• Do you often have pain with intercourse? Yes No
• Have you had 3 or more sexual partners in the past? Yes No
• Have you ever had pelvic inflammatory disease (PID)? Yes No
• Have you ever been diagnosed with a sexually transmitted disease? Yes No
If yes: Chlamydia Condyloma (HPV) Gonorrhea Herpes Trichomonas

E. Review of System

- Have you had significant weight gain or loss over the past year? _____ lbs Yes No
- Do you have excessive facial hair, body hair, acne? Yes No
- Do you have to shave your face? How often? _____ Yes No
- Do you have breast discharge? From which breast? _____, color _____ Yes No

F. Obstetrical History

Year of pregnancy	Is current partner the father?	Miscarriage or Abortion?	Vaginal delivery or C-section?	Term or premature?	Baby's sex	Complication

G. Previous Infertility Treatment

Treatment	# Cycle	Month/Year	#IUI	Physician	Outcome
Clomiphene					
Femara (letrozole)					
Injectables (HMG, Gonal-f, Follistim, Menopur)					
In Vitro Fertilization			NA		

H. Family Medical History

- | | |
|--|--|
| <input type="checkbox"/> Birth defects _____ | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Cystic fibrosis _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Down' syndrome _____ | <input type="checkbox"/> Heart disease _____ |
| <input type="checkbox"/> Hemophilia _____ | <input type="checkbox"/> hypertension _____ |
| <input type="checkbox"/> Mental retardation _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Muscular dystrophy _____ | <input type="checkbox"/> Kidney disease _____ |
| <input type="checkbox"/> Sickle cell disease _____ | <input type="checkbox"/> Mental disorder _____ |
| <input type="checkbox"/> Tay Sach disease _____ | <input type="checkbox"/> Thyroid disease _____ |
| <input type="checkbox"/> Thalassemia _____ | <input type="checkbox"/> Other _____ |

I. Male Partner's Profile

1. Has he been associated with any pregnancy (including miscarriages)? # _____ Yes No
 Number of children? _____ Age of youngest child? _____
2. Has he ever had mumps radiation therapy chemotherapy? Yes No
3. Does he have diabetes hypertension erectile problem Yes No
 Other medical problem(s) _____
4. Does he take regular medications: _____ Yes No
5. Has he ever had prostate infection or problem? _____ Yes No
6. Has he ever had injury to the groin or genitalia? _____ Yes No
7. Did he have varicocele surgery testicular surgery vasectomy hernia repair Yes No
8. Does he use tobacco? _____, alcohol _____, Yes No
 recreational drugs (marijuana, cocaine, amphetamine)? _____ Yes No