Lucile Salter Packard Children's Hospital

Stanford MEDICINE

Fertility and Reproductive Health

CLINICS • REI • FEMALE PATIENT QUESTIONNAIRE

Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

FEMALE PATIENT HISTORY

Please answer the questions to the best of your ability. Leave blank any questions to which you do not know the answer. If you are uncomfortable with any question, you may leave it blank.

IDENTIFYING INFORMATION

Date of initial appointment:_____ Email:_____

Name:_____ Partner's Name:_____

Address:_____

Telephone Number **Day:**_____ **Evening:**_____

Current Age:_____ Date of Birth:_____ Height:_____ Weight:_____

Partner's Date of Birth:_____

Who referred you to our practice?

- ❑ Former patient
- ❑ Physician - list name:_____
- ❑ Friend
- ❑ SART data
- ❑ Stanford Fertility website
- ❑ Internet search - please specify what search terms:_____
- ❑ Self-referred
- ❑ Yelp

Reason for consultation:_____

_____

ETHNICITY / CULTURAL BACKGROUND

Circle all that apply:

Asian Indian, Chinese, Filipino, Japanese, Korean, Pakistani or Southeast Asian
Greek, Italian, Middle Eastern, Portuguese or Spanish
Cajun, French Canadian or Jewish
African American, African Descent, Black, Caribbean, Central American, Haitian, Jamaican or Puerto Rican
Hispanic or Mexican
Caucasian
Alaskan Native or American Indian
Other (specify):

EMPLOYMENT

Please describe all current employment including job title, description of responsibilities, duration of employment

_____

_____

_____

GYNECOLOGICAL HISTORY

How old were you when you had your first period?_____

When did your last period start?_____

How long do your periods last?_____ days.

How frequently do your periods come? every _____ days.

Do you experience cramping with your period? ❑ Yes ❑ No

If yes, when during your cycle does the pain occur? (Circle all that apply) **Before** **During** **After**

How would you describe the cramps? (Circle all that apply) **Mild** **Moderate** **Severe**

Do you take medication for cramps? ❑ Yes ❑ No

If yes, specify medication:_____

Do you bleed or spot between periods? ❑ Yes ❑ No

If yes, please describe:_____

When was your last Pap smear?_____ Was it normal? ❑ Yes ❑ No

Have you ever had an abnormal Pap smear result? ❑ Yes ❑ No

If yes, what therapy was required?

❑ Antibiotics ❑ Cone biopsy ❑ Loop excision (LEEP)

❑ Biopsy ❑ Cryotherapy (freezing of cervix) ❑ Repeat Pap smear

❑ Colposcopy (microscope evaluation) ❑ Laser therapy

❑ Other:_____

Have you ever had any of the following infections involving any part of the reproductive tract (vagina, cervix, uterus, fallopian tubes, ovaries)? (Check all that apply)

❑ Chlamydia trichomonas ❑ Herpes

❑ Genital warts ❑ Syphilis

❑ Gonorrhea ❑ Yeast

Have you ever had a mammogram? ❑ Yes ❑ No If yes, when_____

What was the result? ❑ Normal ❑ Abnormal

Do you have pain with intercourse? ❑ Never ❑ Sometimes ❑ Frequently ❑ Always

How frequently do you and your partner have intercourse per week?_____

OR

How frequently do you and your partner have intercourse per month?_____

How frequently do you and your partner have intercourse around ovulation?_____ per week.

Have you experienced any difficulties with intercourse? ❑ Yes ❑ No

If yes, please explain:_____

Have you ever used contraception in the past? ❑ Yes ❑ No

If yes, please check all that apply:

❑ Condoms ❑ Diaphragm ❑ IUD ❑ Withdrawal

❑ Contraceptive pills ❑ Foam/Sponge ❑ Rhythm ❑ Other:_____

FERTILITY EVALUATION

How long have you and your partner been attempting to achieve pregnancy?_____

Have you had infertility with a previous partner? ❑ Yes ❑ No

Have you been treated for infertility previously? ❑ Yes ❑ No

If yes, where/when:_____

What was the cause of infertility?_____

Which of the following tests have been performed?

❑ Antibody tests ❑ Hysterosalpingogram (dye, x-ray test) ❑ Sonohysterogram

❑ Endometrial biopsy ❑ Hysteroscopy ❑ Thyroid test

❑ Home ovulation predictor kits ❑ Laparoscopy ❑ Ultrasound

❑ Hormonal test ❑ Postcoital test

Have you ever taken any of the medications listed below:

❑ Antibiotics ❑ hCG (Pregnyl, Novarel, Ovidrel)

❑ Aspirin ❑ Heparin

❑ Bromocriptine (Parlodel, Dostinex) ❑ Injectable gonadotropins (Bravelle, Menopur, Gonal-F, Follistim, Repronex)

❑ Clomiphene citrate (Clomid, Serophene) ❑ Progesterone (Suppositories, Injections, Crinone, Prometrium, Endometrin, Provera)

❑ Danazol (Danocrine) ❑ Steroids (Medrol, Prednisone, Dexamethasone)

❑ Estrogens (Estrace, Estraderm) ❑ Testosterone or Male hormone

❑ GnRH agonist (Lupron, Synarel, Zoladex)

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Have you had chemotherapy for cancer? ❑ Yes ❑ No

Have you ever had intrauterine inseminations? ❑ Yes ❑ No

If yes, how many attempts?_____

Specimen was provided by: (Check all that apply) ❑ Partner ❑ Donor

Have you ever attempted in vitro fertilization? ❑ Yes ❑ No

If yes, please specify below (if known)

Date	Location	# Vials of meds/day	# Eggs retrieved	ICSI?* (Y/N)	# Eggs fertilized	# Embryo transferred	# Embryo Frozen	Was donor egg used?	Outcome

*Intracytoplasmic sperm injection

OBSTETRICAL HISTORY

Have you ever been pregnant (including elective terminations, miscarriages, birth)? ❑ Yes ❑ No

Date	Outcome	Gestation age at time of outcome? (in weeks)	Infertility therapy?	Complications with pregnancy?	Was conception with current partner?

PAST MEDICAL HISTORY

Do you have or have you ever had (Check all that apply):

- ❑ Acne
- ❑ Anemia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Autoimmune disease (eg. Lupus, Rheumatoid arthritis)
- ❑ Blood transfusion
- ❑ Breast (nipple) discharge
- ❑ Breast disease
- ❑ Breast tenderness
- ❑ Cancer? (Specify)

  _____

  _____
- ❑ Chicken pox
- ❑ Chronic headaches
- ❑ Colitis
- ❑ Cystic fibrosis
- ❑ Diabetes
- ❑ Endometriosis
- ❑ Hair loss
- ❑ Heart disease
- ❑ Heat/cold intolerance
- ❑ Hepatitis
- ❑ High blood pressure
- ❑ Hirsutism (excess hair growth)
- ❑ Hot flashes
- ❑ Kidney problems
- ❑ Liver problems
- ❑ Measles: German
- ❑ Measles: regular
- ❑ Mumps
- ❑ Neurological problems
- ❑ Ovarian cysts
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ Seizures
- ❑ Thyroid problems
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Vision problems

Immunizations

Hepatitis B date(s)_____

- ❑ Chicken pox
- ❑ German Measles (Rubella)
- ❑ Mumps
- ❑ Polio
- ❑ Tetanus
- ❑ Tuberculosis

REVIEW OF SYSTEMS

Do you presently have any problems or symptoms in the following areas? Circle **YES** or **NO** below.

If yes, please give explanation:

		Patient Comments:	Physician Comments:
Constitutional (good general health lately)	YES / NO		
Eyes	YES / NO		
Ears/Nose/Mouth/Throat	YES / NO		
Cardiovascular (heart/blood vessels/circulation)	YES / NO		
Respiratory (breathing difficulties)	YES / NO		
Gastrointestinal (stomach/intestines)	YES / NO		
Genitourinary (genitals/sexual function/kidney/bladder)	YES / NO		
Neurological (brain/nervous system)	YES / NO		
Integumentary (skin areas and/or breasts)	YES / NO		
Psychiatric (emotions/mood/memory)	YES / NO		
Musculoskeletal (bones/joints/muscles)	YES / NO		
Endocrine (hormones/metabolism/thyroid)	YES / NO		
Allergic/Immunologic (allergies/immune system)	YES / NO		
Hematologic/Lymphatic (blood or bleeding problems; lymph nodes or "swollen glands")	YES / NO		

PAST SURGICAL HISTORY

Have you ever had any surgeries in the past? ❑ Yes ❑ No

If yes, please indicate date, type, findings of surgery:

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MEDICATIONS

Are you allergic to any medications? ❑ Yes ❑ No

If yes, please indicate name of medication and the type of reaction it causes:

Medication	Reaction

Are you currently taking any prescription medications? ❑ Yes ❑ No

If yes, please indicate below:

Medication	Reason

Are you currently taking any over-the-counter medications (including supplements or herbal remedies)? ❑ Yes ❑ No

If yes, please indicate below:

Medication	Reason

SOCIAL HISTORY

Are you currently married/domestic partner? ❑ Yes ❑ No How long?_____

Do you smoke? ❑ Yes ❑ No If so, how many packs per day?_____ Have you ever smoked? ❑ Yes ❑ No

How many caffeinated beverages (coffee, soda, tea) do you drink per day?_____

Do you drink alcohol? ❑ Yes ❑ No If so, how many alcoholic beverages per week?_____

Do you use other recreational drugs? ❑ Yes ❑ No If so, please list:_____

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Do you exercise regularly? ❑ Yes ❑ No

If so, please indicate type of exercise and estimate hrs/week spent in this activity.

Type	Hours/week
_____	_____
_____	_____
_____	_____

Have you had a significant change in weight in the past year? ❑ Yes ❑ No

If so, please indicate: ❑ weight gain_____ lbs ❑ weight loss _____lbs.

Do you follow a particular food diet? ❑ Yes ❑ No

❑ Vegetarian ❑ Diet plan name:_____ ❑ Other:_____

EMOTIONAL STATUS

On a scale of 1-10 (10 being the worst), estimate the level of stress you feel due to infertility and other pressures:_____

Do you see a counselor? ❑ Yes ❑ No

List any anti-depressant/anti-anxiety medication you are currently taking:_____

Has your infertility produced marital or sexual dysfunction? ❑ Yes ❑ No

Would you like us to refer you to a counselor to discuss your concerns? ❑ Yes ❑ No

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FAMILY HISTORY

Have you, your partner or anyone in either of your families had any of the following disorders?

Check all that apply and indicate relationship to you:

a. Bleeding disorder (hemophilia) ❑ Yes

b. Breast cancer ❑ Yes

c. Bone or skeletal disease (dwarfism) ❑ Yes

d. Cleft lip/palate ❑ Yes

e. Cystic fibrosis ❑ Yes

f. Diabetes ❑ Yes

g. Down syndrome ❑ Yes

h. Heart defect at birth ❑ Yes

i. Muscular dystrophy ❑ Yes

j. Neural tube defect (spina bifida, anencephaly) ❑ Yes

k. Neurofibromatosis ❑ Yes

l. Other chromosome abnormality ❑ Yes

m. Other nerve/muscle disorder ❑ Yes

n. Ovarian cancer ❑ Yes

o. Polycystic kidney disease ❑ Yes

p. Sickle cell disease ❑ Yes

q. Tay Sachs/Canavan disease ❑ Yes

r. Thalassemia ❑ Yes

*If yes, please specify who:_____

_____

_____

Form completed by:_____ (please print)

Relationship to patient:_____ (write "self" if you are the patient)

Date completed:_____