

BRANDEIS FERTILITY PROGRAM

Questionnaire for Wife

General Information

Date: _____

Name _____ Husband's Name _____

Address _____

Home Phone Number _____ Work Phone _____ Cell Phone _____

Birth Date _____ Age _____ Occupation _____

What is your Ethnic Background?

<input type="checkbox"/> White non-Hispanic	<input type="checkbox"/> White Hispanic	<input type="checkbox"/> Black non-Hispanic	<input type="checkbox"/> Black Hispanic
<input type="checkbox"/> Asian non-Hispanic	<input type="checkbox"/> Asian Hispanic	<input type="checkbox"/> Native American	<input type="checkbox"/> Other

Height _____ Weight _____ Blood Type _____ Highest Education _____

Name of Gynecologist	Name of Primary Care Physician
Name:	
Address:	
Phone:	
Fax:	

 Please send information regarding my care Please send information regarding my care

Signature: _____

Signature: _____

Referred by: Physician Name: _____

Address: _____

Phone: _____ - _____

Fax: _____

 Please send information regarding my care

Signature: _____

Menstrual History

Age of first period _____ Date of first day of last period _____

Do you experience the following symptoms preceding your Period?

____ Breast soreness

____ Irritability

____ Other: (please describe): _____

Your Menstrual Bleeding Days

How many days do you normally bleed? _____

Are your menstrual cramps associated with pain in your back, thigh & leg? No YesAre your periods painful? No Yes

If Yes, how would you describe the pain? (check one)

 Minimal Moderate SevereHas your menstrual pain gotten worse over time? No YesDo you have to take pain medication for cramps? No Yes

If Yes, please explain: _____

Do you bleed or spot between periods? No Yes

If Yes, please explain: _____

Did your menstrual pain improved while taking birth-control pills? No Yes

If Yes, please explain: _____

Describe the amount of your menstrual flow? (check one)

 Light Moderate Heavy

The Days between your Periods

Cycle Regularity

- The number of days between start of one period to start of the next period, not including the first day of the next period it is important to know if your periods are regular or not**Are your periods regular?** No Yes

If your periods are regular, what is the usual number of days Between the start of one period to the start of the next period, Not including the first day of the next period? _____ number of days.

If your periods are not regular :

What is the most number of days between periods? _____

What is the least number of days between periods? _____

What is the most common number of days between your regular periods? _____

Gynecologic History

Have you been diagnosed with Pelvic Pain, Pelvic Inflammatory Disease or Endometriosis? No Yes

If Yes, explain: _____

PAP Exam			
Breast Exam			
Mammogram			

Have you had abnormal PAP smears? No Yes

If Yes, please explain: _____

Have you had colposcopy and/or LEEP or cervical freezing or cautery? No Yes

Menstrual History

Frequency of sexual intercourse per week _____

Do you use lubricants? No Yes

Name of lubricants: _____

Does your husband ejaculate during intercourse ? No Yes

Is intercourse painful? No Yes

Do you douche before or after intercourse? No Yes

Have you ever been treated for:

	Dates	Treatment
Syphilis	_____	_____
Gonorrhea	_____	_____
Chlamydia	_____	_____
Genital warts	_____	_____

Do you have a history of genital herpes? No Yes

If Yes, please explain: _____

Contraceptive History

Birth control pills No Yes

Name of Pill:	Dates used:

Date when birth control pills were stopped: _____

Were menses regular before birth control pills No Yes

Were menses regular after stopping the pills? No Yes

After stopping the pill, when did your menses start? _____

Previous use of IUD (intrauterine device) No Yes

years of IUD use: _____

When was IUD removed?

Date removed: _____

Reason: _____

Which contraceptive methods have you used? (check all that apply)

Diaphragm condom foam

sponge pills rhythm

Other

Please explain: _____

Obstetrical History

Have you been pregnant? No Yes Total Number of Children _____

Indicate Number of Children: _____ Full Term _____ Pre-term _____ Miscarriage _____ Ectopic _____ Abortion _____

RECORD ALL PREGNANCIES

Year	Over 37 Weeks	Less than 37 weeks	Miscarriages	Ectopic	Abortions	Complications	Were fertility treatments used?	How long were you trying to conceive?

Which pregnancies (state year) were conceived with your current partner? _____

Occupation / Social History

Have you been exposed to chemical or x-rays in work or hobby? No Yes

Do you or have you ever used? (check all that apply):

Alcohol – How many glasses per week do you usually drink? _____ Wine Beer Cocktails

Cigarettes – Number of packs/ day _____ Number of years smoking _____ Year stopped smoking: _____

Recreational Drugs (Marijuana, Cocaine, etc.) Specify: _____

Nutritional Supplements, herbs, etc. Specify: _____

Please describe exercise activities (days per week,length of time, etc.): _____

Family History

Father's age if alive _____ If no longer living, cause of death _____

Medical problems: _____

Mother's age if alive _____ If no longer living, cause of death _____

Medical problems: _____

Sister(s) ages _____ medical problems: _____

Brother(s) ages _____ medical problems: _____

Did your mother have any difficulty with conception or pregnancy? No Yes

Did your mother take any medications (ex. Diethylstilbestrol) while pregnant with you? No Yes Don't Know

If Yes, please specify? _____

Does anyone in your family have:	YES	NO	Relationship / Comments
Birth defects or genetic diseases	<input type="checkbox"/>	<input type="checkbox"/>	_____
Infertility	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hormone problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Polycystic Ovaries	<input type="checkbox"/>	<input type="checkbox"/>	_____
Miscarriages/ stillbirths	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pregnancy problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid/endocrine problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other hormonal problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any women who have never menstruated	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any men who have never had shave	<input type="checkbox"/>	<input type="checkbox"/>	_____

Any additional comments you would like to make that you feel may be pertinent and have not already been addressed:

Medical and Surgery History	YES	NO	Dates / Comments
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	_____
Measles (Regular)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Measles (German)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hirsutism (Excess hair growth)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Elevated Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	_____

	YES	NO	Dates / Comments
Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor sense of smell	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of balance	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____

Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Parasitic Infection	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nongonoccal Urethritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vaginal trichomoniasis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vaginal Yeast Infection	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ovarian Cysts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cervical Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Liver or gall bladder disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney infections	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis (A, B, C)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gout	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinary tract abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breast Tenderness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breast Soreness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breast Milky Discharge	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Auto immune diseases (lupus, rheumatoid arthritis, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other serious or chronic disease _____			_____

Do you have any allergies to medications: No Yes

If yes, which medications: _____

Have you taken prescription medications - Example: Synthroid, Parlodel

If Yes, Please indicate:

Medication	Diagnosis	Dosage/ Frequency	When Taken	Comments

Surgical History _

Example – Laparoscopy, Hysteroscopy, Laparotomy, Appendectomy, Ectopic Pregnancy, Tubal Ligation, Reversal of Tubal Ligation, Ovarian Cyst Surgery, Removal of Ovaries, Removal of Tubes, Mypomectomy, Lysis of Adhesion, Tubal Repair, etc.

Date	Procedure	Findings	Hospital	Surgeon

Any history of radiation treatment or anti-cancer drugs? No Yes

If Yes, please explain: _____

Have you ever been involved in psychotherapy or counseling? No Yes

If Yes, please indicate why, when, with whom, and any other pertinent information. _____

Please fill in a review of any current or recent symptoms:

	Yes	No		Yes	No		Yes	No
Chronic headaches	___	___	Increased thirst	___	___	Excessive Fatigue	___	___
Head injury	___	___	Increased sweating	___	___	Tremors	___	___
Seizures	___	___	Intolerance to heat	___	___	Desire for extra salt	___	___
Eyesight problems	___	___	Intolerance to cold	___	___	Balding	___	___
Dizziness	___	___	Difficulty swallowing	___	___	Change in voice /hoarseness	___	___
Acne	___	___	Change of appetite	___	___	Change in size of clitoris	___	___
Seizures	___	___	Intolerance to heat	___	___	Desire for extra salt	___	___
Change of appetite	___	___	Difficulty sleeping	___	___	Discharge from nipples	___	___

Have you lost or gained greater than 10 lbs of weight in the last year? No Yes

If Yes, please explain: _____

Do you follow a particular food diet or have any special dietary habits? No Yes

If Yes, please specify: _____

Have you ever had an eating disorder (anorexia or bulimia)? No Yes

If Yes, please specify: _____

FERTILITY HISTORY

Pre-conceptual Health Screening

Have you ever been tested for:	Yes	No	Date:	If yes, give results
Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
HIV (AIDS)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Rubella	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
TB (Tuberculosis)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Blood Type	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Tay-Sachs	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Gaucher Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Canavan Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sickle cell	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Anemia or Thallasemia	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Previous Infertility Testing

How many months/ years have you had unprotected intercourse? _____ Additional Information: _____

How many months/ years have you been trying to get pregnant? _____ Additional Information: _____

Which physician have you seen for evaluation or treatment of infertility?

Name: _____

Address: _____

Phone: _____ Fax: _____

What causes for infertility was found? _____

