

Today's Date: _____

Please complete all applicable sections of this questionnaire to the best of your ability.
Your confidential answers will be reviewed by a physician and will help to give you the best possible care.

PATIENT INFORMATION

Patient Legal Name: _____ Preferred Name: _____

Sex assigned at birth: ☐ Male ☐ Female Personal Pronouns: _____ Height: _____ Weight: _____

Date of Birth: ____/____/____ Age: _____ Start Date of last menstrual period: _____

Partner/Spouse Legal Name (if applicable): _____ Preferred Name: _____

Sex assigned at birth: ☐ Male ☐ Female Personal Pronouns: _____ Height: _____ Weight: _____

Partner Date of Birth: ____/____/____ Partner Age: _____ (Male Partner Medical History Continues on Pg 7)

Who is your OB/GYN? Name/Practice: _____ Phone/Fax: _____

Address: _____

☐ Check here if you would like a summary of your consult sent to your Ob/Gyn and/or your referring clinician

Any other clinician you regularly see to manage your health? (cardiologist, hematologist, urologist, endocrinologist, PCP, etc.)

Name/Practice: _____ Phone/Fax: _____

Address: _____

What is the Primary Reason for your Visit? What are your goals/expectations for the consultation?

Please be as specific as possible, including if you are specifically interested in one or more of the following: Egg Freezing, Infertility Evaluation, Donor Egg or Donor Sperm, Genetic Testing, Recurrent Pregnancy Loss, Family Balancing, Second Opinion

How many months have you been actively trying to conceive? _____ ☐ N/AHow many months have you been having vaginal intercourse without using any form of birth control? _____ ☐ N/AHow many times do you have vaginal intercourse per week? _____ times per week ☐ None/Not ApplicableHave you used over-the-counter ovulation predictor kits to time intercourse? ☐ Yes ☐ No

PATIENT MEDICAL HISTORY & HEALTH INFORMATION

SEXUAL & CONTRACEPTION HISTORY:

Do you use lubricants (K-Y Jelly®, etc.) during intercourse? ☐ Yes: *what types?* _____ ☐ No ☐ N/A

Do you currently or have you had any of the following sexually transmitted diseases or pelvic infections? ☐ N/A

☐ Chlamydia – date: _____ ☐ Gonorrhea – date: _____ ☐ Herpes – date: _____ ☐ Hepatitis – date: _____

☐ Genital warts/HPV – date: _____ ☐ Syphilis – date: _____ ☐ HIV/AIDS – date: _____

☐ Trichomoniasis – date: _____ ☐ Pelvic Inflammatory Disease – date: _____ ☐ Other _____ date: _____

Check all forms of contraception ever used, note approx. dates of use, and any complications. ☐ N/A – None Used

Contraception Method	Dates of use	Complications?
<input type="checkbox"/> Barrier Method (Condoms/Diaphragm)		
<input type="checkbox"/> Oral Birth Control Pills		
<input type="checkbox"/> Skin Patch		
<input type="checkbox"/> Depo-Provera or other injection		
<input type="checkbox"/> Nexplanon or other implant		
<input type="checkbox"/> IUD – hormonal / <input type="checkbox"/> IUD – Copper		
<input type="checkbox"/> Tubal Sterilization (tubes tied)	Procedure date: _____	
<input type="checkbox"/> Other: _____		
<input type="checkbox"/>		

Notes: _____

PREGNANCY HISTORY:

Total Number of ALL Pregnancies: _____ Number of Miscarriages: _____

Number of Ectopic/Tubal Pregnancies: _____ Number of Elective Terminations (Abortions): _____

Number of Full-Term Deliveries: _____ Of these: How many were live births? _____ How many were stillborn? _____

Number of Premature Deliveries (less than 37 weeks): _____ Of these: How many were live births? _____ How many were stillborn? _____

Year Pregnancy Ended or Delivered	Months to Conception (how long did it take to get pregnant)	Treatments to Conceive if any	Delivery Type if applicable Vaginal or C-Section	Baby Sex & Weight at birth	Outcomes/Complications (full-term, miscarriage, termination, ectopic, preterm delivery, etc.)	Conceived with Current Partner?
1. _____			<input type="checkbox"/> vaginal <input type="checkbox"/> c-section			<input type="checkbox"/> Yes <input type="checkbox"/> No
2. _____			<input type="checkbox"/> vaginal <input type="checkbox"/> c-section			<input type="checkbox"/> Yes <input type="checkbox"/> No
3. _____			<input type="checkbox"/> vaginal <input type="checkbox"/> c-section			<input type="checkbox"/> Yes <input type="checkbox"/> No
4. _____			<input type="checkbox"/> vaginal <input type="checkbox"/> c-section			<input type="checkbox"/> Yes <input type="checkbox"/> No
5. _____			<input type="checkbox"/> vaginal <input type="checkbox"/> c-section			<input type="checkbox"/> Yes <input type="checkbox"/> No

Additional Comments: _____

MENSTRUAL & GYN HISTORY:

Age at first menstrual period: _____ How many days of bleeding do you usually have? _____ days

Menstrual cycle pattern (check all that apply): ☐ Regular periods ☐ Irregular periods ☐ No Periods ☐ Midcycle spotting
☐ Light periods ☐ Moderate periods ☐ Heavy periods

Number of days between the start of one period to the start of the next period: _____ days
If irregular: what's the shortest and longest number of days? _____ - _____ days

Have you ever gone longer than 3 months without a menstrual period? ☐ YES ☐ NO

Severity of cramping or pelvic pain with your periods: ☐ Mild ☐ Moderate ☐ Severe

Do you experience midcycle cramping? ☐ YES ☐ NO

Do you experience pain with vaginal intercourse? ☐ YES ☐ NO

Month/Year of your last Pap smear? _____ Result: ☐ Normal ☐ Abnormal

Have you had an abnormal Pap smear in the past? ☐ Yes: date of most recent abnormal Pap: _____ ☐ No

Have you undergone any procedures as a result of an abnormal pap smear? ☐ Yes (check all that apply) ☐ No

☐ Colposcopy ☐ Cryosurgery (Freezing) ☐ Laser treatment ☐ Conization ☐ LEEP procedure

Month/Year of your most recent Mammogram? _____ Result: ☐ Normal ☐ Abnormal

Any prior history of abnormal mammograms? _____

PRIOR FERTILITY TESTS & TREATMENTS *(Please provide medical records if possible):*

Have you had prior infertility testing or treatment elsewhere? ☐ No ☐ Yes – where/when: _____

Prior Testing & Results, if known *(check all that apply and provide as much information as known):*

- ☐ Hormonal blood tests (FSH/AMH/TSH) – date: _____ results: _____
- ☐ Pelvic Ultrasound – date: _____ results: _____
- ☐ Hysterosonogram or Saline Sonogram - date: _____ results: _____
- ☐ Hysterosalpingogram (HSG) – date: _____ results: _____
- ☐ Endometrial Biopsy – date: _____ results: _____
- ☐ Infectious disease screening (HIV/Hep C/Hep B/Syphilis) – date: _____ results: _____

Prior Fertility Treatments *(check all that apply):*

Treatment	Outcome	Date(s) of Treatment
<input type="checkbox"/> Intrauterine insemination (IUI) – <input type="checkbox"/> medicated <input type="checkbox"/> un-medicated/natural		
<input type="checkbox"/> In-Vitro fertilization		
<input type="checkbox"/> Frozen Embryo Transfer (FET)		
<input type="checkbox"/> Donor Egg		
<input type="checkbox"/> Other: _____		

Additional Information: _____

GENERAL MEDICAL HISTORY:

Are you experiencing or have you been diagnosed with any of the following? *(check all that apply & provide details in the comments):*

<p>General:</p> <p><input type="checkbox"/> Recent unintentional weight gain or loss of greater than 15 pounds</p> <p><input type="checkbox"/> Anorexia/Bulimia</p> <p><input type="checkbox"/> Lack of energy</p> <p><input type="checkbox"/> Fever/Chills</p> <p><input type="checkbox"/> Chronic Pain</p> <p><input type="checkbox"/> Other _____</p> <p>Cardiovascular:</p> <p><input type="checkbox"/> Palpitations/Skipped beats</p> <p><input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> Heart attack</p> <p><input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Murmurs</p> <p><input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> Rheumatic fever</p> <p><input type="checkbox"/> Mitral Valve prolapse</p> <p><input type="checkbox"/> Other _____</p> <p>Pelvic (Genito-Urinary):</p> <p><input type="checkbox"/> Bladder infections/recurrent UTIs</p> <p><input type="checkbox"/> Kidney infections</p> <p><input type="checkbox"/> Vaginal infections</p> <p><input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> Leaking urine</p> <p><input type="checkbox"/> Blood in the urine</p> <p><input type="checkbox"/> Endometriosis</p> <p><input type="checkbox"/> Fibroids</p> <p><input type="checkbox"/> Polycystic Ovarian Syndrome (PCOS)</p> <p><input type="checkbox"/> Other _____</p> <p>Hematologic:</p> <p><input type="checkbox"/> Blood clotting disorder/Blood clots</p> <p><input type="checkbox"/> Sickle cell Anemia</p> <p><input type="checkbox"/> Easy bruising</p> <p><input type="checkbox"/> Swollen glands/lymph nodes</p> <p><input type="checkbox"/> Blood transfusions (list dates/reasons)</p> <p><input type="checkbox"/> Other _____</p>	<p>Mental Health Conditions:</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Anxiety disorder</p> <p><input type="checkbox"/> Schizophrenia</p> <p><input type="checkbox"/> Other _____</p> <p>Head, Eyes, Ears, Nose, and Throat:</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Loss/poor sense of smell</p> <p><input type="checkbox"/> Blurred vision</p> <p><input type="checkbox"/> Ringing ears</p> <p><input type="checkbox"/> Hearing loss/deafness</p> <p><input type="checkbox"/> Sinus problems/hay fever/allergic rhinitis</p> <p><input type="checkbox"/> Other _____</p> <p>Breasts:</p> <p><input type="checkbox"/> Discharge: <input type="checkbox"/> clear <input type="checkbox"/> bloody <input type="checkbox"/> milky <input type="checkbox"/> Lumpy</p> <p><input type="checkbox"/> Significant or Regular Pain</p> <p><input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> Other _____</p> <p>Skin:</p> <p><input type="checkbox"/> Unexplained rash/inflammation</p> <p><input type="checkbox"/> Acne</p> <p><input type="checkbox"/> Skin cancer</p> <p><input type="checkbox"/> Moles changing in appearance</p> <p><input type="checkbox"/> Excess hair growth</p> <p><input type="checkbox"/> Other _____</p> <p>Neurological Problems:</p> <p><input type="checkbox"/> Weakness/Loss of balance</p> <p><input type="checkbox"/> Seizures/Epilepsy</p> <p><input type="checkbox"/> Severe Headaches or Migraines</p> <p><input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> Memory loss</p> <p><input type="checkbox"/> Other _____</p>	<p>Respiratory:</p> <p><input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Bronchitis</p> <p><input type="checkbox"/> Pneumonia</p> <p><input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> Bloody cough</p> <p><input type="checkbox"/> Other _____</p> <p>Gastrointestinal:</p> <p><input type="checkbox"/> Nausea/Vomiting</p> <p><input type="checkbox"/> Ulcers</p> <p><input type="checkbox"/> Hepatitis</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Blood in your stools</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Irritable Bowel Syndrome</p> <p><input type="checkbox"/> Change in bowel habits</p> <p><input type="checkbox"/> Colitis (ulcerative or Crohn's)</p> <p><input type="checkbox"/> GERD/heartburn</p> <p><input type="checkbox"/> Other _____</p> <p>Endocrine/Hormonal:</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Hair loss</p> <p><input type="checkbox"/> Thyroid gland problems</p> <p><input type="checkbox"/> Excessive hunger/thirst</p> <p><input type="checkbox"/> Temperature intolerance (hot flashes or feeling cold)</p> <p><input type="checkbox"/> Other _____</p> <p>Musculoskeletal:</p> <p><input type="checkbox"/> Unusual muscle weakness</p> <p><input type="checkbox"/> Rheumatoid arthritis</p> <p><input type="checkbox"/> Lupus Erythematosus</p> <p><input type="checkbox"/> Myasthenia gravis</p> <p><input type="checkbox"/> Other _____</p>
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List any other chronic conditions/serious illnesses or Comments:

GENERAL MEDICAL HISTORY, *Continued*:

Allergies: Are you allergic to any medications? ☐ No ☐ Yes (please list and describe reactions)

Are you allergic to any foods? (e.g., peanuts, eggs, etc.) ☐ No ☐ Yes (please list and describe reactions)

List any medications you are taking, including over-the-counter medicines, vitamins, herbals, and supplements:

Medication/Supplement	Dose & Frequency

List all prior surgeries (including on cervix, uterus, ovarian cysts, tubes, endometriosis, appendix, etc.) ☐ Not Applicable

Year	Reason & Type of Surgery

Did you have any anesthesia problems? ☐ No ☐ Yes (describe) _____

Have you had any of these illnesses/diseases/conditions? At what age? ☐ Cancer – age: ____ ☐ Covid-19 – age: ____

☐ Congenital Heart Defect – age: ____ ☐ Chicken pox/Shingles – age: ____ ☐ German Measles (rubella) – age: ____

☐ Other diseases: _____ ☐ N/A – None

Additional information: _____

Vaccination History:

Chickenpox (Varicella): ☐ Yes (date: _____) ☐ No MMR (Measles, Mumps & Rubella): ☐ Yes (date: _____) ☐ No
 BCG (Tuberculosis): ☐ Yes (date: _____) ☐ No Polio: ☐ Yes (date: _____) ☐ No
 Hepatitis A: ☐ Yes (date: _____) ☐ No Hepatitis B: ☐ Yes (date: _____) ☐ No
 Tetanus: ☐ Yes (date: _____) ☐ No Influenza: ☐ Yes (date: _____) ☐ No
 Covid19: ☐ Yes (date: _____) ☐ No

SOCIAL HISTORY:

How many caffeinated beverages (coffee, tea, energy drinks, soda) do you drink per day? _____ ☐ None

Do you smoke cigarettes? ☐ No ☐ Yes - how many/day? _____ How many years? _____ ☐ Quit - when? _____

Do you drink alcohol? ☐ No ☐ Yes: # per week _____

Do you use marijuana, cocaine, or any other recreational drug? ☐ No ☐ Yes - frequency: _____

Do you exercise? ☐ No ☐ Yes – describe: _____

Do you follow a particular food diet or have any special dietary habits? ☐ No ☐ Yes – describe: _____

Are you aware of any radiation exposures other than X-rays? ☐ No ☐ Yes – describe: _____

Do you have any concerns with abuse, past or present? _____

PATIENT FAMILY HISTORY:

Ethnic Background/Ancestry (if known): ☐ African American ☐ East Asian ☐ Southeast Asian

☐ Caucasian ☐ Hispanic ☐ Jewish ☐ Native American ☐ Mediterranean ☐ Middle Eastern

☐ Other _____

Have you had any genetic carrier screening (e.g. cystic fibrosis, spinal muscular atrophy, fragile X, Tay-Sachs, etc.):

Are you related to your current partner? ☐ No ☐ Yes – describe: _____

Did your mother take DES during pregnancy to prevent miscarriage? ☐ No ☐ Yes ☐ Don't know

Is there anyone in the family who has had any of the following disorders?

Condition	Yes	Relationship to you	Condition	Yes	Relationship to you
Breast cancer	<input type="checkbox"/>		Endometriosis	<input type="checkbox"/>	
Ovarian cancer	<input type="checkbox"/>		Infertility	<input type="checkbox"/>	
Colon cancer	<input type="checkbox"/>		Menopause before age 40	<input type="checkbox"/>	
Other cancer or tumors	<input type="checkbox"/>		Two (2) or more miscarriages	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>		Polycystic ovarian syndrome (PCOS)	<input type="checkbox"/>	
Thyroid problems	<input type="checkbox"/>		Birth defects	<input type="checkbox"/>	
Heart disease	<input type="checkbox"/>		Malignant Hyperthermia	<input type="checkbox"/>	
Hypertension/stroke	<input type="checkbox"/>		Inherited diseases	<input type="checkbox"/>	
Blood clots/blood disorders	<input type="checkbox"/>				
Congenital deafness/blindness	<input type="checkbox"/>				
Developmental delay	<input type="checkbox"/>				
Learning delay or disorder	<input type="checkbox"/>				
Tuberculosis	<input type="checkbox"/>				

Other Relevant Family History/Comments: _____

Male Partner history, if applicable, continues on the next page

MALE PARTNER HISTORY (if applicable)

Name: _____

Ethnic Background/Ancestry (if known): ☐ African American ☐ East Asian ☐ Southeast Asian
☐ Caucasian ☐ Hispanic ☐ Jewish ☐ Native American ☐ Mediterranean ☐ Middle Eastern
☐ Other _____

Medical & Health History:

Have you been evaluated by a urologist? ☐ No ☐ Yes – MD name & date of evaluation: _____

Have you previously conceived with another partner? ☐ No ☐ Yes - How many times? _____ How many live births? _____

Have you had a semen analysis? ☐ No ☐ Yes – results: _____

Do you have difficulty with erections? ☐ No ☐ Yes

Do you have retrograde ejaculation of sperm into the bladder? ☐ No ☐ Yes

Do you currently or have you had any of the following sexually transmitted diseases or pelvic infections? ☐ N/A

☐ Chlamydia – date: _____ ☐ Gonorrhea – date: _____ ☐ Herpes – date: _____ ☐ Hepatitis – date: _____

☐ Genital warts/HPV – date: _____ ☐ Syphilis – date: _____ ☐ HIV/AIDS – date: _____

☐ Other _____ date: _____

Have you had a history of undescended testicles? ☐ No ☐ Yes ____ One side ____ Both

Do you have scrotal or testicular pain? ☐ No ☐ Yes

Have you had prior injury to your testicles requiring hospitalization? ☐ No ☐ Yes

Have you had any fever in the last 3 months? ☐ No ☐ Yes

Have you had a vasectomy? ☐ No ☐ Yes – date: _____ Have you had a vasectomy reversal? ☐ No ☐ Yes - date: _____

Have you had surgery for varicocele repair? ☐ No ☐ Yes – date: _____

Have you had hernia surgery? ☐ No ☐ Yes – date: _____

Did you undergo any bladder or penis surgery as a child? ☐ No ☐ Yes – describe: _____

Have you had any other surgeries? ☐ No ☐ Yes – list year, type: _____

Did you have any anesthesia problems? ☐ No ☐ Yes – describe: _____

Are you exposed to any radiation, harmful chemicals, or prolonged heat, in the workplace? ☐ No ☐ Yes

Have you had chemotherapy for cancer? ☐ No ☐ Yes

For any question you answered yes to, please provide additional relevant details such as dates, frequency, etc.:

Male Partner Medical & Health History, *continued*:

List any current chronic illness or medical problem: _____

List any medications you are taking, including over-the-counter pills, creams, vitamins, herbals, and supplements:

Medication/Supplement	Dose & Frequency

Are you allergic to any medication, food, or other toxicant? ☐ No ☐ Yes (please list and describe reactions)

Have you had any genetic carrier screening? (e.g., cystic fibrosis, fragile X, Tay-Sachs, etc.): ☐ No ☐ Yes – describe:

List any family history of infertility, cancer, or serious illness:

Social History:

How many caffeinated beverages (coffee, tea, energy drinks, soda) do you drink per day? _____ ☐ None
 Do you smoke cigarettes? ☐ No ☐ Yes - how many/day? _____ How many years? _____ ☐ Quit - when? _____
 Do you drink alcohol? ☐ No ☐ Yes: # per week _____
 Do you use marijuana, cocaine, or any other recreational drug? ☐ No ☐ Yes - frequency: _____
 Do you exercise? ☐ No ☐ Yes – describe: _____
 Do you use hot tubs regularly? ☐ No ☐ Yes - frequency: _____
 Are you aware of any radiation exposures other than X-rays? ☐ No ☐ Yes – describe: _____
