



# South Jersey Fertility Center

Robert Skaf, M.D., F.A.C.O.G.  
Peter G. Van Deerlin, M.D., F.A.C.O.G.  
Stephen W. Sawin, M.D., F.A.C.O.G.  
Gary Packin, D.O., F.A.C.O.O.G.  
Barbara Alice, APN-C, MSN  
Tracy Krause, APN-C, MSN

## Patient History Questionnaire (Female)

1/09

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date of Appt: \_\_\_\_\_

Nickname or Name you like to be called \_\_\_\_\_

**CHIEF COMPLAINT** (What is the main reason you are coming to South Jersey Fertility Center?)

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**INFERTILITY HISTORY** (Please answer this section if you wish to conceive a pregnancy now. If not, begin at Menstrual History on page 2)

1. Approximately how long (years/months) have you been attempting to conceive a pregnancy? (i.e. having consistent unprotected intercourse.) \_\_\_\_\_
2. How long have you been with your current sexual partner (if applicable)? \_\_\_\_\_
3. Are you married? \_\_\_\_\_ If "Yes", how many years with this spouse? \_\_\_\_\_
4. Previously married? \_\_\_\_\_ If "Yes", list years with previous spouse/s \_\_\_\_\_
5. Have you tried to conceive with a previous partner? \_\_\_\_\_ Were you successful? \_\_\_\_\_
6. When did you last use a contraceptive method \_\_\_\_\_.  
Circle Method: withdrawal, rhythm method, contraceptive pill, Depo-Provera shot, other
7. Have you or your partner had a surgical sterilization procedure done? \_\_\_\_\_
8. About how often do you have intercourse during the "fertile week?" \_\_\_\_\_
9. Do you have pain with intercourse? \_\_\_\_\_
10. Do you use a "personal lubricant" (such as K-Y) with intercourse? \_\_\_\_\_
11. Have you done Basal Body Temperature (BBT) charting to assess ovulation status and timing? \_\_\_\_\_ What were the results? \_\_\_\_\_
12. Have you done urine Ovulation Predictor Kits to check for ovulation timing? \_\_\_\_\_ Did the kits turn positive? \_\_\_\_\_ If yes, what day of the cycle? \_\_\_\_\_

If you have had any tests performed to assess your fertility please indicate "yes" after each of the following tests you have done and briefly describe the results, e.g. "normal" or "not normal"

13. Blood test for progesterone (about 3 weeks after a period) to assess ovulatory status? \_\_\_\_\_
14. Hysterosalpingogram (HSG/dye test) to check fallopian tubes? \_\_\_\_\_
15. Blood test for FSH (ovarian reserve assessment) drawn early in menstrual cycle? \_\_\_\_\_
16. Pelvic Ultrasound? \_\_\_\_\_
17. Laparoscopy (surgical scope near navel to evaluate fertility)? \_\_\_\_\_  
(Were tubes open?) \_\_\_\_\_
18. Hysteroscopy (surgical scope in the uterus)? \_\_\_\_\_
19. Have you undergone any fertility treatment? \_\_\_\_\_

Please indicate the **number of attempts**, if any, you have made with the following treatments.

20. Clomid pills. \_\_\_\_\_
21. Clomid with intrauterine insemination (IUI). \_\_\_\_\_
22. Tamoxifen pills. \_\_\_\_\_
23. Tamoxifen/IUI. \_\_\_\_\_
24. Gonadotropin(daily fertility shots)/IUI. \_\_\_\_\_
25. In Vitro Fertilization (IVF) – need number of attempts and year IVF performed \_\_\_\_\_
26. Were any of the IVF's cycles paid for by any insurance company? If yes, how many? \_\_\_\_\_
27. Frozen Embryo Transfer. \_\_\_\_\_
28. Donor egg recipient – need number of attempts and year performed. \_\_\_\_\_
29. Were any of the Donor egg cycles paid for by any insurance company? If yes, how many? \_\_\_\_\_
30. Donor sperm insemination. \_\_\_\_\_
31. Surgical repair of tubes, uterus, or pelvic scarring. \_\_\_\_\_
32. Any other treatments? \_\_\_\_\_

## **MENSTRUAL HISTORY**

1. What was the date that your last menstrual period began? \_\_\_\_\_
2. What was the date that your previous menstrual period began? \_\_\_\_\_
3. How old were you when your periods began? \_\_\_\_\_
4. Are your periods regular? \_\_\_\_\_ How long is it from the beginning of one period to the beginning of the next period (typically 28-30 days) Please give a range of days if necessary. \_\_\_\_\_

5. How many days of flow are typical for you? \_\_\_\_\_ Is the flow excessively heavy (i.e. passing large clots)?  
\_\_\_\_\_
6. Are your periods excessively painful? \_\_\_\_\_ How bad (scale 1-10) \_\_\_\_\_ What pain medication do you use? \_\_\_\_\_  
Does it help? \_\_\_\_\_ Other symptoms: \_\_\_\_\_
7. Do you experience frequent hot flashes? \_\_\_\_\_

**GYN HISTORY**

1. Have you ever had a sexually transmitted disease (e.g. gonorrhea, chlamydia, syphilis, herpes, trichomonas)?  
\_\_\_\_\_
2. Have you had a pelvic infection called “pelvic inflammatory disease” (PID)? \_\_\_\_\_
3. Do you have fibroids in your uterus? \_\_\_\_\_ How big/how many? \_\_\_\_\_
4. Do you have endometriosis? \_\_\_\_\_
5. Date and result of last pap test (approx.) \_\_\_\_\_
6. Have you had your cervix treated for an abnormal pap test? \_\_\_\_\_ What treatment? \_\_\_\_\_
7. Date of last mammogram. If none, then state none. \_\_\_\_\_
8. Have you been sexually abused? \_\_\_\_\_
10. Do you have milky discharge from your nipples? \_\_\_\_\_
11. Are you bothered by excessive, unwanted hair growth? \_\_\_\_ Where? \_\_\_\_\_
12. Do you have polycystic ovary syndrome (PCOS)? \_\_\_\_\_

**PAST PREGNANCY HISTORY** (Indicate dates, mode of delivery, D+E etc. If none, write zero)

1. How many times have you been pregnant? \_\_\_\_\_
2. How many full term births have you had? \_\_\_\_\_
3. How many deliveries that were premature? \_\_\_\_\_
4. How many miscarriages have you had (if any)? \_\_\_\_\_
5. How many abortions? \_\_\_\_\_
6. Have you had an ectopic (tubal) pregnancy? \_\_\_\_\_
7. How many of your biological children are still living? \_\_\_\_\_
8. How many of your pregnancies were fathered by your current partner? \_\_\_\_\_

## PAST MEDICAL/SURGICAL HISTORY

1. List any medical diagnosis you have (e.g. thyroid disorder, high blood pressure, diabetes, depression, history of hepatitis, anemia, etc).  
\_\_\_\_\_  
\_\_\_\_\_
2. List any surgeries you have had on your ovaries, fallopian tubes, uterus or cervix (including C-sections). \_\_\_\_\_  
\_\_\_\_\_
3. List any other surgeries that you have had (e.g. appendix, gallbladder, wisdom teeth etc).  
\_\_\_\_\_
4. Have you had any problems with anesthesia? \_\_\_\_\_
5. List your medications and their dosages (include prenatal or other vitamins/herbs)  
\_\_\_\_\_  
\_\_\_\_\_
6. List any allergies to medications or latex and your reaction. \_\_\_\_\_  
\_\_\_\_\_

## REVIEW OF SYSTEMS

Do you have any of the following problems (circle all that apply or add any problems not listed):

**General Health** : weight gain/loss; decreased energy, fever, chills, sleep disorder

**Endocrine**: excessive hunger or thirst, temperature intolerance, hair loss, tremor

**GI**: nausea, vomiting, diarrhea, constipation, change in bowel habits

**Musculoskeletal**: weakness, joint pains or swelling, back pain

**Psych**: depression, anxiety, difficulty concentrating

**Neuro**: dizziness, headaches, blurred vision, hearing problems

**Urinary**: burning with urination, frequent urination, blood in the urine

**Hematologic**: excessive bleeding, easy bruising, swollen glands

**Respiratory**: shortness of breath, chronic cough or wheezing

**Skin**: acne, unusual rashes, changing moles

**Cardiovascular**: chest pain, palpitations, skipped beats

## SOCIAL HISTORY

1. What is your occupation (if applicable)? \_\_\_\_\_
2. How many cigarettes do you smoke per day? If none, then state none.  
\_\_\_\_\_
3. How much alcohol do you consume in a typical week? If none, then state none.  
\_\_\_\_\_
4. Have you used illicit drugs in the past year? (please list here) \_\_\_\_\_  
\_\_\_\_\_
5. Do you have what you feel are extreme stressors in your life? \_\_\_\_\_ (If so, please list)  
\_\_\_\_\_
6. Are you currently or recently the victim of domestic violence? \_\_\_\_\_

## FAMILY HISTORY

1. Is there a history of breast cancer in your family? List affected members' relationships to you and age of diagnosis. \_\_\_\_\_
2. Is there a history of GYN (uterine, ovarian, cervical) cancer in your family? List type of cancer and that affected person's relationship to you.  
\_\_\_\_\_
3. Is there a history of birth defects or genetic diseases in your family? (e.g. Down's Syndrome, Sickle Cell Anemia, mental retardation, Cystic Fibrosis)  
\_\_\_\_\_
4. Family heritage: circle all that apply or write in other categories.  
Caucasian, Jewish, African American, Hispanic, Italian, Greek, Filipino, Indian/Pakistani, Middle Eastern, Asian, Other: