Women's Specialists OF NORTHSIDE GWINNETT

Patient Last Name: _____ **DOB:** _____

Reproductive & Sexual History Questionnaire

Name: _____ Date: _____

Please answer all that apply. Skip those that don't apply.

MENSTRUAL HISTORY

Menstrual cycle pattern (check all that apply): ☐ Regular periods ☐ Irregular periods ☐ Spotting before periods ☐ No periods ☐ Heavy periods ☐ Light periods ☐ Bleeding-between periods					
Number of days between the start of one period to the start of the next period: days					
How many days of bleeding do you have? days					
Dates of the 1st day of your last 2 menstrual periods: / / ; / /					
Age when you had your first period: years old					
Age when you first noticed: *Breast development:* years old	*Pubic hair:* years old	*Underarm hair:* years old			
How many periods do you have per year?					
Do you need medication to bring on a period? ☐ Yes, what type?: ☐ No					
If you do not have periods, at what age did you stop having them? years old					
Do you have severe cramping or pelvic pain with your periods?	☐ Yes: ☐ Always ☐ Sometimes ☐ Recently ☐ In the past	☐ No			

PREGNANCY SUMMARY

Total # of ALL pregnancies:		Number of Miscarriages (less tha'n 20 weeks):			
Number of Ectopic/Tubal Pregnancies:		Number of Elective Terminations (Abortions):			
Number of Full Term Deliveries:		How many were live births?		How many were stillborn?	
Number of Premature Deliveries: (less than 37 weeks)		How many were live births?		How many were stillborn?	
Any pregnancies with birth defects? ☐ Yes, explain: ☐ No					

Date pregnancy ended or delivered	Months to Conception	Treatments to Conceive	Delivery Type/D&C/ Complications	Wt.	Sex	Current Partner?
					☐ Boy ☐ Girl	☐ Yes ☐ No
					☐ Boy ☐ Girl	☐ Yes ☐ No
					☐ Boy ☐ Girl	☐ Yes ☐ No
					☐ Boy ☐ Girl	☐ Yes ☐ No
					☐ Boy ☐ Girl	☐ Yes ☐ No
					☐ Boy ☐ Girl	☐ Yes ☐ No

PAP SMEAR HISTORY

When was your last pap smear?: (month/year) /		☐ Normal	☐ Abnormal
When was your last abnormal pap smear? (month/year)		☐ Not applicable	
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

INFERTILITY CONSULT PATIENT FORMS

Patient Last Name: _____ **DOB:** _____

BREAST SCREENING HISTORY

Have you ever had a mammogram? ☐ Yes - date:	☐ No
Mammogram results: ☐ Normal ☐ Abnormal - please explain:	
Do you perform breast self exams? ☐ Yes ☐ No	

SEXUAL HISTORY

How many times do you have intercourse per week?	times per week	☐ None	☐ Not applicable
Have you used over-the-counter ovulation kits to time intercourse? ☐ Yes ☐ No			
Do you have pain with intercourse? ☐ Yes ☐ No	☐ Loss/change in libido		
Do you use lubricants (K-Y Jelly®, etc.) during intercourse? ☐ Yes - what types?			☐ No
Have you had any of the following sexually transmitted diseases or pelvic infections? *Check all that apply*			☐ No
☐ Chlamydia - date:	☐ Gonorrhea - date:	☐ Herpes - date:	☐ Genital warts/HPV - date:
☐ Syphilis - date:	☐ HIV/AIDS - date:	☐ Hepatitis - date:	☐ Other- date:
Is there a history of physical/sexual abuse? ☐ Yes (check all that apply) ☐ Physical ☐ Sexual			☐ No
If you answered yes to abuse, do you wish to discuss this? ☐ Yes ☐ No			

PRIOR FERTIFLITY TREATMENTS *(if applicable)*

Clomiphene citrate	☐ Yes ☐ No	Number of cycles:
Letrozole	☐ Yes ☐ No	Number of cycles:
FSH injectable meds	☐ Yes ☐ No	Number of cycles:
hCG injectable med.	☐ Yes ☐ No	Number of cycles:
Intrauterine insemination	☐ Yes ☐ No	Number of cycles:
IVF	☐ Yes ☐ No	Number of cycles:
Other:		

PRIOR FERTILITY EVALUATION *(if applicable)*

Urine ovulation predicator kits	☐ Yes ☐ No	☐ Normal ☐ Abnormal	Other:
TSH	☐ Yes ☐ No	☐ Normal ☐ Abnormal	
FSH blood test	☐ Yes ☐ No	☐ Normal ☐ Abnormal	
AMH level	☐ Yes ☐ No	☐ Normal ☐ Abnormal	
Semen analysis	☐ Yes ☐ No	☐ Normal ☐ Abnormal	
Hysterosalpingogram	☐ Yes ☐ No	☐ Normal ☐ Abnormal	
Pelvic ultrasound	☐ Yes ☐ No	☐ Normal ☐ Abnormal	
Sonohysterography	☐ Yes ☐ No	☐ Normal ☐ Abnormal	
Hysteroscopy	☐ Yes ☐ No	☐ Normal ☐ Abnormal	

CONTRACEPTIVE HISTORY

☐ None	☐ Condoms - dates of use:	☐ Diaphragm - dates of use:	☐ IUD - dates of use:
☐ Birth control pills - dates of use:		complications? ☐ Yes ☐ No	☐ Never used birth control pills
☐ Injectable contraception (Depo-Provera®, Lunelle™, etc.) - dates of use:			complications? ☐ Yes ☐ No
☐ Skin patch - dates of use:		complications? ☐ Yes ☐ No	☐ Foam or Jelly
☐ Tubal sterilization procedure (tubes tied) - date (month/year) /		☐ Tubes untied - date (month/year) /	

Patient Last Name: _____ **DOB:** _____

Medical History Form

Name:_____ Date: _____

Please answer all that apply. Skip those that don't apply.

ALLERGIES	
Allergies to medications/drug sensitivities:	☐ None
Medication:	Reaction:
Medication:	Reaction:
Allergies to non-medicines: (latex, adhesive tape, specific food allergies, etc.)	☐ None
Allergy:	Reaction:
Allergy:	Reaction:

PATIENT'S MEDICAL HISTORY			
Heart disease	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No
Thyroid problems	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Kidney disease	☐ Yes ☐ No	Rheumatoid arthritis	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Lupus Erythematosus	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Blood clots (deep vein thrombosis/pulmonary embolus)	☐ Yes ☐ No	High blood pressure	☐ Yes ☐ No
Exposure to blood products	☐ Yes ☐ No	☐ Other medical problems:	

MEDICATION REVIEW ***Include prescribed, over-the-counter drugs, folic acid or vitamins, herbal remedies or supplements, inhalers, etc.***			
Name of medication	strength/dose	Frequency taken	Reason for taking

IMMUNIZATIONS & GENETIC HISTORY:			
Have you had a rubella titer checked?	☐ Yes ☐ No	Have you had a chicken pox vaccine?	☐ Yes ☐ No
Have you had chicken pox?	☐ Yes ☐ No		

Patient Last Name: _____ **DOB:** _____

SURGICAL HISTORY

Have you had any surgeries? ☐ Yes (Please list in chronological order) ☐ No

Year	Type of surgery	Reason for surgery

Did you have any problems with anesthesia? ☐ Yes - describe ☐ No

FAMILY HISTORY

Indicate, if yes	Relationship to you		Indicate, if yes	Relationship to you	
☐ Diabetes		☐ Unsure	☐ Neurologic, (brain/spine)		☐ Unsure
☐ Thyroid problems		☐ Unsure	☐ High blood pressure		☐ Unsure
☐ Heart disease		☐ Unsure	☐ Glaucoma		☐ Unsure
☐ Blood clots		☐ Unsure	☐ Gallstones		☐ Unsure
☐ Obesity		☐ Unsure	☐ Hepatitis		☐ Unsure
☐ Psychiatric conditions		☐ Unsure	☐ Tuberculosis		☐ Unsure
☐ Infertility		☐ Unsure	☐ Endometriosis		☐ Unsure
☐ Menopause before age 40		☐ Unsure	☐ Genetic Disease		☐ Unsure
☐ Cystic Fibrosis		☐ Unsure	☐ Irritable Bowel Syndrome		☐ Unsure
☐ Cancer		☐ Unsure	☐ Other:		

SOCIAL HISTORY

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

Do you smoke cigarettes? ☐ Yes - How many/day? How many years? ☐ Quit, year: ☐ No

Are you exposed to second-hand smoke? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes - ☐ Beer (# per week): ☐ Wine (# per week): ☐ Liquor (# per week): ☐ No

Do you use marijuana, cocaine, or any other similar drug? ☐ Yes - describe ☐ No

Do you exercise regularly? ☐ Yes ☐ No

How many hours of exercise per week? ☐ moderate (i.e.walking, yoga): ☐ vigorous (i.e. running):

Do you feel safe in your own home? ☐ Yes ☐ No - explain

Patient Last Name: _____ **DOB:** _____

REVIEW OF SYSTEMS

General ☐ None	**Head, Eyes, Ears, Nose, & Throat** ☐ None	**Respiratory** ☐ None
☐ Recent weight changes (☐ gain ☐ loss) ☐ Anorexia/Bulimia ☐ Lack of energy ☐ Fever/Chills ☐ Other:	☐ Dizziness ☐ Loss of sense of smell ☐ Headaches ☐ Ringing ears ☐ Chronic nasal congestion ☐ Blurred vision ☐ Hearing loss/deafness ☐ Other:	☐ Shortness of breath ☐ Bronchitis ☐ Bloody cough ☐ Other:
Endocrine/Hormonal ☐ None	**Breasts** ☐ None	**Neurological Problems** ☐ None
☐ Hair loss ☐ Thyroid gland problems ☐ Rapid weight change ☐ Excessive hunger/thirst ☐ Temperature intolerance (hot flashes or feeling cold) ☐ Other:	☐ Discharge (☐ clear ☐ bloody ☐ milky) ☐ Lumps ☐ Pain ☐ Cancer ☐ Abnormal mammogram ☐ Reduction ☐ Augmentation/Breast implants (☐ saline ☐ silicone) ☐ Other:	☐ Weakness/Loss of balance ☐ Seizures/Epilepsy ☐ Headaches ☐ Migraine headaches ☐ Numbness ☐ Memory loss ☐ Other:
Gastrointestinal ☐ None	**Genito-Urinary** ☐ None	**Skin/Extremities** ☐ None
☐ Nausea/Vomiting ☐ Ulcers ☐ Blood in your stools ☐ Constipation ☐ Diarrhea ☐ Change in bowel habits ☐ Colitis (ulcerative or Crohn's) ☐ Other:	☐ Bladder infections ☐ Kidney infections ☐ Vaginal infections ☐ Frequent urination ☐ Leaking urine ☐ Blood in the urine ☐ Herpes ☐ Other:	☐ Unexplained rash/inflammation ☐ Acne ☐ Skin cancer ☐ Burn Injury ☐ Moles changing in appearance ☐ Excess hair growth ☐ Other:
Musculoskeletal ☐ None	**Hematologic** ☐ None	**Cardiovascular** ☐ None
☐ Unusual muscle weakness ☐ Decreased energy/stamina ☐ Other:	☐ Blood clotting disorder/Blood clot ☐ Sickle Cell Anemia ☐ Easy bruising ☐ Thrombophlebitis ☐ Swollen glands/lymph nodes ☐ Blood transfusions (dates/reasons) ☐ Other:	☐ Palpitations/Skipped beats ☐ Chest pain ☐ Heart attack ☐ Murmurs ☐ Rheumatic fever
Mental Health Problems ☐ None	**Other**	
☐ Depression ☐ Anxiety ☐ Schizophrenia ☐ Other:		

☐ All other systems negative

Patient signature Date Physician signature Date

Patient Last Name: _____ **DOB:** _____

Spouse/Partner Last Name: _____ **DOB:** _____

Spouse/Partner name: _____ Date of Birth: _____

PREGNANCY SUMMARY

Have you caused a previous pregnancy? ☐ No ☐ Yes - Total # of pregnancies:	List dates:	
How many years have you been attempting pregnancy?	Height:	Weight:
Have you had a prior evaluation? ☐ Yes (if yes, please answer below) ☐ No		
Prior test results:		
Prior treatment & results:		

SEXUAL HISTORY

Do you have (or have you had) erectile difficulty?	☐ Yes ☐ No
Do you have (or have you had) ejaculatory difficulty?	☐ Yes ☐ No
Do you have (or have you had) a loss/change of libido (sex drive)?	☐ Yes ☐ No
Do you use lubricants (K-Y Jelly®, etc.) during Intercourse? ☐ Yes ☐ No If yes, what types:	
Do you or have you had any of the following? ☐ Yes (check all that apply) ☐ No ☐ STDs ☐ Mumps ☐ Varicocele ☐ Undescended testes ☐ Genital surgery	

MEDICAL HISTORY

Do you have any of the following medical problems?:

☐ Yes ☐ No	Heart disease	☐ Yes ☐ No	Multiple sclerosis
☐ Yes ☐ No	Heart murmur	☐ Yes ☐ No	Epilepsy
☐ Yes ☐ No	Hypertension	☐ Yes ☐ No	Neurologic disease
☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Asthma or other lung/pulmonary disorder
☐ Yes ☐ No	Hepatitis		
☐ Yes ☐ No	Cancer - If yes, please indicate type & treatment:		
☐ Other (Please explain):			

SURGICAL HISTORY

Have you had any of the following types of surgery? *If yes, please list specific procedure and date*

Type of surgery		Specific procedure	Date
☐ Yes ☐ No	Orchidopexy (surgical repair of undescended testicle)		
☐ Yes ☐ No	Orchiectomy (surgical removal of testicle) If yes - diagnosis:		
☐ Yes ☐ No	Bladder neck surgery		
☐ Yes ☐ No	Hernia repair		
☐ Yes ☐ No	Pelvic surgery		
☐ Yes ☐ No	Scrotal surgery		
☐ Yes ☐ No	Retroperitoneal surgery (involving abdominal organs)		
☐ Yes ☐ No	Transurethral surgery		
☐ Yes ☐ No	Other:		

Patient Last Name: _____ **DOB:** _____

Spouse/Partner Last Name: _____ **DOB:** _____

Spouse/Partner Medical History Questionnaire

INFECTION HISTORY			
Have you had any of the following types of infections? *If yes, please list how it was treated and date of treatment*			
Type of infection		Treatment	Date
☐ Yes ☐ No	Gonorrhea		
☐ Yes ☐ No	Chlamydia		
☐ Yes ☐ No	Syphilis		
☐ Yes ☐ No	Herpes		
☐ Yes ☐ No	Mumps		
☐ Yes ☐ No	Viral		
☐ Yes ☐ No	Prostatitis		
☐ Yes ☐ No	Urethritis		
☐ Yes ☐ No	Cystitis (bladder infection)		
☐ Yes ☐ No	Pyelonephritis (kidney infection)		
☐ Yes ☐ No	Epididymitis/orchitis (testicle infection)		
☐ Yes ☐ No	Other:		

DISORDERS IN YOUR FAMILY					
Indicate, if yes	Relationship to you		Indicate, if yes	Relationship to you	
☐ Other infertility		☐ Unsure	☐ Diabetes		☐ Unsure
☐ Heart disease		☐ Unsure	☐ Cancer		☐ Unsure

CHILDHOOD & DEVELOPMENT
Have you had testicular torsion/trauma ☐ Yes ☐ No

MEDICATION/CHEMICAL/ENVIRONMENTAL EXPOSURE			
☐ Yes ☐ No	Prescription medications	*If yes, name and dosage:*	
☐ Yes ☐ No	Drug Allergies	*If yes, name of drug:*	
☐ Yes ☐ No	Alcohol	*If yes, how much and how often:*	
☐ Yes ☐ No	Marijuana	*If yes, how much and how often:*	
☐ Yes ☐ No	Other drugs	*If yes, how much and how often:*	
☐ Yes ☐ No	Tobacco	*If yes, how much and how often:*	
☐ Yes ☐ No	Hot tubs		
☐ Yes ☐ No	Anabolic steroids		
☐ Yes ☐ No	Have you now or have you ever used testosterone (gel, injection, patch, pills)		
☐ Yes ☐ No	Are you currently using, or have you ever used, complementary therapies to enhance fertility potential? (i.e., acupuncture, Chinese medicine, herbal remedies)		*If yes, please list:*

Patient Last Name: _____ **DOB:** _____

Spouse/Partner Last Name: _____ **DOB:** _____

Spouse/Partner Medical History Questionnaire

REVIEW OF SYSTEMS		
General ☐ None	**Head, Eyes, Ears, Nose, & Throat** ☐ None	**Respiratory** ☐ None
☐ Recent weight gain or loss ☐ Weakness ☐ Lack of energy ☐ Fever/Chills ☐ Other:	☐ Dizziness ☐ Loss of sense of smell ☐ Headaches ☐ Ringing ears ☐ Chronic nasal congestion ☐ Blurred vision ☐ Hearing loss/deafness ☐ Other:	☐ Shortness of breath ☐ Asthma ☐ Bronchitis ☐ Pneumonia ☐ Tuberculosis ☐ Bloody cough ☐ Other:
Endocrine/Hormonal ☐ None	**Breasts** ☐ None	**Neurological Problems** ☐ None
☐ Diabetes ☐ Hair loss ☐ Thyroid gland problems ☐ Rapid weight gain or loss ☐ Excessive hunger/thirst ☐ Temperature intolerance (hot flashes or feeling cold) ☐ Other:	☐ Discharge (☐ clear ☐ bloody ☐ milky) ☐ Lumps ☐ Pain ☐ Cancer	☐ Weakness/Loss of balance ☐ Seizures/Epilepsy ☐ Headaches ☐ Migraine headaches ☐ Numbness ☐ Memory loss ☐ Other:
Gastrointestinal ☐ None	**Genito-Urinary** ☐ None	**Skin/Extremities** ☐ None
☐ Nausea/Vomiting ☐ Ulcers ☐ Hepatitis ☐ Blood in your stools ☐ Constipation ☐ Diarrhea ☐ Irritable Bowel Syndrome ☐ Change in bowel habits ☐ Colitis (ulcerative or Crohn's) ☐ Other:	☐ Bladder infections ☐ Kidney infections ☐ Frequent urination ☐ Leaking urine ☐ Blood in the urine ☐ Herpes ☐ Other:	☐ Unexplained rash/inflammation ☐ Acne ☐ Skin cancer ☐ Burn Injury ☐ Moles changing in appearance ☐ Other:
Musculoskeletal ☐ None	**Hematologic** ☐ None	**Cardiovascular** ☐ None
☐ Unusual muscle weakness ☐ Decreased energy/stamina ☐ Rheumatoid arthritis ☐ Lupus Erythematosus ☐ Myasthenia gravis ☐ Other:	☐ Blood clotting disorder/Blood clot ☐ Sickle Cell Anemia ☐ Easy bruising ☐ Thrombophlebitis ☐ Swollen glands/lymph nodes ☐ Blood transfusions (dates/reasons) ☐ Other:	☐ Palpitations/Skipped beats ☐ Chest pain ☐ Heart attack ☐ Stroke ☐ Murmurs ☐ High blood pressure ☐ Rheumatic fever ☐ Mitral valve prolapse (Need antibiotics before dental procedures? ☐ Yes ☐ No
Mental Health Problems ☐ None	**Other**	
☐ Depression or Anxiety disorder ☐ Schizophrenia ☐ Other:		

☐ All other systems negative

Spouse/Partner signature Date Physician signature Date