Charles E Miller, M.D., & Associates
New Infertility Patient Questionnaire

Female Questionnaire

Name ________________________________ Birthdate ____/____/____ Ethnicity ________________________

Occupation ________________________________ SS # ________________________________

Height ____ft _____inches Weight__________ lbs.

Menstrual History

' what age did you have your first period?_____ On what date did your last period begin?_________

___ Yes ___ No Are your periods regular?
If yes, how many days from the beginning of one period until the beginning of the next? _______
If no, how many periods in the past year? _______________
How many days does each period last? _______________

List any medications that you have taken in the past year to help bring on your period and how the medication was taken (i.e. daily, weekly, etc):

____

___ Yes ___ No Do you have bleeding in-between periods?

___ Yes ___ No Do you have painful periods?

˜yn History

___ Yes ___ No Do you have pain during intercourse?

___ Yes ___ No Do you have pain with bowel movements?

___ Yes ___ No Do you have any breast discharge?

___ Yes ___ No Do you currently have acne?

___ Yes ___ No Do you have excess hair growth on your upper lip, chin, back or chest?

___ Yes ___ No Have you ever had an abnormal PAP smear? Date of last PAP smear:_____________

___ Yes ___ No Have your fallopian tubes been tied?

List any pelvic infections, as well as any sexually transmitted diseases you have had:

____

Infertility History

How many months total have you been sexually active with your current partner during which neither of you was using any contraception or birth control? _______
With past partners? _______

Please list all of your fertility treatment cycles.

For medications, CC = Clomid, Clomiphine Citrate, or Serophene, HMG = Repronex, Pergonal, FSH = Gonal-F, Follistim, Fertinex, Bravelle, or Metrodin. In addtion, state whether Lupron (leuprolide), Synarel, Antagon (Ganirelix), or Cetrotide (Cetrorelix) were also taken.

For procedure, IC = intercourse, IUI = intrauterine insemination or artificial insemination, or state IVF or ICSI as applicable

Date	Medications	Procedure	Current partner or donor sperm?	Outcome

Tests / Procedures

Not Done	Procedure	Date	Result / Findings
	Hysterosalpingogram (HSG), an X-ray of the uterus		
	Ultrasound of the uterus and/or ovaries		
	Laparoscopy (placing a telescope through the belly button)		
	Laparotomy (an abdominal incision used to operate directly in your abdomen without a telescope)		
	Hysteroscopy (using a telescope to view the inside of your uterus)		
	Post-coital test (a check of your cervical mucus after intercourse)		
	Endometrial biopsy (removing a small piece of tissue from the inside of your uterus)		
	Blood test to look at the cause of infertility		

Pregnancy History (If applicable)

For outcome: EAB = Elective termination, SAB = Miscarraige (loss of pregnancy before 20 weeks), ECT = Ectopic or Tubal Pregnancy, DEL = Delivery of baby or progression past 20 weeks

Year	Current Partner (Y/N)?	Months of trying	Outcome (see key above)	If ECT was tube removed (Y/N)?

Family History

Please check off any of the following that are or have been present in family members:

___ Infertility
___ Irregular periods
___ > 3 miscarriages
___ Genetic Disease
___ Birth defects
___ Mental Retardation
___ Thyroid Disease
___ TB
___ Breast Cancer
___ Ovarian Cancer
___ Cystic Fibrosis
___ Other Cancer
___ High blood pressure
___ Diabetes
___ Sickle Cell
___ Heart Disease

Medical History

Please list any serious medical problems that you have. ______________________________

____

Please list all medications that you are currently taking on a regular basis (either prescription or over the counter).

Medication	Purpose	Dosage

___ Yes ___ No Do you have any allergies (including to medications, iodine, latex)?
If yes, please list. ____

____

Surgical History

List any surgeries you have had (include dates and all procedures that were performed)

____

____

____

____

____

____

____

MALE QUESTIONNAIRE

Name ____________________________________ Birth date: ____/____/____ Ethnicity:__________________

Occupation______________________________ SS#: ____

___ Yes ___ No Have you fathered children with other partners?
If so, how old is the youngest? ________________
How long did it take to become pregnant? ____________

Please list any serious medical problems that you have:____
____

Please list all medications (either prescription or over the counter) that you take on a regular basis: _______________
____

___ Yes ___ No Do you have any allergies (including to medications, iodine, latex)?
If yes, please list: ____
____

List any surgeries you have had (include dates and all procedures that were performed) ________________________
____

Have you ever had a semen analysis? If so, please list when ____
Are results from this testing available? ____

Please list any sexually transmitted diseases you have had____
____

Alcohol: Average drinks per week?___ Most drinks in one night over the past few months? _________

___ Yes ___ No Do you smoke? If so, how many packs per day?____________
___ Yes ___ No Do you take any baths or use hot tubs or saunas?
___ Yes ___ No Have you ever had the mumps?
___ Yes ___ No Have you had any exposure to toxins?
___ Yes ___ No Have you had a urinary tract or prostate infection (prostates)?
___ Yes ___ No Have you been seen by a urologist for infertility?
___ Yes ___ No Have you had surgery to correct a sperm problem?
___ Yes ___ No Have you ever been told you have a varicocele?
___ Yes ___ No If so, have you had a varicocele repair?

Family History

Please check off any of the following that are or have been present in family members:

___ Infertility
___ Mental Retardation
___ Thyroid Disease
___ Genetic Diseases
___ Birth Defects
___ Ovarian Cancer
___ Cystic Fibrosis
___ TB
___ Breast Cancer
___ Diabetes
___ Sickle Cell
___ High blood pressure
___ Heart Disease
___ Other Cancer