East Bay Fertility Center
4000 Dublin Boulevard, Suite 330
Dublin, CA 94568
(925) 828-9235

Date of Consultation: ________________

REPRODUCTIVE PERFORMANCE AND INFERTILITY QUESTIONNAIRE

DUE TO THE SENSITIVE NATURE, WE ASK THAT YOU DO NOT BRING CHILDREN TO YOUR APPOINTMENTS.

Name of Female ________________________________ **DOB**________ **AGE**________

Employer ________________________________ **Driver's License#**______________

Name of Partner ________________________________ **DOB**________ **AGE**________

Employer ________________________________ **Driver's License#**______________

Home Address ________________________________ **City** ____________ State ___ Zip ______

Telephone # (H)____________________ **(W)**____________________ **(Cell)** ____________________

Female Social Security #____________________ **Partner's Social Security #** ____________________

Email: ________________________ **Email:**____________________________

How were you referred to East Bay Fertility Center?

Friend _____ Relative_____ Seminar________ Internet________ Newspaper ______ Television ______

Physician (Name) ________________________________ Other (Please Specify)____________________

OBSTETRICAL HISTORY

How long have you been trying to have a baby? ____

Have you ever been pregnant before? Yes No

Date	Current/Prior Partner	Live Birth (Y/N)	Miscarriage Abortion Ectopic	Weeks	Fetal Heart Beat (Y/N)	D&C (Y/N)	Mode of Delivery	Sex	Complications

GYNECOLOGIC HISTORY

Please circle Yes/No

When was the first day of your last period? ___________________________

When was the first day of your past (previous) Menstrual Cycle? ____________________

Are your periods regular? **Yes** **No**

Age of first period ______ Number of days between periods ______ Days of bleeding _____

Molimina (Premenstrual Syndrome): **Breast Tenderness** **Mood Changes** **Irritable**

Amount of bleeding: **Light** **Medium** **Heavy**

Have you ever needed medication to bring on your period? **Yes** **No**

Degree of pain: **Mild** **Moderate** **Severe**

Pain Relieved by over the counter medications? **Yes** **No**

Pain starts with onset of bleeding? **Yes** **No**

Pain begins after onset of bleeding? **Yes** **No**

Pain persists for more than 48 hours? **Yes** **No**

Do you experience pain with sexual intercourse? **Yes** **No**

Pain is mostly on the exterior? **Yes** **No**

Pain is mostly on the interior (deep)? **Yes** **No**

Are you experiencing vaginal discharge? **Yes** **No**

Associated with itching or burning? **Yes** **No**

Associated with an unusual odor? **Yes** **No**

Have you ever been diagnosed with endometriosis? **Yes** **No**

When?

Do you have a Gynecologist? **Yes** **No**

When was your last pap smear? Date:__________

Result?_________________________

Have you ever had an abnormal Pap Smear? **Yes** **No**

If yes, what follow up was needed?

Have you ever had a Mammogram? **Yes** **No**

Have you ever had a Hysterosalpingogram (where dye is

Injected into your uterus to see if there is tubal blockage? **Yes** **No**

Have you ever had a Hysteroscopy? **Yes** **No**

Have you ever had a sexually transmitted disease? **Yes** **No**

(i.e. Chlamydia, Gonorrhea, Syphilis, Herpes, HPV)

When?______________ How was it treated? _________________________________

Have you ever had Pelvic Inflammatory Disease (PID) **Yes** **No**

When?

Were you hospitalized? **Yes** **No**

Do you experience milk or discharge from your breast/breasts? **Yes** **No**

Have you ever used an IUD? **Yes** **No**

Have you ever used the Oral Contraceptive “the Pill” **Yes** **No**

How many years? When did you last use it?

PREVIOUS SURGERIES

Procedure	Date	Indication	Outcome

MEDICAL CONDITIONS

Do you have a history of any of the following conditions?

Condition	Yes/No	Comments
German Measles (Rubella)		
Migraine		
Prolonged dizziness		
Glasses/contact lenses		
Thyroid problems		
Pneumonia		
Tuberculosis		
Asthma		
Bronchitis		
Other lung conditions		
Heart attack		
Heart Murmur		
Rheumatic fever		
Other heart conditions		
High blood pressure		
Gastric/duodenal ulcer		
Hepatitis		
Cirrhosis		
Intestinal bleeding		
Bleeding tendency		
Problems with anesthesia		
Diabetes		
Kidney stones		
Kidney infections		
Other kidney disorders		
Bladder infection		
Rheumatoid arthritis		
Lupus erythematosis		
Paralysis		
Neurological disorders		
Thrombophlebitis		
Varicose veins		
Breast tumor (benign)		
Breast cancer		
Ovarian cancer		
Uterine cancer		
Other cancer		
Any depressive disorder or bipolar disorders		
In the last 2 years have you been under the care of a psychologist or psychiatrist?		

DRUG ALLERGIES
Please circle Yes/No

Are you allergic to any medications that you know of? **Yes No**

Medication	Reaction

CURRENT MEDICATIONS

Are you currently taking any medications? **Yes No**

Medication	Dose	Frequency

FAMILY HISTORY

Is there a history of any of the following in the family?

Condition	Yes/No	Maternal/Paternal	Comments
Diabetes			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Multiple Births			
Mental Retardation			
Birth Defects			
Inherited diseases			
Rheumatoid arthritis			
Thyroid disease			
Lupus erythematosis			
Blood disorders			
Breast cancer			
Uterine cancer			
Other cancer			
Sickle cell disease			
Cystic fibrosis			
Tay Sachs			
Thalassemia			
Other:			

FEMALE SOCIAL HISTORY
Please circle Yes/No

Occupation: ____

Do you use tobacco? **Yes No #cig/day** ________

Do you use alcohol? **Yes No #drinks/wk** ________

Do you use recreational drugs? (marijuana, cocaine, etc) **Yes No**

Are you currently married? Yes **No**

How long?____________________

Have you ever been married before? **Yes No**

Problems with conceiving in your previous relationship? **Yes No**

How frequently do you have intercourse? **#per/wk or month** ________

Do you use lubricant? **Yes No**

COMMENTS

Please describe the nature of your problem:

MALE HISTORY

Please circle Yes/No

Have you initiated any pregnancies in the past? **Yes** **No**

Number of pregnancies? ____

Number with current partner? ______

When was the most recent pregnancy? ___________

Have you ever been evaluated by a Urologist? **Yes** **No**

Diagnosis?_________________

When: ______________________

Have you ever had a semen analysis? **Yes** **No**

Result: _________________

Date:___________________

Count (Million cell/ml)_______________

Motility (%)

Morphology (% normal forms) ____________

Other:____________________

SOCIAL HISTORY

Please circle Yes/No

Occupation: _______________________________________

Do you use tobacco? **Yes** **No** **#cig/day** ______

Do you use alcohol? **Yes** **No** **#drinks/wk** ______

Do you use a hot tub? **Yes** **No** **#/wk** ________

Are you currently married? **Yes** **No**

How long?

Have you been married before? **Yes** **No**

Problems with conceiving in past relationship? **Yes** **No**

How frequently do you have intercourse? **#per/week or month** _________

Do you use lubricant? **Yes** **No**

Have you had any of the following tests or procedures?

Test/Procedure	**Date**	**Result**	**Comments**
FSH			
LH			
Testosterone			
TSH			
Antisperm Antibodies			
DQ Alpha			
Hamster egg penetration			
Fructose			
Semen culture			
Vasectomy			
Vasectomy reversal			
Testicular biopsy			
Varicocele ligation			
Hernia repair			
Undescended testicle			
Removal of testicle			
Other:			

DRUG ALLERGIES

Please circle Yes/No

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Medication	Reaction

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Glasses/contact lenses		
Thyroid problems		
Pneumonia		
Tuberculosis		
Asthma		
Bronchitis		
Other lung conditions		
Heart attack		
Heart Murmur		
Rheumatic fever		
Other heart conditions		
High blood pressure		
Gastric/duodenal ulcer		
Hepatitis		
Cirrhosis		
Intestinal bleeding		
Bleeding tendency		

Problems with anesthesia		
Diabetes		
Kidney stones		
Kidney infections		
Other kidney disorders		
Bladder infection		
Rheumatoid arthritis		
Lupus erythematosis		
Paralysis		
Neurological disorders		
Thrombophlebitis		
Varicose veins		
Other cancer		
Other:		

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Heart Disease			
High Blood Pressure			
Kidney Disease			
Multiple Births			
Mental Retardation			
Birth Defects			
Inherited diseases			
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Lupus erythematosis			
Blood disorders			
Breast cancer			
Uterine cancer			
Other cancer			
Sickle cell disease			
Cystic fibrosis			
Tay Sachs			
Thalassemia			
Other:			

PREVIOUS INFERTILITY EVALUATION

Have you had or used any of the following tests of procedures?

Test/Procedure	Date	Result
Blood Tests (Non-immunological		
FSH (Cycle Day 3)		
Estradiol (Cycle Day 3)		
LH (Cycle Day 3)		
Progesterone (7 days after ovulation)		
TSH		
Prolactin		
DHEAS		
Testosterone		
17-Hydroxy-Progesterone		
Blood type and RH status		
Rubella		
HIV		
Hepatitis B surface antigen		
Hepatitis C antibody		
RPR/VDRL (syphilis)		
Blood Tests (Immunological)		
Antinuclear Antibodies (ANA)		
Antiphospholipid Antibodies (APA)		
Antipaternal Leukocyte Antibodies (APLA)		
Natural Killer (NK) Cell Assay		
Immunophenotype		
DQ Alpha		
Antithyroglobulin Antibodies (ATA)		
Antimicrosomal Antibodies (AMA, TPO)		
Antisperm Antibodies		
IgA		
Cervical Cultures		
Chlamydia		
Gonorrhea		
Ureaplasma/Mycoplasma		
Routine aerobic/anaerobic		
General Assessment		
Pap Smear		
Mammogram		
Physical Exam		
Basal Body Temperature Charting (BBT)		
Urine Ovulation Predictor Kit		
Post Coital Test (PCT)		
Endometrial Biopsy		
Semen Analysis		

Pelvic Assessment	*Date*	*Result*
Pelvic Exam		
Vaginal Ultrasound		
Hysterosalpingogram (HSG dye test)		
Sonohysterogram (Fluid Ultrasound)		
Hysteroscopy		
Laparotomy		
Other		

PREVIOUS INFERTILITY TREATMENT

Have you ever used any of the following medications or treatments?

Medication	Date	Dose	# of Cycles	Comments
Clomiphene Citrate (Oral)				
Ganirelix				
Luveris				
Repronex				
Bravelle				
Menopur				
Gonal F				
Follistim (Injectable)				
HCG (Profasi)				
Progesterone				
Aspirin				
Heparin				
Prednisilone (Medrol)				
Dexamethasone				
Intravenous Immunoglobulin (IVIG)/Intralipid				
Lupron				

PREVIOUS TREATMENTS

Procedure (IVF, IUI, GIFT, ZIFT)	Date	Medications	# of Follicles	Eggs Retrieved	#Fertilized	#Transferred	#Frozen	Cycle Outcome

PRIMARY INSURANCE:

Insurance Company Name:___________________________________ ID#:_____________________________

Group#:_________________________________ Phone#:___________________________

Mailing Address:____ City:______________ State:______

Zip:__________

Does your insurance company cover fertility benefits? Yes No Not Sure

PRIMARY CARE PHYSICIAN:

Name:_______________________________________

Address: ______________________________________ City:_________________ State:_____ Zip:_____

Phone#:________________________________

OB/GYN:

Name:_______________________________________

Address: ______________________________________ City:_________________ State:_____ Zip:_____

Phone#:________________________________

PSYCHIATRIST OR PSYCHOLOGIST:

Name:_______________________________________

Address: ______________________________________ City:_________________ State:_____ Zip:_____

Phone#:________________________________

EMERGENCY CONTACT:

Name:____

Phone#:___________________________________

Relationship:_______________________________