

Austin Fertility and Reproductive Medicine

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NEW PATIENT QUESTIONNAIRE

1. GENERAL INFORMATION

Name: _____ **Age** _____
Date of Birth _____
Occupation _____

Partner's Name (if applicable): _____ **Age** _____
Partner's Date of Birth _____
Partner's Occupation _____

Who referred you to us for care? _____

2. PROBLEMS

Briefly state your main problem as you see it.

3. MENSTRUAL HISTORY

What was your age when you had your first period? _____ years old
How many periods do you have per year? _____ (**without** medicine to induce)
Number of days between the start of one period to the start of the next period: ___ days
How long does the flow usually last? _____ days
Do you have discomfort during your period (menstrual cramps)? _____
What medication (if any) have you taken for pain/cramps? _____

Do you have or have you had:

- | | | |
|--|--|--|
| <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Increased facial or body hair | <input type="checkbox"/> Breast discharge |
| <input type="checkbox"/> Increased acne | <input type="checkbox"/> Thyroid disorder | <input type="checkbox"/> Special diet habits |
| <input type="checkbox"/> Weight increase > 10 pounds | <input type="checkbox"/> Weight loss > 10 pounds | <input type="checkbox"/> Rigorous exercise |

4. REPRODUCTIVE ANATOMY

Have you ever had:

- | | | |
|---|--|---|
| <input type="checkbox"/> Uterine fibroids (leiomyomata) | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Pelvic adhesions |
| <input type="checkbox"/> Abnormally shaped uterus | <input type="checkbox"/> Ovarian cysts | |

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5. SEXUAL HISTORY

How many months have you been having intercourse without using any form of birth control?
_____ or Not applicable

Have you used over-the-counter ovulation kits to time intercourse? No Yes

➤ Do they turn positive for you? No Yes

Do you use lubricants (K-Y Jelly, etc.) during intercourse?

No Yes – what types? _____

Do you have pain with intercourse?

No Yes

Frequency

Rarely

Usually

Almost always

Type

At the beginning

Deep penetration

Both

Severity

Mild

Moderate

Severe

Have you had any of the following sexually transmitted diseases or pelvic infections?

Yes (check all that apply) No

Chlamydia – date _____

Gonorrhea – date _____

Genital warts/HPV – date _____

Hepatitis – date _____

Syphilis – date _____

HIV/AIDS – date _____

Herpes – date _____

Other – date _____

6. GYNECOLOGIC HISTORY

When was your last Pap smear (month and year)? ____/____/____ Normal Abnormal

When was your last abnormal Pap smear (month and year)? ____/____/____ Not applicable

Have you undergone any procedures due to an abnormal Pap smear?

Yes No (check all that apply)

Colposcopy Cryosurgery (Freezing) Laser treatment Conization LEEP procedure

Have you ever had a mammogram? No Yes – date _____ Result: normal abnormal

7. CONTRACEPTIVE HISTORY

Type	From When to When	Reason Discontinued

Did your mother take DES when she was pregnant with you? Yes No Don't know

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8. PREGNANCY SUMMARY

How many times have you been pregnant? _____

Number of:

miscarriages (less than 20 weeks): _____

ectopic/tubal pregnancies: _____

elective terminations (abortions): _____

full term deliveries: _____

premature (< 37 weeks) deliveries: _____

Any pregnancies with birth defects? No Yes – explain _____

Date Pregnancy Ended or Delivered	Months to Conception	Treatments to Conceive	Delivery Type/D&C/Complications	Current Partner?
1.				<input type="checkbox"/> Y <input type="checkbox"/> N
2.				<input type="checkbox"/> Y <input type="checkbox"/> N
3.				<input type="checkbox"/> Y <input type="checkbox"/> N
4.				<input type="checkbox"/> Y <input type="checkbox"/> N
5.				<input type="checkbox"/> Y <input type="checkbox"/> N
6.				<input type="checkbox"/> Y <input type="checkbox"/> N

9. FERTILITY

Have you been trying to get pregnant? No Yes, for _____ years and _____ months

Have you consulted another doctor about fertility? No Yes _____
(name and location)

Have you and your partner had any of the following tests:

	Not done	Normal	Abnormal	Approx Date	Results (if known)
Semen analysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• _____	_____
Female hormone tests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• _____	_____
Hysterosalpingogram	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• _____	_____
Ultrasound	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• _____	_____
Laparoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• _____	_____
Hysteroscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• _____	_____
Blood type	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• _____	_____
Rubella status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• _____	_____
HIV status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• _____	_____
Hepatitis status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• _____	_____

Prior fertility treatment (check all that apply):

Previous Treatment	# of cycles	Dates	Outcome (Pregnant: delivered, ectopic, miscarriage, Not Pregnant)
<input type="checkbox"/> CLOMID <u>without</u> IUI			
<input type="checkbox"/> CLOMID <u>with</u> IUI			
<input type="checkbox"/> Daily fertility injections <u>without</u> IUI			
<input type="checkbox"/> Daily fertility injections <u>with</u> IUI			
<input type="checkbox"/> In Vitro Fertilization #eggs retrieved _____ #embryos transferred _____ # embryos frozen _____			
<input type="checkbox"/> Frozen embryo transfers: #embryos transferred _____			

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10. MEDICAL HISTORY

Do you or have you had:

	Yes	No
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots in lung/legs/heart	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disorder	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis/Liver disorder	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any other medical conditions? No Yes (please describe):

11. SURGICAL HISTORY

Month/Year of Surgery	Reason for Surgery	Operation	Hospital	Surgeon/Physician

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

12. MEDICATIONS (please list all **prescription** and **over-the-counter drugs** that you are currently taking)

Drug: Dose/Frequency	From When to When	Reason

List any herbal medicines/vitamins or health food store supplements that you are currently taking:

13. ALLERGIES (NO KNOWN DRUG ALLERGY)

List all medicines you have a history of being allergic to and reactions from these medicines:

List all foods (peanuts, eggs, etc) you have a history of being allergic to and reactions from these foods:

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17. MALE MEDICAL HISTORY AND INFORMATION:

Complete with your male partner if applicable.

Have you previously conceived with:

Your current partner? Yes No

Another woman? Yes No If yes, how long ago? _____

List any current medical problem(s): _____

List your current medication(s): _____

List any herbal medicines/vitamins or health food store supplements– (describe: _____)

Have you been evaluated by a urologist? No Yes – MD name: _____

Have you had a **semen analysis**?

Yes (date _____ results: _____)

No

Have you had a vasectomy? Yes (date _____) No

If yes, have you had a vasectomy reversal? Yes (date _____) No

Have you had surgery for a varicocele repair? Yes (date _____) No

How many caffeinated beverages 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 Beer - # per week _____ Wine - # per week _____ Liquor - # per week _____

Do you use marijuana, cocaine, or any other similar drug? No Yes – (describe: _____)

What is your Ancestry?

African-American

American Indian/Native American

Ashkenazi Jewish

Asian-American

Cajun/French Canadian

Caucasian

Eastern European

Hispanic/Caribbean

Northern European

Southern European

Other (specify _____)

Would you like to be screened for:

Cystic Fibrosis: ___Y ___N

Sickle Cell Anemia: ___Y ___N

Tay-Sachs Disease: ___Y ___N

Thalassemia: ___Y ___N

SPOUSE/MALE PARTNER'S SIGNATURE _____ DATE _____