

How did you hear about us?

(please circle all that apply)

Airport Advertising

Newspaper or Magazine Ad

Radio Ad

TV Ad

Web Ad

Web Search

In the News

please circle: print / TV / radio / online

Friend or Family Member

Physician referral

Other: _____

(for instance: Duke Employee, yellow pages, brochure, driving by, etc)

.....

Date: _____

Duke University Medical Center
Division of Reproductive Endocrinology and Fertility

Female Fertility Initial Questionnaire & Medical History Intake Form

Referring Physician _____

Patient Name: _____

Marital Status: _____

SSN or History #: _____

Partner Name: _____

Date of Birth: _____

Partner SSN or Hx#: _____

Height: _____ Weight: _____

Partner DOB: _____

Race: _____ Hispanic or Latino?

Partner Race: _____

Phone (day): _____

Address: _____

Phone (night): _____

E-mail: _____

Education level: _____

Occupation: _____

II. Pregnancy History

How many Pregnancies (including abortions) have you had? _____

	When? (year)	How long To conceive? (months)	Fertility therapy used? Y/N	Is current partner father? Y/N	Duration of Pregnancy (months)	Outcome*	Complications
1 st Pregnancy							
2 nd pregnancy							
3 rd pregnancy							
4 th pregnancy							
5 th pregnancy							

*Outcomes: Vaginal Delivery=VD; Cesarean section=CS; Abortion=AB; Miscarriage=MS; Ectopic=EP

III. Fertility History How long have you and your present partner been trying to conceive? _____

Have you ever been infertile with a past partner? _____ If so, How long? _____

Have you had any of the following tests performed on you? Check all that apply and the results.

	Date	Results
<input type="checkbox"/> Basal Body Temperature	_____	_____
<input type="checkbox"/> Urinary LH (Ovulation) Predictor Kits	_____	_____
<input type="checkbox"/> Postcoital Test	_____	_____
<input type="checkbox"/> Hormone Tests	_____	_____
<input type="checkbox"/> Endometrial Biopsy	_____	_____

	Date	Results
<input type="checkbox"/> Hysterosalpingogram (HSG)	_____	_____
<input type="checkbox"/> Sonohysterogram	_____	_____
<input type="checkbox"/> Ultrasound	_____	_____
<input type="checkbox"/> Antisperm Antibodies	_____	_____
<input type="checkbox"/> Laparoscopy	_____	_____
<input type="checkbox"/> Hysteroscopy	_____	_____
<input type="checkbox"/> Gonorrhea/Chlamydia Cultures	_____	_____
<input type="checkbox"/> Rubella (German Measles)	_____	_____
<input type="checkbox"/> Hepatitis B or C	_____	_____
<input type="checkbox"/> HIV	_____	_____
<input type="checkbox"/> RPR (Syphilis)	_____	_____
<input type="checkbox"/> Blood Type and Rh	_____	_____
<input type="checkbox"/> Antibody Screen	_____	_____

What types of fertility therapy have you received in the past?

Drug/Treatment	Dose	How long or how many cycles?	When?
Clomiphene citrate (Clomid, Seraphene)			
Gonadotropins (Pergonal, Repronex, Humegon, Metrodin, Fertinex, Gonal-F, Follistim)			
HCG (Profasi, Pregnyl)			
GnRH Agonists (Lupron, Zoladex, Synarel)			
Progesterone			
Prednisone or Dexamethasone			
Bromocriptine (Parlodel, Dostinex)			
Artificial Insemination			
Donor Insemination			
In Vitro Fertilization=ICSI			

IV. Gynecological History

	Yes	No
How old were you when you started having periods? _____ Date your last period started _____		
Are your periods regular? _____	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how many days between periods (start until start)? _____		
If no, how many periods per year do you have? _____		
How many days do your periods last? _____		
Do you have cramps with your periods? _____	<input type="checkbox"/>	<input type="checkbox"/>
If yes, are they: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe		
Have you ever missed work or school do to menstrual pains? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have pain with intercourse? _____	<input type="checkbox"/>	<input type="checkbox"/>

Where you ever diagnosed with endometriosis? _____ Yes No

What type of contraception have you used in the past?

- | | | | |
|---|--|---|----------------------------------|
| <input type="checkbox"/> Birth Control | <input type="checkbox"/> IUD | <input type="checkbox"/> Depo Provera (birth control shots) | <input type="checkbox"/> Condoms |
| <input type="checkbox"/> Diaphragm | <input type="checkbox"/> Foams/Jellies | <input type="checkbox"/> Withdrawal | <input type="checkbox"/> Rhythm |
| <input type="checkbox"/> Tubal Ligation | | | |

Contraceptive Complications: _____

When did you last use contraception? _____

Have you ever had an abnormal Pap smear? _____

If so, when? _____

What was done about it? _____

When was your last Pap smear? _____

Have you ever had any of the following (check all that apply):

- | | | |
|------------------------------------|---|--|
| <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Venereal Warts | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Pelvic Inflammatory Disease (PID) |

Have you ever had an abnormal Mammogram? _____

If so, when? _____

What was done about it? _____

When was your last mammogram? _____

V. Medical History

Do you have or have you ever had (check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ovarian cysts |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Gallbladder Problems | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> hepatitis | <input type="checkbox"/> Rubella (German Measles) |
| <input type="checkbox"/> Breast Milky Discharge | <input type="checkbox"/> Hirsutism (Excess facial hair) | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Breast pain | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Chicken Pox or vaccination | <input type="checkbox"/> Kidney Infections | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Chronic Headaches | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Neurological problems | <input type="checkbox"/> Vision Problems |

Current Medications _____

Are you allergic to any medications? _____ Yes No

What? _____

Have you ever had surgery before? _____ Yes No

Date and type _____

VI. Social History	Current or Recent Employer/Position _____		
Do you drink alcohol? _____		Yes	No
Number of drinks per week _____		<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke? _____		<input type="checkbox"/>	<input type="checkbox"/>
Number of cigarettes per day _____ Number of years smoking _____			
Do you now, or have you ever, used illicit drugs (marijuana, cocaine, etc.)? _____		<input type="checkbox"/>	<input type="checkbox"/>
Specify _____			
Do you have a special exercise program? _____		<input type="checkbox"/>	<input type="checkbox"/>
Type _____ Number of hours per week _____			
Are you on a special diet? _____		<input type="checkbox"/>	<input type="checkbox"/>
Type _____			

VII. Review of Systems		Yes	No
Have you had more than a 10 pound weight gain or loss in the past 12 months? _____		<input type="checkbox"/>	<input type="checkbox"/>
Do you have problems with your vision (besides usual glasses), hearing, swallowing, sinuses or throat? _____		<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify: _____			
Do you have heart problems, chest pain, irregular heart beat, or mitral valve prolapse? _____		<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify: _____			
Do you have asthma, wheezing, shortness of breath or trouble breathing? _____		<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify: _____			
Do you have breast pain, breast discharge, or a lump in your breast? _____		<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify: _____			
Do you have chronic nausea or vomiting, stomach pain, diarrhea or constipation, blood in your stool or a history of ulcers? _____		<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify: _____			
Do you have urinary burning, incontinence, kidney stones or blood in your urine? _____		<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify: _____			
Do you have chronic joint or muscle pain or swelling? _____		<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify: _____			
Do you have any chronic skin rashes or moles that have changed in size or appearance? _____		<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify: _____			
Do you have changes in cold or hot tolerance, changes in skin tone or color, changes in your nails or body hair growth? _____		<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify: _____			
Do you have any history of seizures, recurrent headaches or numbness in your extremities? _____		<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify: _____			
Do you have any symptoms of depression such as sadness, frequent crying or anger, emotional lability? _____		<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify: _____			

VIII. Family History

Did your mother take diethylstilbestrol (DES; a tablet given to women with a history of miscarriage or bleeding during pregnancy) when she was pregnant with you? _____ Yes No

Do any family members have significant health problems or inherited diseases? _____

Check all that apply:

- | | | |
|---|--|--|
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> Brain/Spinal Defects | <input type="checkbox"/> Fragile X Syndrome | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Tay-Sachs Disease |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Thalassemia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disease |

Who?

Are you from any of these ethnic backgrounds: (check all that apply)

Italian	Jewish	Caucasian	African American	Other: _____
Greek	French Canadian/Cajun		African	
Middle Eastern			Hispanic	
Spanish				
Southern Chinese				
Asian Indian				
Taiwanese				
Filipino				
Southeast Asian				

If yes, have you had any specific genetic testing to see if you are a carrier of a genetic disease? _____

IX. Additional Health Information

Please bring this form with you to your first appointment. Ensure that records from your current or past physician have been sent or faxed to the address below at least one-week in advance of your visit. We look forward to meeting you.

Name: _____

Date: _____

Duke History #: _____

Ovulatory Dysfunction History Questionnaire

1. At what age did you reach puberty? _____ years old
2. How tall are you? _____ feet _____ inches
3. How much do you weigh? _____ pounds
4. Are you having trouble getting pregnant? _____ yes _____ no
 - a. If yes, why do you think that you are having trouble?

5. Has anyone ever told you that you have polycystic ovarian syndrome?
_____ yes _____ no
6. Has a doctor ever told you that you have a problem ovulating?
_____ yes _____ no
7. Do you have diabetes? _____ yes _____ no _____ I don't know
8. Do you have insulin resistance? _____ yes _____ no _____ I don't know
9. Have you taken any medications to help you get pregnant? _____ yes _____ no
 - a. If yes, check the medicine that you were given
(you may check more than one)
 - i. Clomiphene citrate
 - ii. Glucophage (metformin)
 - iii. Gonadotropins (FSH)
 - iv. Other (please list) _____
10. Approximately how many menstrual cycles do you have per year when you are not on any medication? _____

11. Are your menstrual cycles regular and predictable?

_____ yes _____ no

a. If yes, approximately how often did your menstrual cycles come?
(check the box that best describes most of your menstrual cycles)

- i. More frequently than every 27 days
- ii. Every 27 – 29 days
- iii. Every 30 – 32 days
- iv. Every 33 – 35 days
- v. Less frequently than every 35 days

b. If your periods are not regular and predictable, what is the shortest and longest interval that you have had between periods

longest _____ days

shortest _____ days

c. If your periods are not regular and predictable, at what age did this begin?

_____ years old

12. Have you ever taken medicine to regulate your menstrual cycles?

_____ yes _____ no

a. If yes, check all of the medicines that you were given?

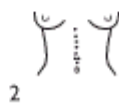
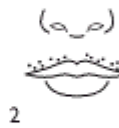
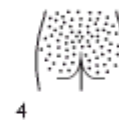
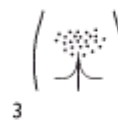
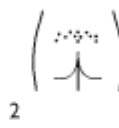
- i. Birth control pills
- ii. Provera
- iii. Other (please name if you remember) _____

b. If yes, when was the last time? _____

13. Do you think that you have more hair than most women on some areas of your body?

_____ yes _____ no

If yes, please check one picture on each row that looks most like the hair pattern that you have or write none next to the row.



[There are 5 more questions on the back of this page]

14. Have you ever removed hair from one of these areas of your body? _____ yes _____ no

a. If yes, what area did you remove hair from? _____

15. As an adult have you had acne? _____ yes _____ no

a. If yes, do you have acne now? _____

16. Do you have any problem with hair loss on your head? _____

17. Would you be willing to consider participating in a research study to look for prenatal factors that might be associated with infertility problems? The study would involve taking two short visual spatial tests, having a pelvic examination and having your hands Xeroxed to measure the length of your fingers? _____

a. If yes, please tell us the best way to contact you.

18. Do you think that your husband would be willing to enroll in this research study as well? His involvement would be taking two short visual spatial tests and having his hands Xeroxed to measure the length of his fingers? _____

Submitting Your Questionnaire to Duke Fertility

Once you have completed the form fields above there are two ways to send us your completed information:

- 1) Email.** Save this PDF to your computer with a unique name. i.e. "Jane Doe's Questionnaire.pdf". Then email this completed form as an email attachment to pdcreic@mc.duke.edu
- 2) Print.** Print the completed questionnaire and bring the form with you to your next appointment.