EVMS
JONES INSTITUTE FOR REPRODUCTIVE MEDICINE

**Patient Questionnaire (Female) PLEASE USE BLACK INK ONLY**

This form is designed to provide information to those of us involved in your health care. Please answer these questions as well as you can. We will review this with you during your physical examination.

Date: _____ Social security number: _____

Name: _____ Date of birth: _____

Address: _____

Street City State/Zip

Home phone: (___)_____ Hours at this number: _____

Work phone: (___)_____ Hours at this number: _____

Occupation: _____

Race (optional): _____

Name of family doctor/referring physician: _____

Address: _____

Marital status: Single □ Separated □ Engaged □

Married □ Divorced □ Widowed □

Spouse/Partner's full name: _____ Date of birth: _____

Spouse/Partner's occupation: _____

Number of year married (if applicable): _____Number of children: _____

Emergency contact: _____

(Person not living in household) Relationship

Phone number: _____ _____

Day Evening

Address:

_____

Street City State/Zip

Physician signature: _____Date: _____

**Chief Complaint:**

_____
_____
_____

How long have you been trying to get pregnant? _____

What tests have been done to check your fertility?

| Test | When | Findings/Results |
|---|---|---|
| Temperature charting | | |
| Semen analysis | | |
| Hysterosalpingogram | | |
| Postcoital test | | |
| Endometrial Biopsy | | |
| Laparoscopy | | |

What, if any, treatments have you had to correct your problem?

_____
_____

**Obstetrical History:**

What was the outcome of any pregnancies you've had?_____

_____
_____

Were previous pregnancies by your present husband (partner)? Yes□ No□
Have you adopted any children? Yes□ No□

**Gynecological History**

How old were you when your periods began? _____ years
How long do your periods last? _____ days
Are they regular? Yes□ No□
What was the longest time between periods during the past year? _____ days
What was the shortest time between periods during the last year? _____ days
When do your cramps occur in relation to your period? _____
When was your last period? Date: ___/___/___
Can you tell when you ovulate? Yes□ No□
Do you ever bleed between periods? Yes□ No□
Do you ever feel moody, depressed, or bloated before your period? Yes□ No□
Most troubling symptoms: _____
Have you used birth control to prevent pregnancies? Yes□ No□
Please check all that apply:
□ Pills □ IUD □ Condoms
□ Spermicide □ Shots □ Implants
Have you ever had any pelvic infection: infected tubes or ovaries? Yes□ No□
If yes, describe any treatment and by whom: _____
_____
When was your last Pap smear? Date: ___/___/___
Has it ever been abnormal? Yes□ No□
Have you ever had a mammogram? Yes□ No□

## General Medical History

Do you feel that you are in good overall health? Yes☐ No☐
Do you have any health problems now or as a child? Yes☐ No☐
Describe: _____
_____

List any surgical procedures (operations) that you have had:

| Date | Operation | Where | Surgeon |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**What medications** are you taking now or have you taken in the last year?
_____

Are you allergic to any medications? Yes☐ No☐
List them and the reactions they cause:
_____

Do you use: tobacco? yes/no amount: _____
alcohol? yes/no amount: _____
recreational drugs? yes/no If so, please list: _____

**What pharmacy do you use? _____**
**Pharmacy address: _____**
**_____**
**Pharmacy phone number: _____**
**Pharmacy Fax number: _____**

## Family History

How many brothers and sisters do you have? _____
Did your mother take any prescription drugs when she was pregnant with you? Yes☐ No☐
Do any siblings or relatives have any infertility problems? Yes☐ No☐
Describe: _____
Have any of your relatives had any significant health problems? Yes☐ No☐
Describe (including cancers): _____
_____
_____
_____

## Marital History

How long have you been with your current partner? _____years
How old is he? _____years
Is he in good health? Yes☐ No☐
Has he had any children in prior relationships? Yes☐ No☐

How often do you have intercourse? _____

Do you ever use a lubricant when you have intercourse? Yes☐ No☐

Do you ever find intercourse painful? Yes☐ No☐

If so, describe (when in cycle; deep or external; at the beginning, during, or after):

_____

**Review of specific conditions:**

| | | | |
|---|---|---|---|
| German measles | Yes☐ | No☐ | _____ |
| Venereal diseases | Yes☐ | No☐ | _____ |
| Pneumonia | Yes☐ | No☐ | _____ |
| High blood pressure | Yes☐ | No☐ | _____ |
| Diabetes | Yes☐ | No☐ | _____ |
| Cancer | Yes☐ | No☐ | _____ |
| Kidney problems | Yes☐ | No☐ | _____ |
| Anemia | Yes☐ | No☐ | _____ |
| Hepatitis (yellow jaundice) | Yes☐ | No☐ | _____ |
| Phlebitis | Yes☐ | No☐ | _____ |
| Nervous breakdown | Yes☐ | No☐ | _____ |
| Severe depression | Yes☐ | No☐ | _____ |
| Epilepsy | Yes☐ | No☐ | _____ |
| Migraine headaches | Yes☐ | No☐ | _____ |
| Bleeding tendencies | Yes☐ | No☐ | _____ |
| Thyroid disease | Yes☐ | No☐ | _____ |
| Heart disease | Yes☐ | No☐ | _____ |
| Radiation Therapy | Yes☐ | No☐ | _____ |
| Breast secretions | Yes☐ | No☐ | _____ |
| Anorexia or bulimia | Yes☐ | No☐ | _____ |
| Mumps | Yes☐ | No☐ | _____ |
| Other serious illnesses | Yes☐ | No☐ | _____ |

Other issues/Comments/Concerns:

_____

_____

_____

_____

_____

_____

_____

_____

Patient signature:_____Date:_____