

Patient Information Form

Date of scheduled visit: ____/____/____ Today's Date: ____/____/____
NAME: _____ SS#: ____-____-____
Date of birth: ____/____/____ Age: _____
Your Occupation: _____
Email address: _____

Referral Information:

Reason for visit: _____

How did you hear about our program? _____

Were you referred by another patient? **Y** or **N**

OR

Referring doctor's name: _____ Phone (____)____-____ Fax (____)____-____

Address: _____
(street) (city) (state) (zip)

Is this the physician you see for routine Gynecologic care? (annual Pap smears, etc) **Y** or **N**

If no, who is your regular gynecologist? _____

Address: _____
(street) (city) (state) (zip)

Is there another physician (s) to whom you would like us to send a letter? **Y** or **N**

If yes, physician name: _____

Address: _____
(street) (city) (state) (zip)

Emergency Contact Information:

In case of emergency please contact: _____ Relationship: _____

Phone: (____)____-____ Beeper: (____)____-____ Cell Phone: (____)____-____

Address: _____
(street) (city) (state) (zip)

MEDICAL INFORMATION

NAME: _____ SS# : _____-____-_____

Years of current marriage (duration of relationship)..... _____

Number of marriages..... _____

Duration of infertility (months of trying w/o birth control)..... _____

Age of first menstrual period..... _____

Number of days bleeding during menstrual period..... _____

Number of days between menstrual periods..... ___ to ___
 (From the 1st day of bleeding to the next, 1st day of bleeding)

	<i>Circle One</i>	Comments
Do you have any symptoms prior to your menses?	Yes No	_____
Do you have painful menses (dysmenorrhea)?	Yes No	_____
Is intercourse painful?	Yes No	_____
Have you ever used an intrauterine device (IUD)?	Yes No	_____
Do you have a history of pelvic infection (PID)?	Yes No	_____
Did you mother take DES during her pregnancy?	Yes No	_____
Do you have discharge from your breasts (galactorrhea)?	Yes No	_____
Do you feel you experience excessive hair growth (hirsutism)?	Yes No	_____

IVF History: Number of previous IVF/GIFT/ZIFT/TET cycles: _____. Please list information regarding any of these prior cycles. Please be as detailed as possible, including dates, locations, dosages of medication and outcomes of cycles.

#	Date	Location of program	Medication dosage	Peak estradiol	# of eggs	# GIFT'd	# Fertilized	Fertilization Method	# Transferred	Pregnancy

(Additional room at the end of the form)

Previous Surgery: Please list all surgeries, related to infertility or not

Date	Location of procedure	Procedure	Findings	Surgeon	Asst.

(Additional room at the end of the form)

Additional Information

Circle One

Circle One

Rubella Immunity...Date Tested ___/___/___ Immune Non-Immune Pap... Date tested ___/___/___ Normal? Yes No

Mycoplasma...Date tested ___/___/___ Positive Negative Blood Type... _____

Chlamydia...Date tested ___/___/___ Positive Negative Mammogram...Date tested ___/___/___

Normal? Yes No

Medical History: Do you have any medical problems unrelated to your infertility? Please check all that apply:

- | | |
|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Deep Vein Thrombosis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Overactive/Underactive Thyroid | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Epilepsy (seizures) | <input type="checkbox"/> Rubella (German measles) |
| <input type="checkbox"/> Frequent urinary tract infections | <input type="checkbox"/> Sexually Transmitted Diseases
(syphilis, gonorrhea, herpes, genital warts) |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Illicit drug use | |

Please explain: _____

Family History: Do any diseases run in your family? Do any of your relatives suffer from a major illness? Please indicate the nature of the illness and family member.

	<i>Circle One</i>	Comments
Does anyone in your family have a history of breast cancer?	Yes No	_____
Does anyone in your family have a history of ovarian cancer?	Yes No	_____
Do you have any family history of birth defects?	Yes No	_____
Do you have any family history of recurrent pregnancy loss?	Yes No	_____
Have you ever suffered from an eating disorder?	Yes No	_____
Do you exercise? How frequently and what type?	Yes No	_____
Do you have any allergies to medication?	Yes No	_____
Do you smoke cigarettes? Cigarettes Per day _____	Yes No	_____
Do you drink alcohol? Per day _____	Yes No	_____
Do you take any medications regularly? Please list.	Yes No	_____
Have you been exposed to any toxins?	Yes No	_____
Do you use vaginal lubricant during intercourse?	Yes No	_____
Did your mother have a hysterectomy?	Yes No	Mother's age of menopause _____
How many times a month do you have intercourse? _____		

Have you ever used an ovulation predictor kit? What days of your cycle does it indicate ovulation? _____

How many cups of coffee or caffeinated beverages do you drink each day? _____

Are you on any special diets or nutritional supplements? If yes, please explain _____

Do you take multivitamin supplements? _____

Do you use any herbal remedies? _____

Do you take any over the counter medication? If yes, please explain _____

Genetic Screening: The following questions will help us determine if you are at increased risk for having a child with a genetic problem and if special screening is indicated.

Do you, or anyone in your family, have a history of: (check all that apply and indicate relationship to you)

- | | <i>Relationship to you</i> | | <i>Relationship to you</i> |
|--|----------------------------|--|----------------------------|
| <input type="checkbox"/> Thalassemia | _____ | <input type="checkbox"/> Muscular Dystrophy | _____ |
| <input type="checkbox"/> Neural Tube defect | _____ | <input type="checkbox"/> Cystic Fibrosis | _____ |
| <input type="checkbox"/> Down Syndrome | _____ | <input type="checkbox"/> Huntington's Chorea | _____ |
| <input type="checkbox"/> Tay Sachs | _____ | <input type="checkbox"/> Mental Retardation | _____ |
| <input type="checkbox"/> Hemophilia | _____ | <input type="checkbox"/> Sickle Cell Anemia | _____ |
| <input type="checkbox"/> Other inherited/chromosomal/genetic abnormalities | _____ | | |

Please Explain: _____

Ethnic Origin: This will help us identify risk factors for particular inherited diseases. (Please choose all that apply)

- _____ White non-Hispanic _____ White Hispanic _____ Black non-Hispanic _____ Black Hispanic
- _____ Asian or Pacific Islander non-Hispanic _____ Asian or Pacific Islander Hispanic
- _____ Native American (American Indian including Aleut and Eskimo)
- _____ French Canadian _____ Jewish Background
- _____ Other: (please explain) _____

Do you use any recreational drugs? Yes No _____

Have you been exposed to any toxins? Yes No _____

Do you have any difficulties with erection? Yes No _____

Do you have any difficulties with ejaculation? Yes No _____

Are your genitals exposed to excessive heat? Yes No _____

Have you had any serious injuries to your genitals? Yes No _____

Have you had any infections of your penis, testicles or prostate? Yes No _____

Is there any history of birth defects in your family? Yes No _____

Do you have any allergies to medications? Yes No _____

Are you on any special diets or nutritional supplements? If yes, please explain: _____

Do you take multivitamin supplements? _____

Do you use any herbal remedies? _____

Do you take any over the counter medication? If yes, please explain _____

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	<i>Relationship to you</i>		<i>Relationship to you</i>
<input type="checkbox"/> Thalassemia	_____	<input type="checkbox"/> Muscular Dystrophy	_____
<input type="checkbox"/> Neural Tube defect	_____	<input type="checkbox"/> Cystic Fibrosis	_____
<input type="checkbox"/> Down Syndrome	_____	<input type="checkbox"/> Huntington's Chorea	_____
<input type="checkbox"/> Tay Sachs	_____	<input type="checkbox"/> Mental Retardation	_____
<input type="checkbox"/> Hemophilia	_____	<input type="checkbox"/> Sickle Cell Anemia	_____
<input type="checkbox"/> Other inherited/chromosomal/genetic abnormalities	_____		

Please Explain: _____

SHOULD YOU HAVE GENETIC SCREENING?

Couples attempting to achieve pregnancy may want to consider genetic counseling and genetic screening. Couples may be at increased risk for carrying genes that could cause genetic disease in their child if they have had a child with a genetic disease or if either member of the couple has a history of a genetic disease, has a family history of particular diseases, or is of a particular ethnic background. For example, people of northern European descent have a 1/25 chance of carrying one copy of the gene for cystic fibrosis. If both parents are carriers, they have a 25% chance of having a child with cystic fibrosis, a serious disease that primarily affects the lungs and pancreas. Similarly, individuals of Jewish ancestry are at increased risk of carrying a gene for Tay –Sachs disease. This fatal disease affects a child when two genes are inherited, one from the father and one from the mother.

The following is a questionnaire designed to assess whether or not genetic counseling and screening may be appropriate for you. If you do not understand a question, please note this on the form. The physician will review your questions at your initial visit. If desired, genetic counseling and/or screening can then be arranged.

Thank you,

The Saint Barnabas Institute for Reproductive Medicine

Family History

Do you or any family members have (check all that apply and indicate relationship to you):

	<i>Relationship to you</i>		<i>Relationship to you</i>
<input type="checkbox"/> Thalassemia	_____	<input type="checkbox"/> Muscular Dystrophy	_____
<input type="checkbox"/> Neural Tube Defect	_____	<input type="checkbox"/> Cystic Fibrosis	_____
<input type="checkbox"/> Down Syndrome	_____	<input type="checkbox"/> Huntington Disease	_____
<input type="checkbox"/> Tay-Sachs Disease	_____	<input type="checkbox"/> Mental Retardation	_____
<input type="checkbox"/> Hemophilia	_____	<input type="checkbox"/> Sickle Cell Anemia	_____
<input type="checkbox"/> Other inherited/chromosomal/genetic conditions	_____		_____

Ethnic Origin (please select all that apply).

Northern European (English, Irish, German, Polish, French, Norwegian, etc.)
 Southern European (Greek, Italian, Spanish)
 Hispanic
 African-American/African/Black
 Asian or Pacific Islander
 Native American (American Indian including Aleut and Eskimo)
 French Canadian
 Jewish
 Other (please explain) _____

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