USF IVF and Reproductive Endocrinology
Patient Questionnaire

Welcome to USF IVF and Reproductive Endocrinology. In order to get to know you and your medical history we ask that you fill out this questionnaire and bring it to your first visit. This will allow us to obtain a thorough assessment as well as minimize any duplicate testing needed for your treatment.

Name_____ Today's Date:_____

Name by which you wish to be addressed:_____ Date of Appointment:_____

Birth date _____ Age _____Occupation _____

Address _____

How did you hear about USF IVF? _____

Contact information: please fill out the methods we may contact you and circle your preferred phone number**.**

Home phone #	**may we leave a confidential voice mail message? ___yes ___no**
Work phone #	**may we leave a confidential voice mail message? ___yes ___no**
Cell phone #	**may we leave a confidential voice mail message? ___yes ___no**
E-mail:	**may we contact you via e-mail? ___yes ___no**

Emergency contact name:	**Phone #** **Relationship:**

Pharmacy name: **location:**	**Phone #**

Referring Physician name:	**Address:**

Gynecologist <u>IF different</u> from above:	**Address:**

Chief Complaint (reason for visit): _____***If*** **Infertility** Duration: _____ yrs.

I. General Information

Are you: ☐ Single ☐Married ☐ Long term relationship ☐ Separated ☐ Divorced ☐ Remarried

Partner's name (if appropriate) _____ Birth date _____

Age _____ Occupation _____

Years with present partner _____ Date of marriage (if applicable) _____

Either partner previously married or had previous pregnancies? Yes _____ No _____ If yes, please explain:_____

Have you or your partner either been surgically sterilized (eg tubal ligation, vasectomy, etc.)? Yes _____ No _____

GYN History

Age of first period? _____ Date of most recent period (1st day)_____

Are your periods regular? _____ Yes _____ No
Usual number of days **between** periods: _____ Usual duration of bleeding: ___ days
Amount of flow? (please circle): Minimal Moderate Severe
Cramps? (please circle): Minimal Moderate Severe

Is pain medication necessary with your menses? ***If so what type:*** Yes No
Are you aware of ovulation? Yes No
Do you have Pelvic Discomfort? Yes No
Do you feel that you have excess hair growth (hirsutism) or acne? Yes No
Previous methods of contraception: (circle all methods used)
Pills, Condoms, Foam, Diaphragm, IUD, Withdrawal, Rhythm, None

Usual frequency of sexual intercourse per week _____ or per month _____
Lubricants used: Yes ___ No___ If yes, please specify: _____
Does your partner ejaculate in the vagina during intercourse? Yes ____ No____
Do you douche _____ before or _____ after intercourse? Yes ____ No____
Is intercourse painful or difficult for you or your partner? Yes ____ No____
If yes, please check all that apply:
Pain is: □ Mild □ Moderate □ Severe □ Always painful □ Rarely painful
□ With all sexual positions □ Just with some positions
□ Getting worse with time □ No change in last few years

Do you have a history of DES *(diethylstilbestrol*) exposure? Yes ___ No ___
Date of last pap smear _____ Results _____
Do you have a history of an abnormal pap smear? Yes ___ No ___
If so, have your recent pap smears been normal? Yes ___ No ___
History of: Pelvic pain ____ Endometriosis ____ Pelvic Infection (PID) _____ Chlamydia ____ Herpes ____
Syphilis____ HPV(genital warts)_____ Gonorrhea ____ Tuberculosis (TB) ____

How many sexual partners have you had in your lifetime? ___I have never had intercourse __ 1 __ less than 5 __ 5 or more

III. Obstetrical History

Have you ever been pregnant? Yes _____ No _____ If yes complete the following:

Month/Year Pregnancy Ended	*Pregnancy Outcome* see below*	*With Current Partner?*	*Infertility Therapy (if so, type)*	*How long to Conceive*	*Sex (M/F) and weight of baby (if delivered)*	*If Miscarriage was a D&C done (Y / N)?*	*Were there any complications with the pregnancy (Y / N)?*
		Y N					
		Y N					
		Y N					
		Y N					
		Y N					
		Y N					

***V** -Vaginal delivery, **CS**-C-Section, **M**-Miscarriage, **TOP** - Termination of Pregnancy, **EP**-Ectopic/tubal Pregnancy

IV. Prior Fertility Testing (if known) Most recent treatment:_____

_____

Diagnosis of your condition (if known)_____
Name of doctor and location:_____
Temperature charts: Yes _____ No _____ Appear ovulatory - day _____
Ovulation Predictor Kit: Yes _____ No _____ Color change occurs - day _____
X-ray of tubes/uterus (hysterosalpingogram, HSG): Yes ____ No ____

If yes, Date _____ Where done _____ Results (if known) _____

Hormone Tests:

Progesterone	Date _____	Results _____
Prolactin	Date _____	Results _____
FSH	Date _____	Results _____
Thyroid tests	Date _____	Results _____

Prior Semen analysis? Yes _____ No _____ Date ____ Results _____
If previous evaluation of your partner: Name of Doctor _____
Do you have a family history of infertility caused by an endocrine (hormonal) disorder? Yes _____ No _____

V. Past Medical History and Review of Systems

Have you ever had any procedures on your cervix such as biopsy, cauterization, cryosurgery, D&C (if yes, please specify)?	Yes	No
Any procedure on uterus, vagina, tubes, ovaries, or operations for inflammatory or infectious pelvic diseases, operations for adhesions or endometriosis?	Yes	No
Have you ever had a Laparoscopy? _____ Hysteroscopy? _____ **If YES when? _____**	Yes	No
Have you ever had stimulation of ovulation with oral or injectable agents such as clomiphene (clomid, serophene), HCG, gonadotropins, FSH (if yes, please circle what used)?	Yes	No
Have you ever had any treatment of endometriosis with drugs?	Yes	No
Have you ever undergone artificial insemination: if YES, with: Partner_____ or Donor _____	Yes	No
Have you ever had an endometrial biopsy and, if yes, when?	Yes	No
Have you experienced depression or anxiety related to your condition?	Yes	No
If you experienced depression/anxiety related to your condition have you received psychological treatment for it?	Yes	No
Have you used alternative medicine for infertility (herbs, acupuncture, etc)?	Yes	No
Do you have a heart murmur or condition which **routinely** requires antibiotics with all surgical or routine dental procedures?	Yes	No

Please list any present medications that you are currently taking:

Name	**Purpose**

Are you taking vitamins containing Folic Acid or a Folic Acid supplement? Yes ____ No ___

Do you have allergies to Medications?: □ Yes □ No If so, please complete the following:

Medication	**Type of reaction**	**Date**

Do you have any other significant allergies?:			Date	Reaction/Symptoms
Latex	Yes	No		
Food(s) such as eggs, peanuts, iodine, shellfish. List:	Yes	No		

Present weight:_____lbs. Weight 2 yrs ago:_____lbs. Exposure to significant chemicals or x-rays: Yes___ No___

Smoking habits: Yes _____ Number/day _____; No _____ If stopped, when _____

Caffeine intake:Cups/day: Coffee _____Tea _____ Cola _____ Alcohol: Describe your intake: _____

Exercise (type, duration, how often):_____

Use of marijuana, opium or other non-medical or recreational drugs: Yes ____No___ If yes, current ____or past _____

Have you ever been the victim of sexual or physical abuse? Yes _____ No _____

If yes, have you received counseling for this? Yes _____ No _____

What would you consider your ethnic background (eg Irish, Italian, etc.)?_____

What would you consider your partner's (if appropriate) ethnic background? _____

Please list below any previous hospital admission (for any reason) Medical/Surgical:

Where (hospital, city,state)	**When**	**Reason**	**Treating physician**

Please indicate if any of the following have been present to a significant degree and, if so, when (year):

	Yes	No	Date		Yes	No	Date
Anemia				Gallbladder disease			
Bleeding tendency				GI reflux; heartburn			
Asthma/Chronic bronchitis/ Pneumonia				Kidney/Bladder disease (other than infection)			
Blood transfusion				Hot flushes and night sweats			
Breast discharge				Irritable Bowel Syndrome			
Breast lump/cyst				High blood pressure			
Cancer, type _____				Liver disease/hepatitis			
Cardiovascular disease				Ovarian tumors			
Chronic bronchitis				Radiation treatment			
Significant Visual Disturbances				Significant neurological problems			
Chronic muscle aches/joint pain				Chronic headaches			
Depression				Seizures			
Diabetes				Thyroid problems			

Have you or anyone in your family (and, if so, whom) suffered from the following?	**Who**	**When**
Thrombophlebitis (blood clot)		
Pulmonary embolism (blood clot in the lung)		
Blood clot during pregnancy		
Blood clot while on birth control pills		
Any blood clot requiring treatment		
Stroke or heart attack prior to their 50th birthday,		
Ever been placed on blood thinners for treatment or suspicion of a blood clot?		

Do you have any other significant medical history? Yes___ No____ If yes, please explain.

VI: Family History: please check if positive and give details where appropriate

Patient's Family	Age	Alive	Deceased	Breast or uterine or ovarian cancer	Diabetes	Tay Sachs	Downs Syndrome	Sickle Cell	Cystic Fibrosis	Chromosomal	Other Health Problems
Mother:											
Father											
Sisters											
Sisters											
Sisters											
Brothers											
Brothers											
Brothers											

VII. Partner's history (if appropriate)

Health Status of partner: Good _____ Fair _____ Poor _____ Explain if other than good or if any significant medical problems: _____

Smoking habits: Yes _____ Number/day _____; No _____ If stopped, when _____

Alcohol: Describe your intake: _____

Use of marijuana, opium or other non-medical or recreational drugs: Yes ____No____ If yes, current _____or past ___

Prior genital or hernia surgery/trauma? Yes _____ No _____ Date of Surgery:_____

Please check if any of the following have been present: □ Chlamydia □ Gonorrhea □ Syphilis

□ Genital warts (HPV) □ Herpes (HSV) □ Tuberculosis (TB)

Allergies to medication _____ _____
Present medications: _____ Purpose: _____
_____ _____

Partner's Family	Age	Alive	Deceased	Cancer	Diabetes	Tay Sachs	Downs Syndrome	Sickle Cell	Cystic Fibrosis	Chromosomal	Other Health Problems
Mother:											
Father											
Sisters											
Sisters											
Sisters											
Brothers											
Brothers											
Brothers											

Please be aware that our practice does not provide primary care services (for example: pap smears and other routine health screens and issues) and we request that you obtain this care from your primary care physician and/or gynecologist. Please describe the services which you hope to receive from our practice:

_____
_____
_____

Please note any other questions or issues which you would like to discuss with your doctor:

_____
_____

The above information is correct.

Signature _____ **Date**_____

Patient Information Concerning *Preconceptual Testing*

Preconceptual testing should be considered before attempting to become pregnant. Preconceptual testing does not affect your ability to become pregnant but based on the results of the testing can guide your physicians in the treatment of you and your baby prior to and after pregnancy is achieved. We recommend testing for infectious diseases similar to testing that would be offered at an initial pregnancy visit.

Recommended Tests:

Rubella (German Measles), **Varicella** (Chicken Pox), **Hepatitis B, Hepatitis C, Syphilis** (RPR)**, Gonorrhea, Chlamydia, and HIV**

If you would like additional information about any of these tests including risk factors or methods of transmission, please ask your physician. Please indicate below whether you would like to be tested or not for these conditions so that we may provide this service for you at your initial visit

_____ I wish _____ I do not wish

to be tested for the infectious diseases as discussed above and offered by my doctor. I understand that I can request additional information and counseling about these conditions.

_____ **Date:**_____

Signature (patient)

_____ **Date:**_____

Signature (witness)

_____ I wish _____ I do not wish

to be tested for the infectious diseases as discussed above and offered by my doctor. I understand that I can request additional information and counseling about these conditions.

_____ **Date:**_____

Signature (partner)

_____ **Date:**_____

Signature (witness)

Inheritable Conditions: The following page asks questions to help us recommend blood tests based on specific risks for your or your partners ethnic background. Some common examples include testing for Cystic Fibrosis in Caucasians, Sickle Cell disease in patient of African-American descent or Tay-Sachs disease in patients of French-Canadian or Ashkenazi-Jewish background.

We would like to offer targeted genetic testing to you should you desire.

_____ I wish _____ I do not wish

to be screened for inheritable diseases based on my ethnic background as recommended by my physician

_____ **Date:**_____

Signature (patient)

_____ **Date:**_____

Signature (witness)

_____ I wish/ _____ I do not wish

to be screened for inheritable diseases base on my ethnic background as recommended by my physician

_____ **Date:**_____

Signature (partner)

_____ **Date:**_____

Signature (witness)

Please note, based on your history or specified treatment plan, we may require some of the above testing.

The following questions are designed to screen for common inheritable conditions.

1 . How old are you? _____

2. Have you, your partner, or anyone in either of your families ever had any of the following disorders:

Down syndrome (mongolism)	No___ Yes___
Other chromosomal abnormality	No___ Yes___
Neural tube defect, i.e., spina bifida (meningomyelocele or open spine), anencephaly.	No__ Yes__
Hemophilia	No___ Yes___
Muscular dystrophy	No___ Yes___
Cystic fibrosis	No___ Yes___

If yes, indicate the relationship of the affected person to you or to your partner:

3. Have you ever **had** or **been vaccinated** for Chicken Pox (please circle which, if yes)? No___ Yes___

4. Have you ever **been vaccinated** for Rubella (German Measles)? No___ Yes___

5. Have you ever **had** or **been vaccinated** for Hepatitis (please circle which, if yes) No___ Yes___

6. Do you or your partner have a birth defect? No___ Yes___
   If yes, who has the defect and what is it? _____

7. In any previous relationship, have you or your partner had a child born, dead or alive, with a birth defect not listed in question 2 above? No___ Yes___

8. Do you or your partner have any close relatives with mental retardation? No___ Yes___
   If yes, indicate the relationship of the affected person to you or to your partner:_____
   Indicate the cause, if known: _____

9. Do you, your partner, or a close relative in either of your families have a birth defect, any familial disorder, or a chromosomal abnormality not listed above? No___ Yes___
   If yes, indicate the condition and the relationship of the affected person to you or to the baby's father: _____

10. In any previous relationship, have you or your partner had a stillborn child or three or more first-trimester spontaneous pregnancy losses? No___ Yes___
    If yes, have either of you had a chromosomal study? No___ Yes___

11. Are you or your partner are of Ashkenazi Jewish ancestry? No___ Yes___
    If yes, have either of you been screened for Tay-Sachs disease? No___ Yes___
    If yes, indicate who and the results: _____

11. Are you or your partner are of French-Canadian ancestry? No___ Yes___
    If yes, have either of you been screened for Tay-Sachs disease No___ Yes___
    Cystic Fibrosis? No___ Yes___
    If yes, indicate who and the results: _____

12. Are you or your partner black? No___ Yes___
    If yes, have either of you been screened for sickle cell? No___ Yes___
    If yes, indicate who and the results: _____

13. Are you or your partner of Italian, Greek, Portuguese, or Mediterranean background? No___ Yes___
    If yes, have either of you been tested for β -thalassemia ? No___ Yes___
    If yes, indicate who and the results: _____

14. Are you or your partner of Philippine, Southeast Asian, or Indian ancestry? No___ Yes___
    If yes, have either of you been tested for α-thalassemia? No___ Yes___
    If yes, indicate who and the results: _____

USF IVF
2 Tampa General Circle, 4th Floor Tampa, FL 33606
(813) 259-0692 Fax: (813) 259-0882

Authorization For Release of Confidential Information

Periodically, to provide optimal care and review your previous history and treatment, it is important to obtain your medical records from other physicians or hospitals. In a similar fashion, we attempt to keep your physician(s) informed of tests and results that they would like to obtain. By signing this form now, you are giving us permission to send these results to your physician(s) to allow for the best communication between our offices. To help us in this, we would appreciate it if you would sign this release form. We are also requesting your permission to talk to your partner about your results.

Patient Name:_____DOB:_____

Address:_____

Treatment Date (s) to be disclosed: _____

1. I hereby authorize USF IVF:

____Obtain From (Please include your current and any prior Gynecologist or other appropriate doctors along with their address:_____
_____

___Release To My Current Health Care Providers (e.g. Gynecologist or other appropriate doctors along with their address):_____
_____

2. All the following from my record **EXCEPT** (be specific:)

□ Lab Results	□ Psychiatric Evaluation	□ Medication	□ Assessment
□ Treatment plan	□ Discharge Summary	□ Progress Reports	□ Physical Examination
□ Urine Drug	□ Radiology Procedures/Films	□ Genetics	Other:_____

3. I understand that this information is needed for the purpose of my assessment and co-ordination of current and ongoing care.
   _____

4. I understand that my records are protected under applicable State and Federal confidentiality regulations, including but not limited to, HIPAA, 42 CFR, Part 2, Confidentiality of Alcohol and Drug Abuse Treatment, RI Mental Health Law and RI General Laws ch. 5-37.3 and cannot be disclosed without my written consent except as otherwise specifically provided by law. I understand this consent to disclose may be revoked by me at anytime in writing, except to the extent that action has already been taken. This consent, unless revoked earlier in writing, will expire **1 (one) year** from date of signature.

5. I give permission to the Department of Reproductive Medicine to discuss my confidential healthcare information, including test results, with my partner.
   My limitations are:_____
   _____

_____

Signature of Patient **Date:**

_____

Signature of Witness **Date:**

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Authorization For Release of Confidential Information FOR YOUR PARTNER

Periodically, to provide optimal care and review your previous history and treatment, it is important to obtain your medical records from other physicians or hospitals. In a similar fashion, we attempt to keep your physician(s) informed of tests and results that they would like to obtain. By signing this form now, you are giving us permission to send these results to your physician(s) to allow for the best communication between our offices. To help us in this, we would appreciate it if you would sign this release form. We are also requesting your permission to talk to your partner about your results.

PARTNER'S Name:_____DOB:_____

Address:_____

Treatment Date (s) to be disclosed: _____

5. I hereby authorize USF IVF:

____Obtain From (Please include your current and any prior Gynecologist or other appropriate doctors along with their address: _____
_____

___Release To My Current Health Care Providers (e.g. Gynecologist or other appropriate doctors along with their address):_____
_____

6. All the following from my record **EXCEPT** (be specific:)

□ Lab Results	□ Psychiatric Evaluation	□ Medication	□ Assessment
□ Treatment plan	□ Discharge Summary	□ Progress Reports	□ Physical Examination
□ Urine Drug	□ Radiology Procedures/Films	□ Genetics	Other:_____

7. I understand that this information is needed for the purpose of my assessment and co-ordination of current and ongoing care.
   _____

8. I understand that my records are protected under applicable State and Federal confidentiality regulations, including but not limited to, HIPAA, 42 CFR, Part 2, Confidentiality of Alcohol and Drug Abuse Treatment, RI Mental Health Law and RI General Laws ch. 5-37.3 and cannot be disclosed without my written consent except as otherwise specifically provided by law. I understand this consent to disclose may be revoked by me at anytime in writing, except to the extent that action has already been taken. This consent, unless revoked earlier in writing, will expire **1 (one) year** from date of signature.

5. I give permission to the Department of Reproductive Medicine to discuss my confidential healthcare information, including test results, with my partner.
   My limitations
are:_____
   _____

_____
Signature of PARTNER **Date:**

_____
Signature of Witness **Date:** revised 1/28/08