How did you hear about us?

(please check all that apply)

- ☐ Physician referral
- ☐ 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

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): _____

Phone (night): _____ Address: _____

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
1st Pregnancy							
2nd pregnancy							
3rd pregnancy							
4th pregnancy							
5th 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
☐	Basal Body Temperature	_____	_____
☐	Urinary LH (Ovulation) Predictor Kits	_____	_____
☐	Postcoital Test	_____	_____
☐	Hormone Tests	_____	_____
☐	Endometrial Biopsy	_____	_____

		Date	Results
☐	Hysterosalpingogram (HSG)	_____	_____
☐	Sonohysterogram	_____	_____
☐	Ultrasound	_____	_____
☐	Antisperm Antibodies	_____	_____
☐	Laparoscopy	_____	_____
☐	Hysteroscopy	_____	_____
☐	Gonorrhea/Chlamydia Cultures	_____	_____
☐	Rubella (German Measles)	_____	_____
☐	Hepatitis B or C	_____	_____
☐	HIV	_____	_____
☐	RPR (Syphilis)	_____	_____
☐	Blood Type and Rh	_____	_____
☐	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? _____	☐	☐
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? _____	☐	☐
If yes, are they: ☐ Mild ☐ Moderate ☐ Severe		
Have you ever missed work or school do to menstrual pains? _____	☐	☐
Do you have pain with intercourse? _____	☐	☐

Yes No

Where you ever diagnosed with endometriosis? _____ ☐ ☐

What type of contraception have you used in the past?

☐ Birth Control ☐ IUD ☐ Depo Provera (birth control shots) ☐ Condoms
☐ Diaphragm ☐ Foams/Jellies ☐ Withdrawal ☐ Rhythm
☐ 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):

☐ Gonorrhea ☐ Venereal Warts ☐ Syphilis
☐ Chlamydia ☐ Genital Herpes ☐ Pelvic Inflammatory Disease (PHD)

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)

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

Current Medications_____
_____
_____
_____

Yes No

Are you allergic to any medications? _____ ☐ ☐
What? _____
Have you ever had surgery before? _____ ☐ ☐
Date and type _____

VI. Social History Current or Recent Employer/Position _____

	Yes	No
Do you drink alcohol? _____	☐	☐
Number of drinks per week _____		
Do you smoke? _____	☐	☐
Number of cigarettes per day _____ Number of years smoking _____		
Do you now, or have you ever, used illicit drugs (marijuana, cocaine, etc.)? _____	☐	☐
Specify _____		
Do you have a special exercise program? _____	☐	☐
Type _____ Number of hours per week_____		
Are you on a special diet? _____	☐	☐
Type _____		

VII. Review of Systems

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

VIII. Family History

	Yes	No
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? _____	☐	☐
Do any family members have significant health problems or inherited diseases? _____	☐	☐

Check all that apply:

☐	Birth Defects	☐	Down Syndrome	☐	Muscular Dystrophy
☐	Brain/Spinal Defects	☐	Fragile X Syndrome	☐	Sickle Cell Disease
☐	Cancer	☐	Heart Disease	☐	Tay-Sachs Disease
☐	Cystic Fibrosis	☐	Hemophilia	☐	Thalassemia
☐	Diabetes	☐	High Blood Pressure	☐	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.

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) Fax: 919-484-0461