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RGI Patient Questionnaire

Date: _____

Patient Name _____
Last First Middle

Date of Birth _____ Age _____ Social Security # _____

Address _____
Street Apt. or POB#

_____
City State Zip Code

Home Phone _____ Work Phone _____

Cell Phone _____ Pharmacy Name _____

Email _____ Pharmacy Phone _____

Partner Name _____
Last First Middle

Date of Birth _____ Age _____ Social Security # _____

Current Gynecologist _____ Office Phone _____

Primary Care Physician _____ Office Phone _____

*It is very important that you take the time to fill out the ***** questions accurately.*

MENSTRUAL HISTORY

Age at first period _____ Date of **last** period _____

	YES	NO
Are your periods regular? ……..	☐	☐
What is the usual number of days between periods? Minimum _____ Maximum _____		
What is the usual duration of your bleeding? Minimum _____ Maximum _____		
Do you have PMS? ……	☐	☐
If yes, specify: ☐ Mild ☐ Moderate ☐ Severe		
Do you have painful menses? ……..	☐	☐
If yes, specify: ☐ Mild ☐ Moderate ☐ Severe		
Do you take pain medication for cramps? ……..	☐	☐
If yes, specify: _____		
Do you bleed or spot between periods? ……..	☐	☐
If you've ever taken oral contraceptives, were your periods regular after stopping the pill? ..	☐	☐
Did your mother have any difficulty with contraception or pregnancy? ……..	☐	☐
Did your mother take diethylstilbestrol (DES) when she was pregnant with you? ……...	☐	☐
At what age did your mother begin menopause? _____		
Is there a family history of infertility? ……...	☐	☐
If yes, who/ relationship: _____		
Is there a history of hormonal disorders in your family? ……..	☐	☐
If yes, who/ relationship/type: _____		
Is there a family history of birth defects? ……	☐	☐
If yes, who/ relationship: _____		
Is there a family history of habitual pregnancy loss? ……	☐	☐
If yes, who/ relationship: _____		
Have you ever used an intrauterine device (IUD)? ……...	☐	☐
If yes, specify type/# of years: _____		
Have you ever had a sexually transmitted disease (STD)? ……	☐	☐
If yes, describe: _____		
Is intercourse painful? ……	☐	☐
If yes, specify: ☐ Mild ☐ Moderate ☐ Severe		
Do you use lubricants for intercourse? ……	☐	☐
If yes, which brand: _____		
Do you douche before or after intercourse? ……..	☐	☐

How many times per week do you and your partner have intercourse? _____

*** How many months has it been since you discontinued methods of birth control?** _____

*** How many months have you been trying to get pregnant?** _____

	YES	NO
Have you used Basal Body Temperature (BBT)? ……	☐	☐
If yes, what day did you ovulate: _____		
Have you used an Ovulation Predictor Kit (OPK)? ……...	☐	☐
If yes, what day did you ovulate: _____		
Do you take vitamins? ……	☐	☐
If yes, what kind and how much: _____		

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

Have you been exposed to any toxins? ……..	☐	☐
If yes, what kind and how much: _____		

Patient Ethnic Origin:

☐ White Non-Hispanic ☐ White Hispanic ☐ Black Non-Hispanic ☐ Black Hispanic

☐ Asian Non-Hispanic ☐ Asian Hispanic ☐ Native American

☐ Unknown/Other, please specify: _____

PREGNANCY DATA

*** How many prior pre-term (< 37 weeks) births have you had?** _____

*** How many prior full-term (> 37 weeks) births have you had?** _____

*** How many pregnancies (including miscarriages) have you had?** _____

*** How many miscarriages have you had?** _____

Please fill in chart below:

Pregnancy	Year	End in Abortion, Miscarriage or Ectopic Pregnancy?	Infertility therapy required to conceive?	How long to conceive? (months)	37 weeks or more?	Baby born alive?	Is current partner the father?
First							
Second							
Third							
Fourth							
Fifth							

Additional Comments: _____

SURGICAL HISTORY

	YES	NO
Have you ever been surgically sterilized? ……..	☐	☐

How many operations have you had? _____

Date	Procedure	Hospital	Surgeon	Findings

MEDICAL HISTORY

Weight _____ Height _____ Blood Type (if known) _____

List the forms and frequency of regular, vigorous exercise (swimming, cycling, running), and age you began:

_____

Exercise _____Hrs/Week _____Exercise _____Hrs/Week _____

	YES	NO
Have you lost more than 20 lbs. of weight in the last year? ……	☐	☐
Do you follow a particular food diet or have any specific dietary habits? ……..	☐	☐
If yes, specify: _____		
Have you ever had an eating disorder (anorexia or bulimia)? ……	☐	☐
If yes, specify: _____		
Do you have any allergies to medications? ……..	☐	☐
If yes, specify: _____		
List any vaccinations you have received ……..		
Specify: _____		

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

- ☐ Scarlet Fever
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ Syphilis
- ☐ Gonorrhea
- ☐ Pelvic Infection
- ☐ Chlamydia
- ☐ Herpes
- ☐ Chronic Bronchitis
- ☐ Measles: Regular
- ☐ Measles: German
- ☐ Pneumonia
- ☐ Kidney Infection
- ☐ Heart Disease
- ☐ Hirsutism (Excess Hair Growth)
- ☐ High Blood Pressure
- ☐ Gallbladder Problems
- ☐ Liver Problems
- ☐ Ulcers
- ☐ Appendicitis
- ☐ Colitis
- ☐ Diabetes
- ☐ Anemia
- ☐ Arthritis
- ☐ Thyroid Problems
- ☐ Breast Tenderness
- ☐ Breast Soreness
- ☐ Breast Milky Discharge
- ☐ Neurologic problems
- ☐ Seizures
- ☐ Epilepsy
- ☐ Visual Disturbances
- ☐ Poor Sense of Smell
- ☐ Dizziness
- ☐ Loss of Balanace
- ☐ Chronic Headaches
- ☐ Blood Transfusions
- ☐ Parasitic Infection

☐ Nongonococcal Urethritis
☐ Breast Cancer
☐ Vaginitis
Trichomoniasis or Yeast
per year: _____

☐ Ovarian Cysts
☐ Cervical Cancer
☐ Other Cancer
Specify:
_____

☐ Endometriosis
☐ Ovarian Cancer
☐ Allergies
Specify:
_____

Within the last year, have you taken any prescription medications? Please note in the chart below.

Medication	Diagnosis	Dosage/Frequency	Duration

Are you taking any over-the-counter medications on a regular basis? Please note in the chart below.

Medication	Diagnosis	Dosage/Frequency	Duration

Do you or have you ever used (check **all** that apply):

☐ Alcohol – How many glasses per week do you usually drink? Wine ____ Beer ____ Cocktails ____
☐ Cigarettes – Number of packs per day _____ Number of years _____
☐ Illicit or Recreational Drugs (Marijuana, Cocaine, etc.) – If you would feel more comfortable not writing anything down, please discuss this directly with your physician. Specify:

_____
_____

HISTORY OF FERTILITY THERAPY

	YES	NO
Have you been treated for infertility before? ……..	☐	☐

If yes, who was your physician: _____

Address: _____

Diagnosed cause of infertility: _____

_____

_____

Have you taken any of the following medications? (Check **all** that apply)

☐ Thyroid medication (e.g. Synthroid) ☐ Bromocriptine (e.g. Parlodel)

Which of the following tests have you had performed? (Check **all** that apply and results if known)

☐ Postcoital Test Date ___/___ Results: _____
☐ Day3 FSH, Estradial Date ___/___ Results: _____
☐ Endometrial Biopsy Date ___/___ Results: _____
☐ Hysterosalpingogram Date ___/___ Results: _____
☐ Antisperm Antibodies Date ___/___ Results: _____
☐ Laparoscopy Date ___/___ Results: _____
☐ Hysteroscopy Date ___/___ Results: _____
☐ Mycoplasma/Chlamydia Cultures Date ___/___ Results: _____
☐ Thyroid Tests Date ___/___ Results: _____
☐ Rubella Date ___/___ Results: _____
☐ HIV Date ___/___ Results: _____
☐ PAP Smear Date ___/___ Results: _____
☐ Mammogram Date ___/___ Results: _____
☐ Sickle Cell Date ___/___ Results: _____
☐ Tay Sachs Date ___/___ Results: _____
Other – Specify: _____ Date ___/___ Results: _____

INFERTILITY CYCLE HISTORY

Clomiphene Citrate

Dates	# of Cycles	Max Starting Dose	Max Follicles	# with Insemination	# of Cycles Resulting in Pregnancy

*** Number of prior Gonadotropin Cycles:** _____

Gonadotropin (Follistim, Gonal-F, etc.)

Dates	# of Cycles	Max Starting Dose	Max Estradiol	Max Follicles	# with Insemination	# of Cycles Resulting in Pregnancy

*** Number of prior Fresh ART (IVF) Cycles:** _____

*** Number of prior Frozen ART (IVF) Cycles:** _____

IVF History

	Cycle 1	Cycle 2	Cycle 3	Cycle 4	Cycle 5	Cycle 6
Date						

IVF Center												
Frozen Embryo Cycle	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐
Max Start Dose												
Max Estradial												
# Eggs Retrieved												
# Eggs Fertilized												
ICSI?	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐
# Embryos Transferred												
Embryo Age (day 2, 3 or 5)												
Pregnancy?	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐
Delivered?	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐

Family History (indicate Relation to You for all that apply)

Disorder	Relation to You	Disorder	Realtion to You
Breast Cancer		Fanconi Anemia	
Ovarian Cancer		Familial Dysautonia	
Colon Cancer		Muscular Dystrophy	
Diabetes		Neurologic (brain/spine)	
Thyroid Problems		Neural Tube Defects	
Heart Disease		Dwarfism	
Blood Clots		Developmental Delay	
Obesity		Learning Problems	
Psychiatric Problems		Polycystic Kidney Disease	
Tuburculosis		Heart defect from birth	
Endometriosis		Down Syndrome	
Infertility		Other chromosome defects	
Menopause before 40		Marfan syndrome	
Birth Defects		Hemophilia	
Cystic Fibrosis		Sickle Cell Anemia	
Tay-Sachs Disease		Thalassemia	
Canavan Disease		Galactosemia	
Bloom Syndrome		Deafness/Blindness	
Gauchers Disease		Color Blindness	
Niemann-Pick Disease		Hemochromatosis	

Other (specify) _____

Review of Systems

(Please indicate any conditions below that apply to you)

General

- ☐ Recent weight gain or loss
- ☐ Anorexia/Bulemia
- ☐ Lack of Energy
- ☐ Fever/Chills

Head, Eyes, Ears, Nose, Throat

- ☐ Dizziness ☐ Loss of smell
- ☐ Headaches ☐ Blurred Vision
- ☐ Blurred Vision ☐ Hearing Loss
- ☐ Chronic Nasal Congestion

Respiratory

- ☐ Shortness of breath
- ☐ Asthma ☐ Bronchitis
- ☐ Pneumonia ☐ Tuberculosis
- ☐ Bloody cough

☐ Other:_____
☐ None

Endocrine/Hormonal

☐ Diabetes ☐ Hair Loss
☐ Thyroid gland problems
☐ Rapid weight loss or gain
☐ Excessive hunger/thirst
☐ Temperature Intolerance – feeling hot or cold
☐ Other:_____
☐ None

Genito-Urinary

☐ Bladder infections
☐ Kidney Infections
☐ Vaginal infections
☐ Frequent urination ☐ Leaking urine
☐ Blood in urine
☐ Herpes
☐ Other:_____
☐ None

Musculoskeletal

☐ Unusual muscle weakness
☐ Decreased energy/stamina
☐ Rheumatoid Arthritis
☐ Lupus Erythematosus
☐ Myasthenia gravis
☐ Other:_____
☐ None

Mental Health Problems

☐ Depression
☐ Anxiety disorder
☐ Schizophrenia
☐ Other:_____
☐ None

☐ Other: _____
☐ None

Breasts

☐ Discharge(clear__ bloody__ milky__)
☐ Lumps ☐ Pain ☐ Cancer
☐ Abnormal Mammogram
☐ Reduction
☐ Augmentation/Breast Implants (saline? ___ silicone? ___)
☐ Other:_____
☐ None

Gastrointestinal

☐ Nausea/Vomiting ☐ Ulcers
☐ Hepatitis ☐ Diarrhea
☐ Blood in stools ☐ Constipation
☐ Irritable Bowel Syndrome
☐ Change in bowel habits
☐ Colitis (ulcerative or Crohn's)
☐ Other:_____
☐ None

Hematologic

☐ Blood clotting disorder/Blood clot
☐ Sickle cell Anemia ☐ Thrombophlebitis
☐ Blood transfustions (dates/reasons_____
☐ Easy Bruising
☐ Swollen glands/lymph nodes
☐ Other:_____
☐ None

☐ Other:_____
☐ None

Neurological Problems

☐ Weakness/Loss of balance
☐ Seizures/Epilepsy
☐ Headaches
☐ Migraine headaches
☐ Numbness ☐ Memory Loss
☐ Other:_____
☐ None

Skin/Extremities

☐ Unexplained rash/inflammation
☐ Acne
☐ Skin Cancer
☐ Burn Injury
☐ Moles changing in appearance
☐ Excess hair growth
☐ Other:_____
☐ None

Cardiovascular

☐ Palpitations/Skipped beats
☐ Chest pain ☐ Heart Attack
☐ Stroke ☐ Murmurs
☐ High Blood Pressure
☐ Rheumatic fever
☐ Mitral valve prolapsed (Need antibiotics before dental procedures? Yes__ No__)
☐ Other:_____
☐ None

MALE DATA, if applicable

Name: _____
First Last

Marriage #: _____

Number of pregnancies conceived with current partner: _____

Number of pregnancies conceived with previous partners: _____

Pregnancies Conceived with a Previous Partner

Date of Pregnancy	Pregnancy Outcome		
	Delivered	Aborted	Miscarried

Urologist: _____ Phone: _____

Address: _____

Male Ethnic Origin:

- ☐ White Non-Hispanic
- ☐ White Hispanic
- ☐ Black Non-Hispanic
- ☐ Black Hispanic
- ☐ Asian Non-Hispanic
- ☐ Asian Hispanic
- ☐ Native American
- ☐ Unknown/Other, please specify: _____

Have you ever had a semen analysis (sperm count) performed? …….. YES ☐ NO ☐

Date of Semen Analysis	Location of Analysis	Count (Million/ml)	Motility	Grade	Morphology

Do you have any medical problems unrelated to your fertility?

Nature of Problem (Diagnosis)	Treatment	Physician

MALE SURGICAL HISTORY

Have you ever had surgery? If yes, please specify:

Date	Hospital	Procedure	Findings	Surgeon

Do you take any medications? If yes, please specify:

Medication	Diagnosis	Dosage/Frequency	Duration

Do you or have you ever used (check **all** that apply):

☐ Alcohol – How many glasses per week do you usually drink? Wine ____ Beer ____ Cocktails ____
☐ Cigarettes – Number of packs per day _____ Number of years _____
☐ Illicit or Recreational Drugs (Marijuana, Cocaine, etc.) – If you would feel more comfortable not writing anything down, please discuss this directly with your physician. Specify:

_____

Do you or have you ever had any difficulties with (check **all** that apply):

☐ Erection If yes, please explain:

_____

☐ Ejaculation If yes, please explain:

_____

	YES	NO
Have your genitals ever been exposed to excessive heat? ……	☐	☐
Have you had any serious injuries to your genitals? ……	☐	☐
Have you had any infections of your penis, testicles or prostate gland? ……..	☐	☐
Is there any history of birth defects in your family? ……...	☐	☐
Is there any history of recurrent miscarriage in your family? ……..	☐	☐
Do you have any allergies to medications? ……	☐	☐

If yes, specify: _____

PATIENT COMMENTS

What do you understand about the cause of your infertility and possible treatment options?

Please use this space to add any additional comments or information you feel your physician should know.