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Please complete and bring this questionnaire with you to your first visit.

MEDICAL ALLERGIES

Which drugs or medicines are you allergic or sensitive to?

Drug	Reaction

PATIENT INFORMATION

Name: _____

Address: _____

Phone: Day (____) ____ - ____ Evening (____) ____ - ____ Cell (____) ____ - ____

Age: ____ Date of Birth: _____

Marital Status: Married Single Widowed Divorced Separated

Ethnic Group/Race: _____ Religion: _____

Occupation: _____ Yrs of Education: _____

Emergency Contact: _____ Relationship: _____ Phone: (____) ____ - ____

SPOUSE/SIGNIFICANT OTHER INFORMATION

Name of Spouse/Significant Other: _____

Age: _____

Phone numbers: Day (____) ____ - ____ Evening (____) ____ - ____ Cell (____) ____ - ____

Ethnic Group/Race: _____ Religion: _____

Occupation: _____ Yrs of Education: _____

GYNECOLOGICAL HISTORY

How old were you when you had your first period _____

How frequently do your periods come? Every ___ days

How long do your periods last? _____ days. When did your last period start? _____

Was there a time in the past, when your cycles were irregular while not on the "Pill"?

If so, please describe: _____

Have you ever taken the "Pill"? Yes No

If so, for how many years in total: _____

Do you experience cramping with your periods? Yes No

If yes, when during your cycles do you have pain (check all that apply):

Before During After

How would you describe the cramps? Mild Moderate Severe

Do you take pain medication for the cramps? Yes No

If yes, specify medication: _____

Do you bleed or spot between periods? Yes No

If yes, please describe: _____

Have you ever had an abnormal Pap smear result? _____

If yes, what therapy was required: Cryotherapy (freezing of cervix) Laser therapy

Cone biopsy LEEP Other: _____

Have you ever had any of the following infections involving any part of the reproductive tract?

(Check all that apply)

Chlamydia Trichomonas Gonorrhea Herpes Genital warts

What treatment did you receive? _____ Year: _____

Do you have pain with intercourse? Never Sometimes Frequently Always

If yes, does the pain remain in your lower abdomen or back after intercourse if over?

Yes No if yes, for how many minutes? : _____

How frequently do you and your partner have intercourse? _____ Per week month

How frequently do you and your partner have intercourse around ovulation?

_____ times per month

Do you usually use lubrication during intercourse? Yes No

If yes, please specify: _____

Have you experienced any difficulties with intercourse that may be contributing to not getting pregnant?

Yes No If yes, please explain: _____

Have you ever used contraception in the past? Yes No

if yes, please check all that apply:

Contraceptive pills Condoms IUD Foam/Sponge Rhythm

Withdrawal Other: _____

PAST FERTILITY EVALUATION

How long have you and your partner been attempting to achieve pregnancy? _____

Have you been using temperature charts? Yes No

If yes, for how long? _____ months

Have you been using urine ovulation predictor kits? Yes No

if yes, what kind and for how long? _____

Have you ever tried to achieve a pregnancy with a different partner? Yes No

Have you ever conceived with a different partner? Yes No

Has your male partner ever gotten someone else pregnant? Yes No

Have you been treated for infertility previously? Yes No

If yes, where & when: _____

What was the cause of infertility? _____

Which of the following tests have already been performed?

Infection test (mycoplasma, Chlamydia) Postcoital test Endometrial biopsy

Hysteroscope Hormonal tests (FSH, Prolactin, TSH) Antichlamydia Antibody Ultrasound

Sonohysterogram Hysterosalpingogram (HSG) Antisperm antibody Laparoscopy

If done, indicate date and findings of the laparoscopy: _____

Have you ever taken any of the medications listed below?

- Clomiphene (Clomid, Serophene) Letrozole (Femara) Injectable gonadotropins
(Menopur, Repronex, Humagon, Gonal-F, Follistim)
- HCG (Profasi, Pregnyl) GnRH agonist (Lupron, Synarel, Zoladex) Estrogens
- Steroids (prednisone, dexamethasone) GnRH Antagonist (Antagon)
- Bromocriptine (Parlodel, Dostinex) Baby aspirin
- Glucophage (Metformin) Progesterone Heparin or Lovenox

Have you ever had intrauterine inseminations (IUI)? Yes No

if yes, for how many cycles? _____

If yes, sperm specimen was provided by: (Check all that apply) Partner Donor

How many cycles of IUI without any medications? _____

How many cycles of IUI with Clomid? _____

How many cycles of IUI with Letrozole? _____

How many cycles of IUI with Injectable medications (Menopur, Repronex, Humagon, Gonal-F, Follistim): _____

Have you ever attempted in vitro fertilization? Yes No if yes, please put more details below:

OBSTETRICAL HISTORY

Have you ever been pregnant (including elective terminations, miscarriages, and births)? Yes No

If yes, please describe:

PAST MEDICAL HISTORY

Do you have or have you ever had any of the following (check all that apply):

- Ovarian cysts Anemia Endometriosis Gallbladder disease Arthritis

- Heat or cold intolerance Hair loss Seizures Mumps
- High blood pressure Hirsutism (excess hair growth) Hot flashes Vision problems
- Cystic Fibrosis Diabetes Breast (Nipple discharge)
- Colitis Acne Chronic headaches Kidney or Liver problems German Measles
- Regular Measles Neurological problems Autoimmune disease (e.g. Lupus Multiple Sclerosis, Arthritis)

PAST SURGICAL HISTORY

Have you ever had any surgeries besides laparoscopies in the past? Yes No

If yes, please indicate date, type, and findings of the surgery:

FAMILY HISTORY

Have any of these problems occurred in your family? Check all that apply and indicate relationship to you:

- High blood pressure _____ Ovarian cancer _____
- Infertility _____ DES exposure in utero _____
- Early menopause _____
- Heart disease _____ Colon or Breast Cancer _____
- Diabetes _____ Thyroid disease _____
- Autoimmune disease (Lupus, Multiple Sclerosis, Rheumatoid Arthritis) _____

REVIEW OF SYSTEMS

Have you noted any significant:

Heat or Cold intolerance recently? Yes No

if yes, please explain: _____

Unusual hair distribution changes or breast nipple discharge? Yes No

if yes, please explain: _____

Significant weight change in the last year? If so, please describe how many lbs

and over what time: _____

HABITS

Do you smoke? Yes No if yes, how many packs per day? _____

Do you drink alcohol? Yes No if yes, how many alcoholic beverages per week: _____

Do you smoke marijuana? Yes No if yes, how much per week: _____

Do you exercise regularly? Yes No if yes, please indicate type of exercise and estimate hours per week spent

MEDICATIONS:

Are you currently taking any prescription medications? Yes No

Medications

Reason

_____	_____
_____	_____

Do any of you use herbal medications? Yes No

if yes, types of medications used: _____

Are you using Acupuncture or Chinese Herbal Medicine Currently? Yes No

If yes, please describe: _____

SECTION FOR MALE PARTNER FERTILITY EVALUATION

Which of the following test have already been performed?

- Semen analysis Chromosome test Blood tests (FSH,LH,Prolactin,Testosterone)
 Ultrasound of testis Antisperm antibody test Mycoplasma and Ureaplasma culture
 Testicular biopsy

Have you ever had any of the following procedures done? (Check all that apply)

- Varicocele repair hernia repair Prostate surgery Testicular torsion repair
 Testicular biopsy Vasectomy reversal Other (please specify): _____

Have you ever had any significant testicular injury? Yes No

If yes, please describe: _____

Have you ever taken any of the medications listed below?:

- Clomiphene (Clomid,Serophene) Proxeed Testosterone Viagra/Viagra like medications
 GnRH agonist (Lupron,Synarel,Zoladex Bromocriptine (Parlodel, Dostinex)
 Other (please list): _____

Do you have or have you ever had any of the following (check all that apply):

- Cystic Fibrosis Delay of puberty Anemia Arthritis Cancer
 Autoimmune disease Heat or cold intolerance Seizures Neurological problems
 High blood pressure Vision problems Testicular tumor
 Chronic headaches Kidney /Liver problems Colitis Cystic Fibrosis Diabetes
 Regular Measles German Measles mumps Mumps with testes involved

PAST SURGICAL HISTORY

Have you ever had any surgeries in the past? Yes No

If yes, please indicate date, type, and findings of surgery:

FAMILY HISTORY

Have any of these problems occurred in your family? Check all that apply and indicate relationship to you:

- High blood pressure _____ Ovarian cancer _____
- Infertility _____ Prostate CA _____
- Heart disease _____ Colon/breast CA _____
- Diabetes _____ Other _____

REVIEW OF SYSTEMS

Have you noted any significant:

Heat/Cold intolerance recently? Yes No

if yes, please explain: _____

Unusual hair distribution changes? Yes No

if yes, please explain: _____

Significant weight change in the last year? Yes No

If so, please describe how many lbs and over what time: _____

HABITS

Do you smoke? Yes No if yes, how many packs per day? _____

Do you drink alcohol? Yes No if yes, how many alcoholic beverages per week: _____

Do you smoke marijuana? Yes No if yes, how much per week: _____

Do you take hot baths? Yes No if yes, how much per week: _____

Do you exercise regularly? Yes No if yes, please indicate type of exercise and

Estimate hrs per week spent:

MEDICATIONS:

Are you currently taking any prescription medications? Yes No

If yes, please describe:

Medications: _____ Reason: _____

Do any of you use herbal medications? Yes No

If yes, types of medications used: _____