Garrison Women's Health Center
"Supporting Women with Excellence and Compassion"
Obstetrics ~ Gynecology ~ Infertility ~ Midwifery
770 Central Avenue, Dover, NH 03820
Telephone (603) 742-0101

Female Infertility Intake Worksheet

Consult Date ___/___/____

Patients - Please complete both sides of this form in addition to the enclosed OB/GYN Questionnaire & Genetics Questionnaire.

Name:_____ _____ Age:____ DOB:___/___/____
Last *First*

Occupation:_____

Partner's Name:_____ _____ Age:____ DOB:___/___/____
Last *First*

Marital Status: ☐ Single ☐ Separated ☐ Divorced ☐ Married ___ years

Please answer the following questions. Enter additional informaiton on reverse side in "Patient Comments" section.

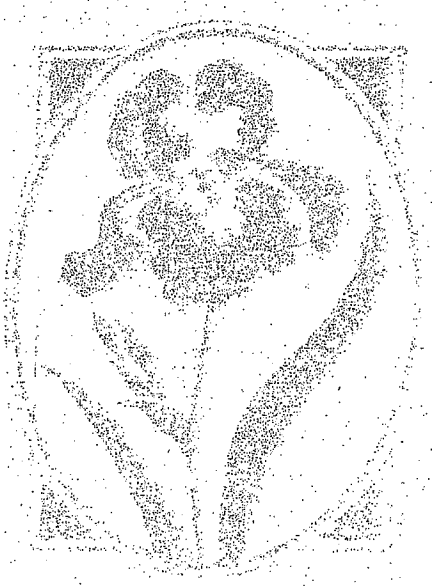
Gynecological/Medical History

Gonorrhea	☐ Yes	☐ No	Prior IUD use	☐ Yes	☐ No
Pelvic Infection	☐ Yes	☐ No	Mom took DES	☐ Yes	☐ No
Painful Sex	☐ Yes	☐ No	Douche	☐ Yes	☐ No
Breast Discharge	☐ Yes	☐ No	Physical Abuse	☐ Yes	☐ No
Birth Control Pills	☐ Yes	☐ No	Mammogram	☐ Yes	☐ No
Vaginal Lubricants	☐ Yes	☐ No	Acne	☐ Yes	☐ No
Sexual Abuse	☐ Yes	☐ No	Blood Clots	☐ Yes	☐ No
Abnormal Pap	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Date last Pap: ___/___/____			Endometriosis	☐ Yes	☐ No
Weight Change	☐ Yes	☐ No	Excessive Thirst	☐ Yes	☐ No
Chlamydia	☐ Yes	☐ No	Fibroids	☐ Yes	☐ No
Herpes	☐ Yes	☐ No	High blood pressure	☐ Yes	☐ No
Excessive Hair	☐ Yes	☐ No	Thyroid problems	☐ Yes	☐ No

For office use

Prior Infertility Evaluation *(if applicable)*

		Date	*Result*	
Basal temp records	☐ No	_____	☐ Normal	☐ Abnormal
Urine ovulation kits	☐ No	_____	☐ Normal	☐ Abnormal
Endometrial biopsy	☐ No	_____	☐ Normal	☐ Abnormal
Semen analysis	☐ No	_____	☐ Normal	☐ Abnormal
Hysterosalpinogram	☐ No	_____	☐ Normal	☐ Abnormal
Post coital test	☐ No	_____	☐ Normal	☐ Abnormal
Laparoscopy	☐ No	_____	☐ Normal	☐ Abnormal
Hysteroscopy	☐ No	_____	☐ Normal	☐ Abnormal
FSH blood test	☐ No	_____	☐ Normal	☐ Abnormal



Prior Infertility Treatments *(if applicable)*

			Date	
Clomid or Serophene	☐ No	☐ Yes:	_____	#of cycles ____
FSH injectable meds	☐ No	☐ Yes:	_____	#of cycles ____
hCG injectable meds	☐ No	☐ Yes:	_____	#of cycles ____
Intrauterine insemin.	☐ No	☐ Yes:	_____	#of cycles ____
IVF or GIFT	☐ No	☐ Yes:	_____	#of cycles ____

Patient Comments: _____

_____

_____

_____

_____

_____

_____

For Office Use:

Ht_____ Wt_____ BP_____ G_____ P_____ AB_____ LMP_____

Medications: _____

Multivits: ☐ Yes ☐ No

Herbs/Supplements _____

Myco/Ureaplasm culture ☐ GC/CT ☐ Comments: _____

Evaluation: ☐ CD #3 labs _____

☐ Baseline U/S ☐ SIS

☐ PCOS labs _____

☐ RPL labs

☐ HSG - 2nd cycle ovulatory _____

☐ Semen analysis

☐ POD #7 P4 ☐ EB _____

Records release: _____ _____

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Male Infertility Intake Worksheet

Consult Date ___/___/_____

Name:_____ _____ Age:____ DOB:___/___/_____
Last *First*

Partner's Name:_____ _____ Age:____ DOB:___/___/_____
Last *First*

Primary Care Physician:_____ Occupation:_____

If trying to conceive, how long? ☐Yes ____Years

Have you had a semen analysis? ☐Yes ☐No Urological evaluation? ☐Yes ☐No

Please answer the following questions. Make any comments in the comment section below.

Number of pregnancies with current partner:____
Number of years married:____
Number of prior marriages: Husband:_____ Wife:____
Number of pregnancies with previous partner(s):____
Ages of children, if any:_____

Past Medical History

Do you have any heart problems? ☐Yes ☐No
Do you have any lung problems?(asthma,etc)☐ Yes ☐ No
Do you have bowel or stomach problems? ☐Yes ☐No
Do you have bowel or stomach problems? ☐Yes ☐No
Problems with muscles or joints? ☐Yes ☐No
Ever had mumps? ☐Yes ☐No
Do you have neurological problems? ☐Yes ☐No
Hormonal problems? (thyroid, diabetes) ☐Yes ☐No
Other medical problems?

_____
_____
_____

Have you had any surgery?

_____
_____
_____

Current medications, including herbs/supplements:

_____
_____

ALLERGY to medications:☐No ☐Yes:_____
_____

Urological History

Undescended testicles? ☐Yes ☐No
Injury to testicles? ☐Yes ☐No
Hernia repair? ☐Yes ☐No
Varicocele? ☐Yes ☐No
Vasectomy? ☐Yes ☐No
Bladder or prostate surgery? ☐Yes ☐No
Problem achieving erections? ☐Yes ☐No
History of epididymitis? ☐Yes ☐No
Urinary tract infections? ☐Yes ☐No
Sexually transmitted disease? ☐Yes ☐No
Problems with sex drive? ☐Yes ☐No
Early puberty (before age 12)? ☐Yes ☐No
Late puberty? ☐Yes ☐No
Abnormal sexual development? ☐Yes ☐No
Fever within the last 3 months? ☐Yes ☐No
Other family members with fertilty problems? ☐Yes ☐No

Social History

Any special exposure to heat on a regular basis? (sauna, baths, Jacuzzi, etc)? ☐ Yes ☐No
Recreational drug use? ☐ Yes ☐No
Do you smoke? ☐ Yes ☐No
Exposure to chemicals? ☐ Yes ☐No
Exposure to radiation? (Not routine x-rays) ☐ Yes ☐No
How many alcoholic drinks/wk:_____

*Comments on any of the questions to which you answered "Yes":*_____

_____

_____

_____

First PAGE Genetic History Questionnaire for Fertility Patients

- The answers to these questions will help in the care of your pregnancy.
- Please answer these questions as well as you can. All answers will remain private.
- If you need help answering the questions, please ask.

1. Are you 35 years of age or older? ☐ No ☐ Yes

Where your ancestors came from may sometimes give us important information about the health of your baby.

2. Is your family...

....from Southeast Asia, Taiwan, China, or the Philippines? ☐ No ☐ Yes ☐ Not sure

....from Italy, Greece or the Middle East? ☐ No ☐ Yes ☐ Not sure

....African American (Black)? ☐ No ☐ Yes ☐ Not sure

....Hispanic/Puerto Rican? ☐ No ☐ Yes ☐ Not sure

3. Is your family, or your baby's father's family European (Ashkenazi) Jewish? ☐ No ☐ Yes ☐ Not sure

Of French Canadian Descent? ☐ No ☐ Yes ☐ Not sure

The next nine questions will be about you, your baby's father, and both of your families. When we say "blood relative", we mean your children (or unborn baby), mother, father, sister, brother, grandparent, aunt, uncle, niece, nephew, or cousin.

4. Were you, or your partner, or any blood relative born with an opening in the back or spine, also called spina bifida? ☐ No ☐ Yes ☐ Not sure

5. Was there ever a baby (or unborn baby) in your family or your paratner's family who had an opening in the head, also called anencephaly? ☐ No ☐ Yes ☐ Not sure

6. Is any blood relative in your family or your partner's family mentally retarded? ☐ No ☐ Yes ☐ Not sure

7. Have you, or your partner, or any blood relative had an unborn baby or a child who had Down syndrome (some call it trisomy 21)? ☐ No ☐ Yes ☐ Not sure

8. Do you, or your partner, or any blood relative have any other chromosome problems? ☐ No ☐ Yes ☐ Not sure

Patient's Name: _____ Date of Birth: ____/____/____

9. Do you, or your partner, or any blood relative have:

a. ...cystic fibrosis (CF)? ☐ No ☐ Yes ☐ Not sure

b. ...fragile X syndrome? ☐ No ☐ Yes ☐ Not sure

c. ...muscular dystrophy? ☐ No ☐ Yes ☐ Not sure

d. ...hemophilia or other bleeding disorder? ☐ No ☐ Yes ☐ Not sure

e. ...Huntington disease? ☐ No ☐ Yes ☐ Not sure

10. Were you, or your partner, or any blood relative born with:

a. ...a heart defect? ☐ No ☐ Yes ☐ Not sure

b. ...a cleft lip and/or cleft palate? ☐ No ☐ Yes ☐ Not sure

c. ...any other birth defect? ☐ No ☐ Yes ☐ Not sure

11. Have you ever had:

...two or more miscarriages? ☐ No ☐ Yes

...a stillborn baby ***and*** one or more miscarriage(s)? ☐ No ☐ Yes

12. Do you, or does your partner, or any blood relative have any other disease or health problem that is inherited (passed on in the family)? ☐ No ☐ Yes ☐ Not sure

The next three questions will be about medical conditions that you may have.

13. Do you have diabetes? ☐ No ☐ Yes ☐ Not sure

14. Do you have, or have you ever been treated for PKU (phenylketonuria) or hyperphenylalaninemia (hyperphe)? ☐ No ☐ Yes ☐ Not sure

15. Have you taken or are you taking:

a. seizure medication? (Dilantin, valproic acid, Depakene, tegretol, Atretol, Mysoline, Tridione) ☐ No ☐ Yes

b. lithium (Eskalith, Lithobid, Lithonate) for bipolar disorder or depression? ☐ No ☐ Yes

c. pills (Accutane, isotretinoin) for acne? ☐ No ☐ Yes

d. chemotherapy/immunosuppressive medication (methotrexate, amniopterin, Rheumatrex) ☐ No ☐ Yes

Completed by:_____ **Date:**_____/_____/_____