

Medical Questionnaire

Reproductive Care of Indiana

Name: _____

Problems and Diagnoses:

List any medical problems or diagnoses	Age or date diagnosed

Are your menstrual cycles irregular? _____

Are your menstrual cycles infrequent? _____

Have you had your tubes tied, burned, or ligated? _____

If so, when or at what age? _____

Have you had trouble getting pregnant? _____

If so, when or at what age did you stop using some form of birth control? _____

How much pain or cramping do you have with your periods? none mild moderate severe

Do you experience excess facial hair? _____

Have you ever had Chlamydia, gonorrhea, pelvic inflammatory disease or PID? _____

If so, when or at what age? _____

Has your husband or partner had a vasectomy?

If so, when or at what age? _____

Has your husband or partner had a vasectomy reversal?

If so, when or at what age? _____

How many times have you been pregnant? _____

	Year	Baby born alive?	End in Miscarriage?	Tubal pregnancy?	End in abortion?	How long to conceive?	Fertility treatment required?	Is current partner the father?
1 st Pregnancy								
2 nd Pregnancy								
3 rd Pregnancy								
4 th Pregnancy								
5 th Pregnancy								

List any complications that you had with your pregnancies.

Do you smoke? _____ How many packs per day? _____

Allergies:

List the medicines you know that you are allergic to _____

Medication profile:

List your current medications (both prescription and over-the-counter) _____

Histories:

Procedures and Fertility Treatments:

List all surgeries that you've had	Age or date performed

Have you had a hysterosalpingogram (“HSG or dye test”)

If so, when or at what age? _____

What were the results? _____

Have you been treated with **clomiphene** (Clomid or Serophene)?

If so, for how many months or cycles? _____

How many were with IUI (intrauterine insemination)

When or at what age? _____

Did you get pregnant? _____, if so what was the result? _____

Have you been treated with **FSH injections** (such as Follistim, Gonol-F, or Repronex)?

If so, for how many months or cycles? _____

How many were with IUI (intrauterine insemination)

When or at what age? _____

Did you get pregnant? _____, if so what was the result? _____

Have you been treated with ***In Vitro* Fertilization** (IVF)?

If so, for how many months or cycles? _____

How many were frozen embryo transfers? _____

When or at what age? _____

Did you get pregnant? _____, if so what was the result? _____

Gynecological History:

When was the first day of your last menstrual period? _____

How often do your periods come? _____

When was your last pap test? _____ Was it normal? _____

Has your husband or partner had a sperm count? _____

If so, what was the result? _____

Has he fathered any children or pregnancies that ended in a miscarriage or abortion? _____