

Sujatha Gunnala, MD
3125 North 32nd Street Suite 200
Phoenix, Arizona 85018
Phone: (602) 956-7481

Southwest Fertility Center
Initial Visit
Female Questionnaire

Linda Nelson, MD, PhD
1520 S Dobson Rd Suite 215
Mesa, AZ 85202
Fax (602) 956-7591

Please fill out the following information and have it returned to our office prior to your consultation.

Patient's Name _____
Partner's Name _____
Address: _____
City: _____ State: _____ Zip: _____
Phone (day#): () _____ (eve#) () _____ (cell) () _____
Referring Dr: _____ Prim Care Dr. _____
Patient's Age _____ Date of birth: _____ Ethnic origin: _____
Partner's Age: _____ Date of birth: _____ Ethnic origin: _____
Occupation (patient): _____
Occupation (partner): _____
Marital Status: _____ Length of marriage: _____
Children (ages /sex): _____

Chief Complaint (M.D. use only): _____

History of Present Illness: (M.D. use only): _____

Menstrual History

Last Menstrual Period: _____ Previous Menstrual Period: _____
Menarche (first period): _____ Age of Menarche: _____
Regular/Irregular Cycles: _____ Length of flow: _____
Days in between cycles (from the start of one cycle to the beginning of the next): _____
How many times a year do you have vaginal bleeding? _____
Do cramps start before or with flow? _____
Are the cramps Mild? _____ Moderate? _____ Severe: _____
Do you take pain medication for cramps? Yes _____ No _____ If yes, specify: _____
Do you bleed or spot in between periods? Yes _____ No _____ If yes, specify: _____
Is constipation or diarrhea associated with periods? Yes _____ No _____
If you have ever been on oral contraceptives (birth control pills), were your periods regular after stopping the medication? Yes _____ No _____ If yes, date/length of use: _____
How many times per week do you and your partner have sexual intercourse? _____
Is sexual intercourse painful or difficult for you? Painful _____ Difficult _____ Neither _____
How long have you been trying to get pregnant? _____

Comments (MD use only): There is no inter-menstrual bleeding, premenstrual spotting or bleeding. ____
She has the usual premenstrual molimina and breast tenderness. _____
She has no previous history suggestive of pelvic infections. _____
She has no previous conization, cautery or abnormal pap smears. _____
She has never used an IUD for contraception. _____ She has no Galactorrhea. _____
There is no evidence of Hirsutism. _____

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Obstetric History

How many pregnancies, including abortions, have you had?

	When? (Year)	End in Abortion	End in Miscarriage?	Ectopic Pregnancy?	Infertility therapy required to conceive?	How long to conceive?	Baby born alive?	Is current partner the father?
1st Pregnancy								
2nd Pregnancy								
3rd Pregnancy								
4th Pregnancy								
5th Pregnancy								

Were there any complications during or after your pregnancies? Yes ___ No ___

If yes, explain: _____

Did your mother or father have any difficulty with conception or pregnancy? . . . Yes ___ No ___

If yes, explain: _____

Did your mother take Diethylstilbestrol (DES) when she was pregnant with you? . . Yes ___ No ___

Past Medical History

Weight: _____ Height: _____ BP: _____ BMI: _____

Have you ever been treated for Cancer? Yes ___ No ___

If yes, explain therapy: _____

Have you ever received X-rays to the pelvic area for therapy or treatment of diagnosis? . . Yes ___ No ___

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

- | | | |
|---|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Ovarian Cysts |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Gallbladder Problem | <input type="checkbox"/> Parasitic Infection |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Pelvic Infection |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Breast – Milky Discharge | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Poor Sense of Smell |
| <input type="checkbox"/> Breast Soreness | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Breast Tenderness | <input type="checkbox"/> Herpes | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Cancer? Specify: _____ | <input type="checkbox"/> Hirsutism (Excess Hair Growth) | <input type="checkbox"/> Seizures |
| _____ | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sought Psychiatric help |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Immunization: German Measles | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> Thyroid Problems _____ |
| <input type="checkbox"/> Chronic Headaches | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Color Blind | <input type="checkbox"/> Measles: German | <input type="checkbox"/> Vaginitis (Trichomoniasis, Yeast:
specify # of episodes: _____) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Measles: Regular | <input type="checkbox"/> Visual Disturbances |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Migraines | <input type="checkbox"/> Any Allergies (list): _____ |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Non-gonococcal Urethritis | _____ |
| <input type="checkbox"/> Emotional difficulties | <input type="checkbox"/> Neurological Problems | |

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Past Surgical History

Please give chronological order, date and procedure
(most recent first)

If any of the following categories do not allow enough space, please list any further procedures and information on page 5 under "Other Information..."

Procedure	Month and Year of Surgery
1	
2	
3	
4	
5	
6	

Medications

(List all medication you are currently taking)

Name of Medication	Dosage	Frequency of Use	Reason for Use
1			
2			
3			
4			
5			
6			

Allergies:

(to medication, iodine and shellfish)

Social History:

(Occupation – Hobbies – Habits)

Smoking History: Never smoked: Packs per day: How many years? Still smoking/ Quit:

Recreational Drugs: _____ Alcohol Intake: _____

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Past Contraception:

What form of contraception method do you use now or have used in the past? Check all that apply:

- Pills (name): _____ IUD (name): _____ other: _____
 Diaphragm Withdrawal Foams/Jellies Condoms Rhythm None

For each method of contraceptive used, specify the length of use and reason for discontinuation:

Method	Length of Use	Reason for Discontinuation
1		
2		
3		

Psychiatric History/Emotional Problems Personal and/or Family Members:

Do you follow any particular food diet or have any special dietary habits? If yes, specify: _____

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

Exercise: _____ Hrs. per week: _____ Age began: _____

Exercise: _____ Hrs. per week: _____ Age began: _____

Exercise: _____ Hrs. per week: _____ Age began: _____

Body Weight: _____ how much weight have you gained or lost in the last year? _____

Review of Symptoms (M.D. use only): _____

Parents: _____

Siblings: _____

Hirsutism: _____ Breast Cancer: _____ Diabetes: _____

High Blood Pressure: _____ Birth Defects: _____

Congenital Anomalities: _____ Endometriosis: _____

Thyroid: _____ Heart Disease: _____

Ovarian Cancer: _____ Colon Cancer: _____

Other: _____

Previous Evaluation for Infertility or Gynecological Problems:

Have you ever been treated for infertility before? Yes _____ No _____

If yes, who was your physician? _____

What cause of infertility was diagnosed? _____

What drugs have you taken for infertility? Check all that apply:

- | | |
|---|--|
| <input type="checkbox"/> clomiphene citrate (Serophene [®]) | <input type="checkbox"/> hCG (Profasi [®] A.P.L [®]) |
| <input type="checkbox"/> hMG(Repronex [®] , Menopur [®]) | <input type="checkbox"/> bromocriptine(Parlodel [®]) |
| <input type="checkbox"/> estrogens | <input type="checkbox"/> danazol (Danocrine [®]) |
| <input type="checkbox"/> progesterone | <input type="checkbox"/> urofollitropin or FSH (Follistim [®] , Metrodin [®]) |
| <input type="checkbox"/> prednisone (or cortison-like drugs [®]) | <input type="checkbox"/> None |
| <input type="checkbox"/> antibiotics | <input type="checkbox"/> Any Others? Specify: _____ |
| <input type="checkbox"/> GnRh or LHRH (Factrel [®]) | _____ |

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Previous Evaluation for Infertility or Gynecological Problems: (con't. from previous page)

Which of the following test have you had performed? Check all that apply and the results if known:

- BBT When: _____ Results: _____
- Postcoital Test When: _____ Results: _____
- Hormal Assays (FSH, LH prolactin, estrogen, Dhea-S, testosterone, progesterone) When: _____ Results: _____
- Endometrial Biopsy When: _____ Results: _____
- Hysterosalpingogram When: _____ Results: _____
- Ultrasound. When: _____ Results: _____
- Antibodies. When: _____ Results: _____
- Laparoscopy, Hysteroscopy When: _____ Results: _____
- Mycoplasma/ Chlamydia Cultures When: _____ Results: _____
- Thyroid Tests. When: _____ Results: _____
- Other? Specify: When: _____ Results: _____

Have you ever had surgery for Tubal Reversal? Yes _____ No _____

If yes, specify dates: _____

Have you ever had surgery for removal of Adhesions? Yes _____ No _____

Have you ever had Cervical Conization or Cautery? Yes _____ No _____

Have you ever had any other surgery? (D&C, Ovarian, Appendectomy, Thyroid) Yes _____ No _____

If yes, specify dates: _____

Have ever undergone Artificial Insemination or In Vitro Fertilization? Yes _____ No _____

If yes using partner or donor sperm? _____

Is your partner seeing a doctor for evaluation of infertility? Yes _____ No _____

If yes, specify physician name and location: _____

Does the doctor feel that your partner has an infertility problem? Yes _____ No _____

If yes, what is the diagnosis and how is he being treated? _____

Has he ever fathered a child with another woman? Yes _____ No _____

If yes, when: _____

If there is any other information that you feel would help us in your diagnosis or treatment, please enter below:
