Southwest Fertility Center
3125 North 32nd Street Suite 200
Phoenix, Arizona 85018

Initial Visit

Female Questionnaire

Sujatha Gunnala, M.D.
Phone: (602) 956-7481
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. _____
_____
_____

Southwest Fertility Center **Initial Visit** **Sujatha Gunnala, M.D.**
3125 North 32nd Street Suite 200 **Phone: (602) 956-7481**
Phoenix, Arizona 85018 **Female Questionnaire** **Fax (602) 956-7591**

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):

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

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: _____

Southwest Fertility Center **Initial Visit** **Sujatha Gunnala, M.D.**
3125 North 32nd Street Suite 200 **Phone: (602) 956-7481**
Phoenix, Arizona 85018 **Female Questionnaire** **Fax (602) 956-7591**

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:

clomiphene citrate (Serophene®)
hMG(Repronex®, Menopur®)
estrogens
progesterone
prednisone (or cortison-like drugs®)
antibiotics
GnRh or LHRH (Factrel®)
hCG (Profasi®A.P.L®)
bromocriptine(Parlodel®)
danazol (Danocrine®)
urofollitropin or FSH (Follistim®, Metrodin®)
None
Any Others? Specify: _____
_____

Southwest Fertility Center
3125 North 32nd Street Suite 200
Phoenix, Arizona 85018

Initial Visit

Female Questionnaire

Sujatha Gunnala, M.D.
Phone: (602) 956-7481
Fax (602) 956-7591

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:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____