



shady grove fertility

# QUESTIONNAIRE FOR FEMALES

Name: \_\_\_\_\_

Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_

Referred by: \_\_\_\_\_

### Please indicate the reason for your visit:

- Infertility (trouble getting pregnant)
- Recurrent miscarriages
- Interested in conceiving using donor sperm
- Egg or embryo freezing (fertility preservation)
- Other \_\_\_\_\_

## SECTION 1 [SKIP ANY QUESTIONS THAT ARE NOT APPLICABLE]

### MENSTRUAL AND GYNECOLOGIC HISTORY

Age at first period _____	<b>With your period, do you experience:</b> <input type="checkbox"/> Very heavy periods <input type="checkbox"/> Significant pain or cramps <input type="checkbox"/> Other symptoms: _____
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### Are your periods:

#### Regular [if yes, answer questions below]

How often do your periods come? (# of days from 1<sup>st</sup> day of 1 period to the 1<sup>st</sup> day of the next period) \_\_\_\_\_  
 For how many days do you bleed? \_\_\_\_\_

#### Irregular [if yes, answer questions below]

Over the last year:

How many periods have you had? \_\_\_\_\_

How close have 2 periods come together? \_\_\_\_\_

How far apart have 2 periods been? \_\_\_\_\_

Do you have?

Extra hair growth on your face or body

Significant acne

Breast discharge

Changes in your weight

<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">When was your last:</th> <th style="width: 20%;">Date:</th> <th style="width: 50%;">Result:</th> </tr> </thead> <tbody> <tr> <td>Pap smear</td> <td></td> <td></td> </tr> <tr> <td>Gynecologic exam</td> <td></td> <td></td> </tr> <tr> <td>Mammogram</td> <td></td> <td></td> </tr> </tbody> </table> <p><b>Have you ever had an abnormal Pap smear?</b>  <input type="checkbox"/> No  <input type="checkbox"/> Yes, please explain follow up and treatment: _____</p> <p><b>Have you had any of the following? [check all that apply] List dates of treatment.</b>  <input type="checkbox"/> Gonorrhea _____  <input type="checkbox"/> Chlamydia _____  <input type="checkbox"/> Pelvic inflammatory disease (PID) _____  <input type="checkbox"/> Other sexually transmitted infections _____</p>	When was your last:	Date:	Result:	Pap smear			Gynecologic exam			Mammogram			<p><b>In your current relationship, have you used contraception? [check all that apply]</b>  <b>Approximate dates?</b>  <input type="checkbox"/> Oral contraceptive pills, vaginal ring, patch _____  <input type="checkbox"/> Intrauterine device (IUD) _____  <input type="checkbox"/> Contraceptive implant _____  <input type="checkbox"/> Injection _____  <input type="checkbox"/> Condoms _____  <input type="checkbox"/> Tubal ligation _____  <input type="checkbox"/> Vasectomy _____  <input type="checkbox"/> Natural family planning _____  <input type="checkbox"/> Withdrawal _____  <input type="checkbox"/> Other: _____</p>
When was your last:	Date:	Result:											
Pap smear													
Gynecologic exam													
Mammogram													

**Do you track your menstrual cycles?** Please write any pertinent information:

- No
- Calendar/app \_\_\_\_\_
- Ovulation predictor kits \_\_\_\_\_
- Basal body temperature \_\_\_\_\_
- Other \_\_\_\_\_

**How long have you been having unprotected intercourse?** \_\_\_\_\_

**How often do you have unprotected intercourse?** \_\_\_\_\_

**Do you have pain with intercourse? Please explain.** \_\_\_\_\_

**FERTILITY TESTING AND TREATMENT**

**Testing completed and results:**

- None
- FSH \_\_\_\_\_
- LH \_\_\_\_\_
- Estradiol \_\_\_\_\_
- Anti-Müllerian hormone (AMH) \_\_\_\_\_
- TSH \_\_\_\_\_
- Pelvic ultrasound/follicle count \_\_\_\_\_
- Hysterosalpingogram (HSG) \_\_\_\_\_
- Saline sonogram \_\_\_\_\_
- Hysteroscopy \_\_\_\_\_
- Laparoscopy \_\_\_\_\_
- Other \_\_\_\_\_

**Have you undergone any type of fertility treatment?**

Treatment type	# of cycles and outcome
Oral medication (clomiphene / letrozole)	
Injectable medication	
Intrauterine insemination (IUI)	
In vitro fertilization (IVF)	

<p><b>Are you:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> In a heterosexual relationship</li> <li><input type="checkbox"/> In a same sex relationship</li> <li><input type="checkbox"/> Single</li> <li><input type="checkbox"/> Other _____</li> </ul>	<p><b>Do you plan to use:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Partner's sperm</li> <li><input type="checkbox"/> Anonymous sperm donor (sperm bank)</li> <li><input type="checkbox"/> Known sperm donor</li> <li><input type="checkbox"/> Unsure</li> <li><input type="checkbox"/> Not applicable</li> </ul>
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**MEDICATIONS AND ALLERGIES**

<p><b>List all current prescription and over-the-counter medications, vitamins, and supplements:</b></p>          	<p><b>List medication allergies:</b></p>          <p><b>List non-medical allergies:</b></p>          <p><b>Are you allergic to latex?</b></p>
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**OBSTETRIC HISTORY**

If you have been pregnant, please fill out chart below:

Year	Length of time to conceive	Fertility treatment used to conceive? Type of treatment?	Pregnancy outcome <ul style="list-style-type: none"> <li>• Miscarriage</li> <li>• Termination</li> <li>• Ectopic pregnancy</li> <li>• Preterm birth</li> <li>• Term birth</li> </ul>	Describe complications, if any

**MEDICAL HISTORY**

Describe any current medical problems:

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Describe any previous medical problems:

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**SURGICAL HISTORY**

Have you had any surgeries? Please list below with dates:

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**SOCIAL HISTORY**

Occupation: \_\_\_\_\_

Race/Ethnicity: \_\_\_\_\_

<p><b>Do you use tobacco or nicotine products?</b></p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Cigarettes   How many per day? _____</p> <p><input type="checkbox"/> Chew   How often? _____</p> <p><input type="checkbox"/> E-cigarette/nicotine vaporizer ("Vape")   How many per day? _____</p>	<p><b>Do you consume alcohol?</b></p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Number of drinks each week _____</p> <p><b>Do you use any recreational drugs?</b></p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes   Type and frequency: _____</p>
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**Do you exercise regularly? Please describe exercise type, frequency and duration:** \_\_\_\_\_

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**Is your weight:**

stable

increasing

decreasing

**FAMILY HISTORY:** Please list any medical issues for the following family members:

Father: \_\_\_\_\_

Mother: \_\_\_\_\_

Siblings: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

<p><b>Do you have a family history of:</b></p> <p><input type="checkbox"/> Birth defects: _____</p> <p><input type="checkbox"/> Cognitive impairments: _____</p> <p><input type="checkbox"/> Menopause prior to age 40: _____</p>	<p><input type="checkbox"/> Genetic diseases: _____</p> <p><input type="checkbox"/> Other: _____</p>
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**Is there anything else you would like to discuss with your doctor?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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**WHO REFERRED YOU/HOW DID YOU HEAR ABOUT US? (please check all that apply)**

<input type="checkbox"/> Physician*	<input type="checkbox"/> Other Patient	* Physician Name: _____
<input type="checkbox"/> Friend/Relative	<input type="checkbox"/> Radio	Street Address: _____
<input type="checkbox"/> Internet/Web Site	<input type="checkbox"/> Other _____	City: _____ Phone: _____
		Specialty: _____

**PATIENT**

SOCIAL SECURITY NO:		PATIENT ID NO:	
LEGAL NAME	LAST	FIRST	MIDDLE INITIAL
ADDRESS			
CITY		STATE	ZIP
HOME PHONE		WORK PHONE	
CELL PHONE	DATE OF BIRTH		AGE
IS IT OK TO CONTACT YOU BY EMAIL?			
E-MAIL ADDRESS:			

**PATIENT'S EMPLOYMENT**

COMPANY NAME	OCCUPATION
ADDRESS	
CITY	STATE ZIP

**PATIENT'S PRIMARY INSURANCE**

INSURANCE COMPANY NAME	
POLICY HOLDER NAME	RELATIONSHIP TO POLICY HOLDER
POLICY #	GROUP #

**PATIENT'S SECONDARY INSURANCE**

INSURANCE COMPANY NAME	
POLICY HOLDER NAME	RELATIONSHIP TO POLICY HOLDER
POLICY #	GROUP #

**EMERGENCY CONTACT**

NAME	DAY PHONE	NIGHT PHONE	RELATIONSHIP
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I authorize the release of any medical information necessary to process a claim to the above named insurance carrier(s). I hereby assign my medical benefits to, and direct that payments be made to my Shady Grove Fertility physician. I have disclosed all insurance policies including insurance policies that Shady Grove Fertility is a non-participating provider. I understand that if I choose not to disclose all insurance policies, I waive my insurance coverage and will be financially responsible to pay for all services.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## EMAIL AUTHORIZATION

Patient MPI# \_\_\_\_\_

Partner MPI#: \_\_\_\_\_

The physicians and staff of Shady Grove Fertility (SGF) offer patients the opportunity to communicate electronically using secure messaging for general questions or concerns. In order to use secure messaging, we require an email address. Although secure messaging will be used for communication, there may be times when it is necessary to send an email. Because your privacy and security are some of our primary concerns, e-mail has certain risks that patients should consider before giving consent. These risks include but are not limited to:

- 1) E-mail can be circulated, forwarded and stored in numerous paper and electronic files.
- 2) E-mail can occasionally be broadcast to both intended and unintended recipients.
- 3) E-mail senders can misaddress e-mail.
- 4) E-mail can be more easily falsified than handwritten or signed documents.
- 5) Backup copies of e-mail may exist, even after the sender or the recipient has deleted his or her copy.
- 6) E-mail can be altered, forwarded or used without authorization or detection.
- 7) E-mail can be used to introduce viruses into computer systems.

The physicians and staff of SGF will use reasonable means to protect security and confidentiality of e-mail information sent and received. Because of the risks outlined above, however, we cannot guarantee the security and confidentiality of e-mail communication and therefore you should not ever include your social security number or date of birth in any e-mail communications to us.

In addition, *secure messaging should never be used to communicate acute and/or urgent clinical problems* such as pain or abnormal bleeding. Our physicians and staff always try to respond to secure messages in a timely fashion, but for any clinical problems, you should follow proper guidelines by calling our office or the answering service after hours. In a medical emergency, call 911.

**Please be advised that while it is not mandatory to provide an email address, we will not be able to communicate via secure messaging without an email address on file.**

**By signing below, I/we authorize SGF to communicate with me/us by email in regards to my/our medical care and associated charges. I/We also agree to promptly notify SGF of change in my/our email address.**

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Patient's printed name

Patient's signature

Date

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Patient's email address (please print very clearly)

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Partner's printed name (if applicable)

Partner's signature

Date

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Partner's email address (please print very clearly)