QUESTIONNAIRE FOR FEMALES

Name: ____________________ **Email:** ____________________
Date of Birth: ____________________ **Age:** ____________
Referred by: ____________________
OB/Gyn Name and Phone #: ____________________ **PCP Name and Phone #:** ____________________

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____________________

Partner name: ____________________
Marriage date (if applicable): ____________________

SECTION 1 [SKIP ANY QUESTIONS THAT ARE NOT APPLICABLE]

MENSTRUAL AND GYNECOLOGIC HISTORY

Age at first period____________

1st day of last period: ____________

With your period, do you experience:
[ ] Very heavy periods
[ ] Significant pain or cramps
[ ] Other symptoms: ____________________

Are your periods:
[ ] Regular [if yes, answer questions below]
How often do your periods come? (# of days from 1st day of 1 period to the 1st 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

When was your last:	Date:	Result:
Pap smear		
Gynecologic exam		
Mammogram		

Have you ever had an abnormal Pap smear?
[ ] No
[ ] Yes, please explain follow up and treatment:
____

Have you had any of the following? [check all that apply] List dates of treatment.
[ ] Gonorrhea ____________
[ ] Chlamydia ____________
[ ] Pelvic inflammatory disease (PID) ____________
[ ] Other sexually transmitted infections ____________

In your current relationship, have you used contraception? [check all that apply]
Approximate dates?
[ ] Oral contraceptive pills, vaginal ring, patch ____________
[ ] Intrauterine device (IUD) ____________
[ ] Contraceptive implant ____________
[ ] Injection ____________
[ ] Condoms ____________
[ ] Tubal ligation ____________
[ ] Vasectomy ____________
[ ] Natural family planning ____________
[ ] Withdrawal ____________
[ ] Other: ____________

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)	

Are you:	**Do you plan to use:**
[ ] In a heterosexual relationship [ ] In a same sex relationship [ ] Single [ ] Other_______________	[ ] Partner's sperm [ ] Anonymous sperm donor (sperm bank) [ ] Known sperm donor [ ] Unsure [ ] Not applicable

MEDICATIONS AND ALLERGIES

List all current prescription and over-the-counter medications, vitamins, and supplements:	**List medication allergies:** **List non-medical allergies:** **Are you allergic to latex?**

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

Year	Length of time to conceive	Conceived with current partner?	Fertility treatment used to conceive? Type of treatment?	Pregnancy outcome • Miscarriage • Termination • Ectopic pregnancy • Preterm birth • Term birth	Describe complications

MEDICAL HISTORY
Height: __________ Weight: __________
Please check any medical problems that you have currently or have had in the past:

[ ] high blood pressure
[ ] diabetes
[ ] thyroid problems
[ ] asthma
[ ] depression
[ ] anxiety
[ ] seizures
[ ] blood clots (DVT or PE)
[ ] cancer

Describe any other medical problems:

____

____

Describe any previous medical problems and hospitalizations:

____

____

____

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

____

____

____

SOCIAL HISTORY
Occupation: ____
Race/Ethnicity: ____

Do you use tobacco or nicotine products?	**Do you consume alcohol?**
[ ] No [ ] Cigarettes | How many per day? ______ [ ] Chew | How often? ________________ [ ] E-cigarette/nicotine vaporizer (“Vape”) | How many per day? ______	[ ] No [ ] Number of drinks each week _______ **Do you use any recreational drugs?** [ ] No [ ] Yes | Type and frequency: __________

Do you exercise regularly? Please describe exercise type, frequency and duration: ___________________________

____

Is your weight: [ ] stable [ ] increasing [ ] decreasing

Do you consume caffeine? Describe your intake: ____

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

Father: ____

Mother: ____

Siblings: ____

____

____

Do you have a family history of:	
[ ] Birth defects: ______________________________	[ ] Genetic diseases: ___________________________
[ ] Cognitive impairments:________________________	[ ] Blood clots (DVT or PE): ______________________
[ ] Menopause prior to age 40: ____________________	[ ] Other: _____________________________________

Is there anything else you would like to discuss with your doctor?

____

____

____

____

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

☐ **Physician***
☐ **Friend/Relative**
☐ **Internet/Web Site**
☐ **Other Patient**
☐ **Radio**
☐ **Other** ____________

*** Physician Name:** ____________
Street Address: ____________
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

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 dress, 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.

____

Patient’s printed name Patient’s signature Date

____

Patient’s email address (please print very clearly)

____

Partner’s printed name (if applicable) Partner’s signature Date

____

Partner’s email address (please print very clearly)