FERTILITY CENTER OF SOUTHERN CALIFORNIA

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PATIENT HEALTH QUESTIONNAIRE

Referring M.D.: _____
Patient Name: _____ Date of Birth: _____
Occupation: _____
Partner's Name: _____ Date of Birth: _____
Occupation: _____
Reason for your visit: _____
Any previous fertility treatment? (if yes, when and what type) _____

PERSONAL HISTORY

Medical problems: _____

☐ High blood pressure ☐ Diabetes ☐ Thyroid Disease ☐ Seizures
☐ Migraines ☐ Asthma ☐ Blood clots (DVT) ☐ Lupus

Surgeries: _____
Allergies to medications: _____
Medications: _____
Height: _____ Weight: _____ Ethnicity: _____

HABITS

Do you exercise? ☐Yes ☐No Type of Exercise: _____ How often: _____
How much caffeine do you drink a day? _____
Do you drink? ☐Yes ☐No If yes, how many drinks per week? _____
Do you smoke? ☐Yes ☐No If yes, how much _____ How long? _____
Have you ever smoked? ☐Yes ☐No If yes, how much _____ When did you quit? _____
Any history of drug use? ☐Yes ☐No If yes, when and what? _____

GYNECOLOGICAL/OBSTETRICAL HISTORY

Age of Onset of Menses: _____ Date of last menstrual period: _____
Number of days from beginning of period to first day of next period: _____
Duration of Flow (days): _____ How many pads/tampons per day? _____
Bleeding between periods? ☐Yes ☐No
Pain with periods? ☐Yes ☐No Pain with sex? ☐Yes ☐No
Date of last Pap Smear _____ Any previous abnormal Pap smears? ☐Yes ☐No
Have you used birth control in the past? ☐Yes ☐No If yes what type? _____
Date of last Mammogram (if over 40-years-old) _____
Have you ever been diagnosed with an STD? ☐Yes ☐No
Number of Pregnancies: _____
Miscarriages: _____ Ectopic Pregnancies: ____ Terminations: ____
Preterm delivery (<37 weeks): _____ Full term delivery (>37 weeks): _____
Type of Birth(s): ☐ vaginal ☐ C-section

PATIENT FAMILY HISTORY

Ovarian cancer ☐Yes ☐No If Yes, who and at what age? _____
Colon cancer ☐Yes ☐No If Yes, who and at what age? _____
Breast cancer ☐Yes ☐No If Yes, who and at what age? _____
Uterine cancer ☐Yes ☐No If Yes, who and at what age? _____
Infertility ☐Yes ☐No If Yes, who? _____
Miscarriage ☐Yes ☐No If Yes, who? _____
Birth defects ☐Yes ☐No If Yes, who? _____
Genetic conditions ☐Yes ☐No If Yes, who and what type? _____
Autoimmune disease ☐Yes ☐No If Yes, who and what type? _____
Bleeding disorders ☐Yes ☐No If Yes, who and what type? _____
Blood clots in legs or lungs ☐Yes ☐No If Yes, who? _____
Tremor/ataxia ☐Yes ☐No If Yes, who? _____
Intellectual delay ☐Yes ☐No If Yes, who? _____

SYMPTOM REVIEW

Do you have any of the following?

☐ Fevers
☐ Vomiting
☐ Dry skin
☐ Cold intolerance
☐ Headache
☐ Excessive thirst
☐ Chest pain
☐ Diarrhea
☐ Brittle nails
☐ Palpitations
☐ Vision changes
☐ Urinating often
☐ Shortness of breath
☐ Constipation
☐ Thinning of hair
☐ Easy bleeding
☐ Nipple discharge
☐ Dark hair on face/body
☐ Nausea
☐ Burning on urination
☐ Heat intolerance
☐ Blood clots (DVT)
☐ Acne

MALE PARTNER'S HISTORY (if applicable)

Medical problems: _____
Surgeries: _____
Medications: _____
Allergies to medications: _____ Ethnicity: _____

Do you exercise? ☐Yes ☐No Type of Exercise:_____ How often: _____
Do you smoke? ☐Yes ☐No If yes, how much _____ How long? _____
Have you ever smoked? ☐Yes ☐No If yes, how much _____ When did you quit? _____
Do you drink? ☐Yes ☐No If yes, how many drinks per week? _____
Any previous drug use? ☐Yes ☐No If yes, when and what? _____

Any pregnancies with a previous partner?
If yes, how many? _____
What was the outcome(s) [delivery, miscarriage, termination]? _____

Have you ever been diagnosed with an STD? ☐Yes ☐No

Any history of the following?

☐ Childhood illness ☐ Hernia repair ☐ Testicular trauma ☐ Testicular tumor
☐ Mumps after puberty ☐ Steroid use ☐ Exposure to chemicals or radiation
☐ None of above

Do you have any issues getting or maintaining an erection? ☐Yes ☐No
Do you have problem with ejaculation? ☐Yes ☐No
Do you have normal libido? ☐Yes ☐No
Do you have normal energy? ☐Yes ☐No
Do you spend time with direct heat to the testes (hot tubs, saunas, long bike rides)? ☐Yes ☐No
Have you ever had a semen analysis? ☐Yes ☐No If yes, what was the result? _____

Family History:

Infertility	☐Yes ☐No	If yes, who?	_____
Miscarriage	☐Yes ☐No	If yes, who?	_____
Birth defects	☐Yes ☐No	If yes, who?	_____
Genetic conditions	☐Yes ☐No	If Yes, who and what type?	_____
Cancer	☐Yes ☐No	If yes, who and what type?	_____
Tremor/ataxia	☐Yes ☐No	If Yes, who?	_____
Intellectual delay	☐Yes ☐No	If Yes, who?	_____

Additional Comments: _____

_____

_____

_____

Patient Signature Today's Date