

**GREATER SOUTHERN ALAMEDA AREA
FERTILITY CLINIC – PATIENT QUESTIONNAIRE**

IMPRINT AREA

Date: _____

Patient's Name: _____ Medical No.: _____

Age: _____ Height: _____ Weight: _____

Occupation: _____ Home Phone: _____ Work No: _____

Address _____

Is there a partner pursuing this pregnancy with you? Yes No

If yes: Name of partner _____ Relationship _____

Duration of relationship _____ Occupation _____

Age _____ ht _____ wt _____ M. R. # _____

Pregnancies in the past? No Yes (_____) Year of last pregnancy _____

Pregnancy with current partner? _____

Pregnancy with other relationships? _____

Problems with past pregnancies? _____

Has your partner fathered prior pregnancies? _____

Medical problems? _____

Do you have any problems with infections? _____

Do you have any problems with drug use? Smoking? _____

How long have you been trying to get pregnant? _____

Previous evaluation or treatment for infertility? _____

History of surgery in the past? _____

Age of first menstrual period? _____ Date of last period? _____

Regular monthly periods? Yes No If yes, _____ days between cycles.

If your periods are irregular, how many days between periods? _____

Can you feel yourself ovulate? _____ "PMS" symptoms? _____

Painful periods? _____

How many times per week do you have intercourse? _____

Have you used birth control before? Yes No Lubricants? Yes No

Do you smoke? Yes No Use any drugs or medications? Yes No Drink alcohol? Yes No

MEDICAL HISTORY	NO	YES	COMMENT (Filled out by provider)
Drug Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory Disease/TB/Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Stomach/Intestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Gall Bladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Liver Disease/Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney Disease/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
Neuro Disease/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	
Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding Tendency	<input type="checkbox"/>	<input type="checkbox"/>	
Emotional Illness	<input type="checkbox"/>	<input type="checkbox"/>	
Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Herpes (Patient)	<input type="checkbox"/>	<input type="checkbox"/>	
Herpes (FOB)	<input type="checkbox"/>	<input type="checkbox"/>	
Abnormal Pap	<input type="checkbox"/>	<input type="checkbox"/>	
DES Exposure	<input type="checkbox"/>	<input type="checkbox"/>	
Infertility	<input type="checkbox"/>	<input type="checkbox"/>	
Surgeries/Hosp.	<input type="checkbox"/>	<input type="checkbox"/>	
Hospitalized	<input type="checkbox"/>	<input type="checkbox"/>	
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	

FAMILY HISTORY	NO	YES	COMMENT (Filled out by provider)
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Mental Disease	<input type="checkbox"/>	<input type="checkbox"/>	
TB	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
Multiple Births	<input type="checkbox"/>	<input type="checkbox"/>	
Congenital Births	<input type="checkbox"/>	<input type="checkbox"/>	
Thalassemia/Sickle	<input type="checkbox"/>	<input type="checkbox"/>	

MALE PARTNER MEDICAL HISTORY	NO	YES	COMMENT (Filled out by provider)
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Stomach/Intestinal	<input type="checkbox"/>	<input type="checkbox"/>	
Liver Disease/Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Reproductive Tract Disease or Surgery (e.g., Vasectomy)	<input type="checkbox"/>	<input type="checkbox"/>	
_____	<input type="checkbox"/>	<input type="checkbox"/>	
_____	<input type="checkbox"/>	<input type="checkbox"/>	
_____	<input type="checkbox"/>	<input type="checkbox"/>	