PATIENT INFORMATION/QUESTIONNAIRE

Female:

Name: _____ Age: _____

Birth date: _____ SS#: _____

Home Address: _____

_____

Home Phone: (___) _____ Work Phone: (___) _____

Employer: _____ Occupation: _____

Employer Address: _____

Marital Status: _____ Years married to this spouse: _____

# of marriages: _____ Religious preference: _____

Insurance Co: _____ Policy #: _____

ID#: _____ Phone #: _____

Primary Care Physician: _____

Gynecologist: _____

Referring Physician or person: _____

Male:

Name: _____ Age: _____

Birth date: _____ SS#: _____

Employer: _____ Occupation: _____

Employer Address: _____

Work Phone: _____

# of marriages: _____ Religious preference: _____

Primary Care Physician: _____

Urologist: _____

Emergency Name & Phone #: _____

Relation: _____

Please complete and return this form to:

Cohen Center
7777 Forest Lane, Suite C-625
Dallas, TX 75230
(972) 566-8506

Also, please arrange to have a copy of your previous medical records and the films of your Hysterosalpingogram (HSG), if applicable, sent to Cohen Center. No appointment will be made unless the records and films are available for the physician. You may call approximately one week after having this information sent to confirm our receipt of your records and to see if an appointment can be scheduled.

FOR OFFICE USE ONLY

Name (Female): _____

Age at onset of menstruation: _____

Menstrual cycle: ☐ Regular ☐ Irregular

Days bleeding/days between cycles: _____

(For example: 5 days bleeding/28 days between ? 5/28)

Pain with periods: ☐ Yes ☐ No

Treatment for this pain: _____

Bleeding between periods: ☐ Yes ☐ No

Bleeding after intercourse ☐ Yes ☐ No

Number of pregnancies: _____ Live births: _____

Still births: _____

Miscarriages: _____ (please see detailed history on page 8)

Tubal pregnancies: _____

Date: Right tube: _____

Left tube: _____

Terminations: _____

Numbers of years attempting conception: _____

Prior history of birth control method:

Type: _____

Duration: _____

History of pelvic infection: ☐ Yes ☐ No

Previous sterilization: ☐ Yes ☐ No

Request for sterilization reversal: ☐ Yes ☐ No

Reason for seeking reversal: _____

Any vaginal discharges: ☐ Yes ☐ No

Treatment: _____

Urinary Difficulties: ☐ Burning ☐ Increased frequency

☐ Prior urinary infections, treatment: _____

Regular bowel habits: ☐ Yes ☐ No

☐ Constipation ☐ Diarrhea

Treatment: _____

Pain accompanying bowel movements: ☐ Yes ☐ No

Related to menses: ☐ Yes ☐ No

Frequency of sexual intercourse: _____ # times per week

Painful intercourse: ☐ Yes ☐ No

Superficial pain Deep (inside lower abdomen)

Use of vaginal lubricants: ☐ Yes ☐ No

Use of douche: ☐ Yes ☐ No; frequency: _____

Name (Female): _____

Current Weight: _____ Has there been any major weight loss or gain recently: ☐ Yes ☐ No

Reason why: _____

Weight at age 16_____ Since the age of 16 your **highest**_____ and **lowest**_____weight

Have you ever been diagnosed with ☐ anorexia ☐ bulemia If yes, please describe_____

_____

Height: _____ Current Exercise: _____# hours per week

From the age of 16 to the present, have you participated in any of the following activities:

☐ drill team ☐ dance ☐ running/jogging ☐ aerobic dance ☐ other_____

Please give a brief description of the type and level of exercise you have participated in_____

_____

_____

Skin problems: acne ☐ Yes ☐ No Treatment: _____

blotchiness ☐ Yes ☐ No Diagnosis & Treatment: _____

Excessive hair: ☐ Facial ☐ Abdominal ☐ Inner thighs

Any milky discharge from breasts: ☐ Yes ☐ No

Any problems with headaches: ☐ Yes ☐ No

Are you frequently hot or cold (circle one) when people around you are comfortable.

Do you have cold: ☐ Hands ☐ Feet

Do you ever have blueness in your ☐ Hands ☐ Feet

Visual problems: ☐ Eyeglasses ☐ Contacts

Difficulties in peripheral vision: ☐ Yes ☐ No

Any heart palpitations: ☐ Yes ☐ No

Any known drug allergies: _____

Any known drug reactions: _____

Smoking: ☐ Yes ☐ No Number per day: _____

Alcohol: ☐ Yes ☐ No Number per week: _____

per month: _____

per day: _____

Recreational Drugs: ☐ Yes ☐ No Name of Drug or Substance_____

_____

Name (Female): _____

Personal Medical History:

			Comment
Diabetes	☐ Yes	☐ No	_____
High blood pressure	☐ Yes	☐ No	_____
Heart disease	☐ Yes	☐ No	_____
Thyroid problems	☐ Yes	☐ No	_____
Breast cancer	☐ Yes	☐ No	_____
Other cancers	☐ Yes	☐ No	_____
Autoimmune disorders	☐ Yes	☐ No	_____
Lupus	☐ Yes	☐ No	_____
Roseola	☐ Yes	☐ No	_____
Rheumatoid arthritis	☐ Yes	☐ No	_____
Ulcerative colitis	☐ Yes	☐ No	_____
Chrones Disease	☐ Yes	☐ No	_____
Kidney disease	☐ Yes	☐ No	_____
Blood clotting disorders	☐ Yes	☐ No	_____
Asthma	☐ Yes	☐ No	_____
Hepatitis or other liver disease	☐ Yes	☐ No	_____
Anemia	☐ Yes	☐ No	_____
Eating disorder	☐ Yes	☐ No	_____
Sexually transmitted disease	☐ Yes	☐ No	_____
Psychiatric disorders	☐ Yes	☐ No	_____
Genetic disorders	☐ Yes	☐ No	_____
Birth defects	☐ Yes	☐ No	_____
Other health problems	☐ Yes	☐ No	_____

_____

_____

Medication(s) you currently take and dosage(s) per day: _____

_____

List any herbs you currently take and dosage(s) per day: _____

_____

Name (Female): _____

Family history:

			Comment
Diabetes	☐ Yes	☐ No	_____
High Blood Pressure	☐ Yes	☐ No	_____
Heart Disease	☐ Yes	☐ No	_____
Thyroid Problems	☐ Yes	☐ No	_____
Breast Cancer	☐ Yes	☐ No	_____
Other reproductive or genital cancers	☐ Yes	☐ No	_____
Autoimmune Disease	☐ Yes	☐ No	_____
Downs Syndrome	☐ Yes	☐ No	_____
Mental Retardation	☐ Yes	☐ No	_____
Birth Defects	☐ Yes	☐ No	_____
Cystic Fibrosis	☐ Yes	☐ No	_____

Mothers age at menopause: _____

Genetic Screening Tests:

Are either you or your husband from:

1) Eastern European Jewish ancestry?	☐ Yes	☐ No	
If yes, have you been tested for Tay Sachs carrier status?	☐ Yes	☐ No	Result: _____
2) African American ancestry?	☐ Yes	☐ No	
If yes, have you been tested for sickle cell trait?	☐ Yes	☐ No	Result: _____
3) Italian, Greek, or Mediterranean ancestry?	☐ Yes	☐ No	
If yes, have you been tested for beta thalassemia minor?	☐ Yes	☐ No	Result: _____
4) Philippine or Southeast Asian ancestry?	☐ Yes	☐ No	
If yes, have you been tested for alpha thalassemia minor?	☐ Yes	☐ No	Result: _____
Have you or your husband ever been tested for cystic fibrosis	☐ Yes	☐ No	Result: _____

Previous testing and treatments:

Name of Test	Date	Results
Rubella (German measles)	_____	_____
Post Coital test	_____	_____
Endometrial biopsy	_____	_____
Prolactin	_____	_____
DHEAS	_____	_____
TSH	_____	_____

Name (Female): _____

Previous testing and treatments, continued:

Name of Test	**Date**	**Results**
Progesterone	_____	_____
Testosterone	_____	_____
Blood type & Rh	_____	_____
Last pap smear	_____	_____
Chlamydia culture	_____	_____
Sperm antibody test	_____	_____
Day 3: FSH	_____	_____
LH	_____	_____
E2	_____	_____
Inhibin	_____	_____
Other	_____	_____

Have you ever had: Hysterosalpingogram (x-ray) ☐ Yes ☐ No

Date: _____ Results: _____

Have you ever had: Laparoscopy ☐ Yes ☐ No

Date: _____ Results: _____

Date: _____ Results: _____

Hysteroscopy ☐ Yes ☐ No

Date: _____ Results: _____

Have you ever had: Artificial Insemination (Husband's sperm): ☐ Yes ☐ No

Artificial Insemination (Donor sperm): ☐ Yes ☐ No

Washed Intrauterine Insemination: ☐ Yes ☐ No

Gamete Intra-fallopian Transfer: ☐ Yes ☐ No Date: _____

In Vitro Fertilization: ☐ Yes ☐ No Date: _____

Prior In Vitro Fertilization(s):

Medication_____ # of ampules____ Medication_____ # of ampules____ Medication_____ # of ampules____

# of follicles_____ # of eggs retrieved_____ # of embryos_____

# of blastocysts_____ # of embryos transferred_____ # of embryos frozen_____

Please add additional cycles, if applicable, on the back of this sheet or print additional copies of this page

Please include ALL In Vitro LAB RECORDS

Name (Female): _____

Have you ever used:

Clomiphene Citrate (Clomid or Serophene): ☐ Yes ☐ No

For how long: _____

HCG injections: ☐ Yes ☐ No

For how long: _____

Fertility (ovarian stimulation) injections: ☐ Yes ☐ No Type:_____

For how long: _____

Progesterone supplementation: ☐ Yes ☐ No

For how long: _____

GnRH agonists (Lupron): ☐ Yes ☐ No

For how long: _____

GnRH antagonists (Antagon or Cetrotide): ☐ Yes ☐ No

For how long: _____

Danocrine or Danazol: ☐ Yes ☐ No

For how long: _____

Bromocryptine (Parlodel): ☐ Yes ☐ No

For how long: _____

Please list previous surgeries or hospital admissions (date and procedure), including previous laparotomies:

_____

_____

_____

_____

_____

_____

_____

Please give a personal summary (treatment goals and objectives):_____

_____

_____

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_____

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_____

**If you are seeking treatment for Recurrent Miscarriage please complete the following section for each miscarriage. If not, please skip to the male partner's information section:*

Name (Female): _____

Pregnancy Length_____ Was a heartbeat present? Yes ☐ No ☐ Spontaneous Loss ☐ or D & C ☐

Chromosome analysis? Yes ☐ No ☐ (if yes, please include results)

Infection or fever after loss or D&C? Yes ☐ No ☐ Length of antibiotics post Loss/D&C _____days

Any post miscarriage complications?_____

_____

Stimulation before pregnancy? Yes ☐ No ☐ If yes, Clomiphene ☐ or Injectables ☐

If injectables, what type?_____

Progesterone therapy? Yes ☐ No ☐ if yes, did you **commence** progesterone therapy **before** ☐ or **after** ☐ pregnancy?

If yes, what type of progesterone did you take?_____ For how long?_____

During your pregnancy did you use anticoagulants? Yes ☐ No ☐ If yes, ☐ Heparin ☐ Aspirin ☐ Lovenox

Did you use steroids? Yes ☐ No ☐ If yes, ☐ Prednisone ☐ Dexamethasone

Did you have gammaglobulin infusions? Yes ☐ No ☐ If yes, how many and what dosages_____

_____

What hormonal measurements were taken during your pregnancy?

Name of Test	**Date**	**Results**
Estrogen	_____	_____
Progesterone	_____	_____
Prolactin	_____	_____
TSH	_____	_____
T4	_____	_____
HCG #1	_____	_____
HCG #2	_____	_____
HCG #3	_____	_____
Other	_____	_____

Comments or additional information about this pregnancy_____

_____

_____

Please fill out one sheet for each miscarriage. Print out as many sheets as you need.

Name (Male): _____

Number of children fathered: _____

Number of ejaculations/week: _____

Blood type/Rh: _____

Number of years attempting conception with this partner: _____

Any urinary difficulties or infections: ☐ Yes ☐ No

Treatment: _____

Any prior testicular injuries: ☐ Yes ☐ No

Any prior inguinal or testicular surgeries, e.g. hernia repair, varicocele: ☐ Yes ☐ No

Year of operation: _____

Regular bowel habits: ☐ Yes ☐ No

☐ Constipation ☐ Diarrhea

Treatment: _____

Frequency of sexual intercourse: _____ # times per week

Decreased sexual desire: ☐ Yes ☐ No

Orgasmic dysfunction: ☐ Yes ☐ No

Height: _____ Weight: _____ Has there been any major weight loss or gain: ☐ Yes ☐ No

Reason why: _____

From the age of 16 to the present, have you regularly participated in: ☐ running/jogging ☐ cycling

Please give a brief description of the type and level of exercise you have participated in _____

_____

_____

Skin problems/Acne: ☐ Yes ☐ No

Treatment: _____

Any problems with headaches: ☐ Yes ☐ No

Treatment: _____

Any visual problems: ☐ Eyeglasses ☐ Contacts

Difficulties in peripheral vision: ☐ Yes ☐ No

Any problems with anxiety attacks: ☐ Yes ☐ No

Any heart palpitations: ☐ Yes ☐ No

Any known drug allergies: _____

Any know drug reactions: _____

Name (Male): _____

Smoking: ☐ Yes ☐ No Number per day: _____

Alcohol: ☐ Yes ☐ No Number per week: _____

per month: _____

per day: _____

Recreational Drugs: ☐ Yes ☐ No Name of Drug or Substance _____

_____

Vocational Hazards: ☐ Gases ☐ Toxins ☐ Chemicals ☐ Insecticides ☐ Other poisons

What type? _____

Personal Medical History:

			Comment
Diabetes	☐ Yes	☐ No	_____
Kidney disease	☐ Yes	☐ No	_____
Asthma	☐ Yes	☐ No	_____
High blood pressure	☐ Yes	☐ No	_____
Hepatitis or other liver disease	☐ Yes	☐ No	_____
Sexually transmitted disease	☐ Yes	☐ No	_____
Psychiatric disorders	☐ Yes	☐ No	_____
Genetic disorders	☐ Yes	☐ No	_____
Birth defects	☐ Yes	☐ No	_____
Other health problems	☐ Yes	☐ No	_____

Medication(s) you currently take and dosage(s) per day: _____

_____

List any herbs you currently take and dosage(s) per day: _____

_____

Family history:

			Comment
Diabetes	☐ Yes	☐ No	_____
Testicular Cancer	☐ Yes	☐ No	_____
Prostate Cancer	☐ Yes	☐ No	_____
Downs Syndrome	☐ Yes	☐ No	_____
Mental Retardation	☐ Yes	☐ No	_____
Birth Defects	☐ Yes	☐ No	_____
Cystic Fibrosis	☐ Yes	☐ No	_____

Name (Male): _____

Do you wear: ☐ briefs/jockey underwear ☐ boxer shorts

Do you use hot tubs or jacuzzis: ☐ Yes ☐ No

Have you ever had:

Semen analysis: ☐ Yes ☐ No

Date: _____ Result: _____

Hamster test: ☐ Yes ☐ No

Date: _____ Result: _____

Sperm antibody test: ☐ Yes ☐ No

Date: _____ Result: _____

Have you ever been on any medication to increase your sperm count or motility: ☐ Yes ☐ No

Type of medication: _____

Please list previous surgeries or hospital admissions (date and procedure):

_____

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Please give a personal summary (treatment goals and objectives):_____

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