Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

STANFORD HOSPITAL and CLINICS
STANFORD, CALIFORNIA 94305

CLINICS • REI • FEMALE PATIENT QUESTIONNAIRE

Please answer the questions to the best of your ability. Leave blank any questions to which you do not know the answer. If you are uncomfortable with any question, you may leave it blank.

IDENTIFYING INFORMATION

Date of initial appointment: ____________

Name: ____________ Partner's Name: ____________

Address: ____________

Telephone Number - Day: ____________ Evening: ____________

Current Age: ____ Date of Birth: ____ Height: ____ Weight: ____ Partner's Date of Birth: ____

Reason for consultation: ____________

EMPLOYMENT

Please describe all current employment including job title, description of responsibilities, duration of employment

____

GYNECOLOGICAL HISTORY

How old were you when you had your first period? ____

How frequently do your periods come? every ____ days.

How long do your periods last? ____ days. When did your last period start? ____

Do you experience cramping with your period? ☐ Yes ☐ No

If yes, when during your cycle does the pain occur? (circle all that apply) before during after

How would you describe the cramps? ☐ Mild ☐ Moderate ☐ Severe

Do you take pain medication for cramps? ☐ Yes ☐ No

If yes, specify medication ____________

Do you bleed or spot between periods? ☐ Yes ☐ No If yes, please describe: ____________

When was your last Pap smear? ____ Was it normal? ☐ Yes ☐ No

Have you ever had an abnormal Pap smear result? ☐ Yes ☐ No If yes, what therapy was required?

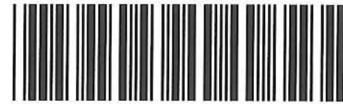
☐ repeat Pap smear ☐ antibiotics ☐ colposcopy (microscope evaluation) ☐ biopsy
☐ cryotherapy (freezing of cervix) ☐ laser therapy ☐ cone biopsy ☐ loop excision (LEEP)
☐ other ____________

Have you ever had any of the following infections involving any part of the reproductive tract (vagina, cervix, uterus, fallopian tubes, ovaries)? Check all that apply

☐ yeast ☐ chlamydia trichomonas ☐ gonorrhea ☐ herpes ☐ syphilis ☐ genital warts

Have you ever had a mammogram? ☐ Yes ☐ No If yes, when? ____

Result? ☐ normal ☐ abnormal



CLINICS • REI • FEMALE
PATIENT QUESTIONNAIRE

Do you have pain with intercourse? ❑ never ❑ sometimes ❑ frequently ❑ always

How frequently do you and your partner have intercourse?________ per week/month (circle)

How frequently do you and your partner have intercourse around ovulation? ________per week

Have you ever used contraception on the past? ❑ Yes ❑ No If yes, please check all that apply:
❑ contraceptive pills ❑ condoms ❑ diaphragm ❑ IUD ❑ foam/sponge ❑ rhythm
❑ withdrawal ❑ other

Do you use herbal medications? ❑ Yes ❑ No If yes, types of medications used ________________

FERTILITY EVALUATION

1. How long have you and your partner been attempting to achieve pregnancy?____________________
2. Have you ever conceived a pregnancy with a different partner? ❑ Yes ❑ No
3. Have you ever tried to achieve a pregnancy with a different partner? ❑ Yes ❑ No
4. Have you been treated for infertility previously? ❑ Yes ❑ No
   If yes, where/when?____
   What was the cause of infertility?______________________________
5. Which of the following tests have been performed?

❑ Basal body temperature
❑ Postcoital test
❑ Hormonal tests
❑ Thyroid test
❑ Infection test (mycoplasma, chlamydia)
❑ Endometrial biopsy
❑ Ultrasound
❑ Hysterosalpingogram (dye, x-ray test)
❑ Laparoscopy
❑ Hysteroscopy
❑ Sonohysterogram
❑ Antibody tests

6. Have you ever taken any of the medications listed below:

❑ clomiphene citrate (Clomid, Serophene)
❑ injectable gonadotropins (Bravelle, Menopur Luveris, Gonal-F, Follistim, Repronex)
❑ steroids (medrol, prednisone, dexamethasone)
❑ bromocriptine (Parlodel or Dostinex)
❑ heparin
❑ aspirin
❑ danazol (Danocrine)
❑ hCG (Pregnyl) Novarel
❑ estrogens (Estrace, Estraderm)
❑ testosterone or male hormone
❑ GnRH agonist (Lupron, Synarel, Zoladex)
❑ progesterone (suppositories, injections, Crinone, Prometria)
❑ antibiotics
❑ progestins (Provera, Cycrin)

7. Have you ever had intrauterine inseminations? ❑ Yes ❑ No
   If yes, specimen was provided by: (check all that apply) ❑ Partner ❑ Donor
8. Have you ever attempted in vitro fertilization? ❑ Yes ❑ No
   If yes, please specify below (if known)

Date	Location	# Vials of meds/day	# Eggs retrieved	ICSI?* (Y/N)	# Eggs fertilized	# Embryo transferred	Pregnancy? (Y/N)	Outcome

* Intracytoplasmic sperm injection

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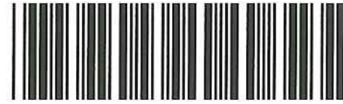

CLINICS • REI • FEMALE PATIENT QUESTIONNAIRE

OBSTETRICAL HISTORY

Have you ever been pregnant (including elective terminations, miscarriages, birth)? ❑ Yes ❑ No

Date	Outcome	How long to conceive?	Infertility therapy?	Complications w/ pregnancy?	Is current partner the father?

PAST MEDICAL HISTORY

Do you have or have you ever had (check all that apply):

- ❑ Acne
- ❑ Anemia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Autoimmune disease (eg. Lupus, rheumatoid arthritis)
- ❑ Blood transfusion
- ❑ Breast (nipple) discharge
- ❑ Breast disease
- ❑ Breast tenderness
- ❑ Chicken pox
- ❑ Chronic bronchitis
- ❑ Chronic headaches
- ❑ Cancer? (Specify) ________ ____________________
- ❑ Colitis
- ❑ Cystic fibrosis
- ❑ Color blindness
- ❑ Diabetes
- ❑ Dizziness
- ❑ Endometriosis
- ❑ Gallbladder disease
- ❑ Hair loss
- ❑ Heat/cold intolerance
- ❑ Heart disease
- ❑ Hepatitis
- ❑ Hirsutism (excess hair growth)
- ❑ High blood pressure
- ❑ Hot flashes
- ❑ Kidney problems
- ❑ Liver problems
- ❑ Loss of balance
- ❑ Measles: German
- ❑ Measles: regular
- ❑ Mumps
- ❑ Neurological problems
- ❑ Ovarian cysts
- ❑ Poor sense of smell
- ❑ Pneumonia
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ Seizures
- ❑ Thyroid problems
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Vision problems

Immunizations

Hepatitis B date(s)____________

- ❑ Tetanus
- ❑ German Measles (Rubella)
- ❑ Polio
- ❑ Mumps
- ❑ Tuberculosis
- ❑ Chicken pox

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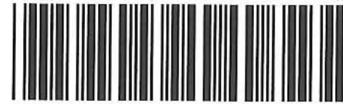

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REVIEW OF SYSTEMS

Do you presently have any problems or symptoms in the following areas? Circle YES or NO below. If YES, please give explanation:

		Patient Comments:	Physician Comments:
Constitutional (good general health lately)	YES / NO		
Eyes	YES / NO		
Ears/Nose/Mouth/Throat	YES / NO		
Cardiovascular (heart/blood vessels/circulation)	YES / NO		
Respiratory (breathing difficulties)	YES / NO		
Gastrointestinal (stomach/intestines)	YES / NO		
Genitourinary (genitals/sexual function/kidney/bladder)	YES / NO		
Neurological (brain/nervous system)	YES / NO		
Integumentary (skin areas and/or breasts)	YES / NO		
Psychiatric (emotions/mood/memory)	YES / NO		
Musculoskeletal (bones/joints/muscles)	YES / NO		
Endocrine (hormones/metabolism/thyroid)	YES / NO		
Allergic/Immunologic (allergies/immune system)	YES / NO		
Hematologic/Lymphatic (blood or bleeding problems; lymph nodes or "swollen glands")	YES / NO		

PAST SURGICAL HISTORY

Have you ever had any surgeries in the past? ☐ Yes ☐ No

If yes, please indicate date, type, findings of surgery:

________ ________________________________

________ ________________________________

MEDICATIONS

Are you allergic to any medications? ☐ Yes ☐ No If yes, please indicate name of medication and type of reaction it causes:

Medications Reaction

________ ________________________________

________ ________________________________

Are your currently taking any prescription medications? ☐ Yes ☐ No If yes, please indicate below:

Medications Reaction

________ ________________________________

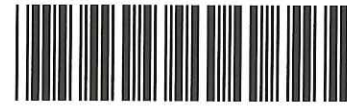
________ ________________________________

Are you currently taking any over-the-counter medications? ☐ Yes ☐ No

Medications Reaction

________ ________________________________

________ ________________________________



CLINICS • REI • FEMALE PATIENT QUESTIONNAIRE

SOCIAL HISTORY

Are you currently married/domestic partner? ________ If so, how long? ________

Have you previously been married? ________

Do you smoke? ________ If so, how many packs per day? ________

Do you drink alcohol? ________ If so, how many alcoholic beverages per week? ________

Have you ever used illicit (Illegal) drugs? ________ If so, please list ____________________

Do you exercise regularly? ________ If so, please indicate type of exercise and estimate hrs/week spent in this activity.

Type	Hours/week	Type	Hours/week

Have you had a significant weight change in the last year? ❑ Yes ❑ No

If yes, please indicate: ❑ weight gain ________lbs ❑ weight loss ________lbs

Do you follow a particular food diet? ❑ Yes ❑ No

❑ vegetarian ❑ diet plan name: ________________ ❑ other ____________________

FAMILY HISTORY

Have any of these illnesses occurred in your family? Check all that apply and indicate relationship to you:

Illness	Relationship to you:	Illness	Relationship to you:
❑ high blood pressure		❑ ovarian cancer	
❑ diabetes		❑ colon cancer	
❑ heart disease		❑ other	
❑ breast cancer			

Form completed by:____________________ (please print) Relationship to patient: ____________________ (write self if you are the patient)

Date Completed: ________________

Instructions to Attending Physician:

Your signature below indicates that you have reviewed the information contained in the entire questionnaire and that you have reviewed the pertinent or key finding(s) with the patient and/or family. Key finding(s) must be summarized in your progress note, however, the questionnaire may be referenced for additional details.

Attending Physician Signature:______________________________ Date: ____________