



Fertility Specialists
of
San Diego

Fertility Specialists Medical Group & San Diego Center for Reproductive Surgery 8010 Frost Street, Plaza Level, San Diego, CA 92123



San Diego Center
for
Reproductive Surgery®

FEMALE PRE-CONSULT QUESTIONNAIRE

1. IDENTIFYING INFORMATION

Name _____ DOB ____/____/____ Age _____

Significant Other Name _____ DOB ____/____/____ Age _____

Primary Language spoken: English Spanish Other: _____

Date this form completed ____/____/____ Referred by: _____

Primary GYN _____ Primary Care MD _____

How long have you been attempting conception? _____ Number of years married/together _____

Reasons you are coming to see us: _____

2. PREGNANCY HISTORY

Times Pregnant _____ Term births _____ Premature births _____ Miscarriages _____ Elective abortion _____ Adopted children _____

Date	Mis-carriage?	Elective Abortion?	Ectopic?	Months to conceive?	Infertility Treatment?	Weight and sex?	C-section?	Complications?	Is current partner the father?
1. _____	_____	_____	_____	_____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____	_____	_____	_____	_____

3. CONTRACEPTIVE USE

Type	From when to when	Reason discontinued
1. _____	_____	_____
2. _____	_____	_____

4. OPERATIONS AND HOSPITALIZATIONS

Date	Diagnosis	Operation	Where	Physician
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____

5. MEDICATIONS *List all prescriptions and over-the-counter drugs used during the past year*

Date	Dose and frequency	From when to when	Reason
1. _____	_____	_____	_____

11. SYSTEMIC REVIEW

Height _____ Weight _____ Maximum Weight _____ Minimum Weight _____ Weight change in last 2 yrs _____

Do/have you participated in any significant dietary changes over the past 3 years?.....

Do/have you participated in any vigorous exercise programs over the past 3 years?.....

If so please document : Vigorous exercise: type hrs/week

- The effect of being overweight on fertility therapies have been well documented.
- Please speak with your physician regarding weight loss attempts and ideal weight range for you height.
- Obesity does not usually cause infertility but obesity may have significant impact on treatment responses and may have multiple negative effects on both yourself and the fetus

Headaches: Number per week _____ Medication used _____

- mild moderate severe improving worsening no change
 with visual symptoms with vomiting stress related migraines

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Wear glasses | <input type="checkbox"/> Bladder/kidney infections | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Acne |
| <input type="checkbox"/> Wear contact lenses | <input type="checkbox"/> Urgent / frequent / painful urination | <input type="checkbox"/> Nausea and vomiting | <input type="checkbox"/> Skin disorder |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Blood / abnormal color of urine | <input type="checkbox"/> Vomiting blood | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Hayfever | <input type="checkbox"/> Unable to control urination | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Abnormal urinary tract | <input type="checkbox"/> Food intolerance | <input type="checkbox"/> Skin cancer |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Kidney x-ray | <input type="checkbox"/> Gallstones | |
| <input type="checkbox"/> Denture / bridges | <input type="checkbox"/> Bladder cystoscopy | <input type="checkbox"/> Jaundice / hepatitis | |
| <input type="checkbox"/> Counseling | <input type="checkbox"/> Chronic constipation | <input type="checkbox"/> Recent stress increase | |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Recent anxiety increase |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Blood in bowel movement | |
| <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Prolonged bleeding | <input type="checkbox"/> Irritable bowel | <input type="checkbox"/> Sensation loss / numbness |
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Bleeding from gums | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Muscle control / weakness |
| <input type="checkbox"/> Leg swelling | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Hernia | <input type="checkbox"/> Heat or cold intolerance |
| <input type="checkbox"/> Calf pain | <input type="checkbox"/> Take aspirin/ibuprofen frequently | <input type="checkbox"/> Abnormal liver test | <input type="checkbox"/> Damp skin |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Unusual hair loss | | |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Breast mass | <input type="checkbox"/> Back pain | <input type="checkbox"/> Extraordinary fatigue |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Fibrocystic changes | | |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Breast implants | | |
| <input type="checkbox"/> Cough up blood | <input type="checkbox"/> Do monthly breast self-exam | | |
| <input type="checkbox"/> Chest x-ray / TB skin test | | | |

OTHER: _____

If yes, please comment: _____

12. FAMILY HISTORY / GENETIC HISTORY

	Mother	Father	Brothers: #	Sisters: #	Children: #	Other
Cancer (type)						
Diabetes						
Hypertension						
High Cholesterol						
Heart Disease						
Stroke						
Uterine fibroids						
Endometriosis						
Premature Menopause						

13. ETHNICITY *Data will be used for genetic testing recommendation purposes

- Caucasian Hispanic Asian African American Other (_____)

Do you or anyone in either family have?

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Neural tube defects/spina bifida/anencephaly | <input type="checkbox"/> Cystic fibrosis | <input type="checkbox"/> Tay-Sachs disease | <input type="checkbox"/> Chromosomal disorder |
| | <input type="checkbox"/> Muscular dystrophy | <input type="checkbox"/> Sickle cell disease or trait | <input type="checkbox"/> Genetic / inherited disorder |
| <input type="checkbox"/> Thalassemia | <input type="checkbox"/> Huntington chorea | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Baby with birth defects |
| <input type="checkbox"/> Down syndrome | <input type="checkbox"/> Mental retardation / fragileX | <input type="checkbox"/> Hormonal disorder | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Hydrocephalus | <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Stillbirth | <input type="checkbox"/> Phenylketonuria | <input type="checkbox"/> Neurofibromatosis | <input type="checkbox"/> Myotonic dystrophy |
| <input type="checkbox"/> 3 or more miscarriages | <input type="checkbox"/> Diabetes | | |
| <input type="checkbox"/> Any birth defects? | <input type="checkbox"/> Any inherited disorders? | | |

Please explain a "Yes" answer to any of the above _____

Genetic Screening:

It is recommended that **all couples** attempting conception be offered cystic fibrosis screening. Cystic Fibrosis is a pulmonary disease affecting children and the most common genetic disease. The effectiveness of the test varies dependent on your ethnic background. You may be offered additional screening based on your ethnicity. Are you: African-American Yes No

Ashkenazi Jewish Yes No Mediterranean/Asian/French Canadian Yes No

If you answered YES to any of these, please let your physician know at the visit, so that the additional genetic screening can be offered to you. If you have any specific genetic concerns and desire to see a geneticist, please let the physician know.

14. HISTORY OF FERTILITY THERAPY (Fill out, if applicable).

Have you been treated for infertility previously? YES NO

If yes, who was your physician?

What cause of infertility was diagnosed?

What drugs have you taken for infertility? Please check all that apply:

- | | | |
|---|---|--|
| <input type="checkbox"/> Clomid (Serophene) | <input type="checkbox"/> hCG Profasi | <input type="checkbox"/> Antibiotics |
| <input type="checkbox"/> Gonol F | <input type="checkbox"/> Progesterone | <input type="checkbox"/> Baby aspirin |
| <input type="checkbox"/> Follistim | <input type="checkbox"/> Lupron | <input type="checkbox"/> Heparin |
| <input type="checkbox"/> Repronex | <input type="checkbox"/> Microdose Lupron | <input type="checkbox"/> Steroids |
| <input type="checkbox"/> Pergonal | <input type="checkbox"/> Antagon | <input type="checkbox"/> Oral Contraceptives |
| <input type="checkbox"/> Fertinex | <input type="checkbox"/> Parlodel | <input type="checkbox"/> Other |

Which of the following tests have you or your partner had performed? Please check all that apply and results, if known:

- | | | |
|--|---------------------|---------------|
| <input type="checkbox"/> Hysterosalpingogram | When ____/____/____ | Results |
| <input type="checkbox"/> Sonohystogram | When ____/____/____ | Results |
| <input type="checkbox"/> Laparoscopy, Hysteroscopy | When ____/____/____ | Results |
| <input type="checkbox"/> Thyroid tests | When ____/____/____ | Results |
| <input type="checkbox"/> Chromosomes | When ____/____/____ | Results |
| <input type="checkbox"/> Genetic screening | When ____/____/____ | Results |
| <input type="checkbox"/> OTHER _____ | | |

Have you ever undergone Artificial Insemination (IUI) or In Vitro Fertilization (IVF)? YES NO

If yes, partner donor sperm #IUI's ____ #IVF cycles ____

15. We, at FSMG, understand that infertility can place a significant burden on the respective couple. This stress can have a profound impact on the reproductive system. Given these facts and our emphasis on treating the whole person, we would like to know your experience with / willingness to try alternative therapies. These include, but are not limited to:

- Acupuncture (if so, which acupuncturist)_____
- Dates: + Current + Previous _____
- Herbal treatment_____
- Dates: + Current + Previous _____
- Massage_____
- Dates: + Current + Previous _____
- Psychological/group therapy_____
- Dates: + Current + Previous _____
- Yoga / biofeedback / stress reduction techniques_____
- Dates: + Current + Previous _____

Welcome, we look forward to working with you. Please write down any specific concerns you want to review at your visit.

-The FSMG Team