USF IVF AND REPRODUCTIVE ENDOCRINOLOGY

New Patient Intake Questionnaire

Welcome to USF IVF and Reproductive Endocrinology. In order to get to know you and your medical history, we ask that you fill out this questionnaire and bring it to your first visit. This will allow us to obtain a thorough assessment as well as minimize any duplicate testing needed for your treatment and allow the doctor to spend more time with you at your visit. Please questions to the best of your ability! If you are unable to answer everything/do not know the answers to questions, we will follow up with the rest at your visit.

NAME: _____

Date of Birth: _____

Date of Appointment: _____

Contact information: please fill out the methods we may contact you and ***check your preferred number***.

☐ **Home Phone:**	**May we leave a confidential voice mail?** ☐ Yes ☐ No
☐ **Work Phone:**	**May we leave a confidential voice mail?** ☐ Yes ☐ No
☐ **Cell Phone:**	**May we leave a confidential voice mail?** ☐ Yes ☐ No
☐ **Email:**	**May we contact you via email?** ☐ Yes ☐ No

Emergency contact:	**Phone:** **Relationship:**

Pharmacy:	**Phone:** **Location:**

Please read questions carefully and answer completely

1. Are you taking any medications? (This includes any supplements/herbs) ☐ Yes ☐ No

   If yes, which ones? (please give dose and how many per day): _____

   _____

   _____

   _____

2. Do you have any allergies to medications/food/latex? ☐ Yes ☐ No

   If yes, please list what they are and your reaction: Allergy/reaction: _____

   _____

   _____

3. How old were you when you got your first period? _____

4. What is your cycle length? (cycle day 1 to the next cycle day 1):

   Cycle length _____ If it varies, what is the shortest cycle: _____and longest cycle: _____

5. How many days do you bleed? _____ Is it: ☐ light ☐ moderate ☐ heavy

6. Any pain that accompanies your period? ☐ Yes ☐ No Do you take medication for it? ☐ Yes ☐ No

   If yes, what medication do you take?: _____

7. Any premenstrual symptoms? ☐ Yes ☐ No

   If yes, please list (ex: breast tenderness, cramping, acne...): _____

8. When was your last menstrual period? (first day of full flow): _____

9. Any past illnesses: ☐ Yes ☐ No If yes, date of Illness and diagnosis: _____

10. Any history of surgeries?: ☐ Yes ☐ No

    If yes, please indicate the year, surgery and hospital: _____

11. In a brief sentence, please describe why you are coming to see us. _____

_____

12. What name do you like to go by and the pronunciation? _____

13. Who is your Primary Care Physician? _____

14. Are there any other doctors involved in your care?

    If yes, please list their name and specialty): _____

15. Did someone refer you to us? If yes, who: _____

16. Are you taking any medications? (This includes any supplements/herbs) ☐ Yes ☐ No

    If yes, which ones? (please give dose and how many per day): _____

    _____

17. When was the last time you used contraception?: _____

18. What have you used for contraception in the past?: _____

19. Any history of sexually transmitted diseases?: If yes, date/diagnosis: _____

    _____

20. Any history of an abnormal PAP smear? If yes, date/diagnosis: _____

    _____

21. When was your last PAP smear? (If done at an outside hospital, please provide the most resent report):

    _____

22. Do you currently use tobacco? ☐ Yes ☐ No If yes, how many packs per day?: _____

23. Did you ever use tobacco? ☐ Yes ☐ No

    a) If yes, what years?: _____How many packs per day?: _____

    b) When did you stop?: _____

24. Do you drink alcohol?: ☐ Yes ☐ No If yes, how much? Number of drinks day/week: _____

25. Any illicit drug use? Marijuana?: ☐ Yes ☐ No If yes, please list:_____

26. Any history of eating disorders: ☐ Yes ☐ No If yes, please explain: _____

    a) Please give the years and age: _____

27. Are you currently employed? ☐ Yes ☐ What do you do for work?_____

We are particularly interested in knowing if you work with any chemicals/have radiation exposure.

28. Do you perform self breast exams monthly: ☐ Yes ☐ No

29. Any special diet: (ex: gluten free, diabetic...): _____

30. Do you exercise?: ☐ Yes ☐ No If yes, what type and how many hours a day/times per week?:

_____

31. We ask everyone this - Do you feel safe at home?: ☐ Yes ☐ No

32. What is your ethnic background? (ex. Irish, Eastern European...) Please do not list your race such as Caucasian.

a) We ask this in case the doctor may want to do genetic testing: _____

33. What is your marital status: _____ How many years married or in relationship?:_____

34. If applicable, how long have you been trying to become pregnant?:_____

35. Do you use Ovulation Predictor Kits or tracking? ☐ Yes ☐ No

a) If yes, do you notice a surge?: ☐ Yes ☐ No

36. Do you use lubricants?: ☐ Yes ☐ No If yes, what kind?: _____

37. Have you ever become pregnant? ☐ Yes ☐ No # Pregnancies:_____

38. Did any of your pregnancies result in a birth?: ☐ Yes ☐ No If yes, how many?: _____

a) If yes, please indicate month/year:_____

b) If yes, what type of delivery did you have (vaginal/c-section)?: _____

c) Where there any complications?: ☐ Yes ☐ No If yes, please explain: _____

_____

39. Did any of your pregnancies result in a miscarriage(s): ☐ Yes ☐ No If yes, how many?:_____

a) Month/year and Treatment (Misoprostol/D+C)?: _____

40. Did you have any ectopic pregnancies?: ☐ Yes ☐ No If yes, how many?: _____

a) Please list the month/year: _____

41. Did any of your pregnancies result in an abortions: ☐ Yes ☐ No If yes, how many?: _____

a) Please list month/year: _____

42. Have you ever had any fertility testing done?: ☐ Yes ☐ No If yes, please indicate when, where and what type of testing: _____

(Pease be sure to provide us with those records. You may fax them to 813-259-0882)

Fertility Treatment

Have you ever received any treatment for fertility? If yes, please indicate in boxes below:

Type of Treatment (ex: Timed intercourse/IUI/IVF): _____

Month/year of treatment: _____

Medicines used: _____

Dosages of medications (if known): _____

Outcome of treatment: _____

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Month/year of treatment: _____

Medicines used: _____

Dosages of medications (if known): _____

Outcome of treatment: _____

Type of Treatment (ex: Timed intercourse/IUI/IVF): _____

Month/year of treatment: _____

Medicines used: _____

Dosages of medications (if known): _____

Outcome of treatment: _____

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Type of Treatment (ex: Timed intercourse/IUI/IVF): ______________________________

Month/year of treatment:______________________________

Medicines used:______________________________

Dosages of medications (if known):______________________________

Outcome of treatment:______________________________

Type of Treatment (ex: Timed intercourse/IUI/IVF): ______________________________

Month/year of treatment:______________________________

Medicines used:______________________________

Dosages of medications (if known):______________________________

Outcome of treatment:______________________________

Type of Treatment (ex: Timed intercourse/IUI/IVF): ______________________________

Month/year of treatment:______________________________

Medicines used:______________________________

Dosages of medications (if known):______________________________

Outcome of treatment:______________________________

Type of Treatment (ex: Timed intercourse/IUI/IVF): ______________________________

Month/year of treatment:______________________________

Medicines used:______________________________

Dosages of medications (if known):______________________________

Outcome of treatment:______________________________

Your Family history:

Mother: Is she living?: ☐ Yes No ☐ If yes, what is her age?: _____

Is she healthy?: ☐ Yes ☐ No Any illnesses?: _____

Did she have difficulty conceiving?: ☐ Yes ☐ No

If yes, please explain and give age: _____

Father: Is he living?: ☐ Yes ☐ No If yes, what is his age?:_____

Is he healthy?: ☐ Yes ☐ No Any illnesses?: _____

Any siblings?: ☐ Yes ☐ No If yes, are they healthy?: ☐ Yes ☐ No

Any illnesses?: _____

Any difficulty conceiving?: ☐ Yes ☐ No If yes please explain:_____

Ages: _____

Family History (this includes grandparents, aunts/uncles and immediate family)

History of heart disease?: ☐ Yes ☐ No If yes, who: _____

History of high blood pressure?: ☐ Yes ☐ No If yes, who: _____

History of high cholesterol?: ☐ Yes ☐ No If yes, who: _____

History of osteoporosis?: ☐ Yes ☐ No If yes, who: _____

History of diabetes?: ☐ Yes ☐ No If yes, who: _____Type 1 ☐ Type 2 ☐

History of breast cancer?: If yes, what type and who?: _____

History of colon cancer?: If yes, what type and who?: _____

History of GYN (ovarian, cervical, endometrial or uterine...) cancer?: ☐ Yes ☐ No

a) If yes, what type and who?: _____

Any known genetic disorders in you or your partner's families?: ☐ Yes ☐ No

a) If yes, what is the disorder and who?:_____

Any known bleeding/clotting disorders in you *or* your partner's families?:

a) ☐ Yes ☐ No If yes, who: _____

Partner information

If MALE Partner:

1. Name: _____
2. Date of birth: _____
3. Is he registered at USF?: ☐ Yes ☐ No If not, please call **(813) 259-0692** to have him register.
4. How many years have you been together or married?: _____
5. What is his ethnic background (Irish, French, Greek, please do not provide his race)?

   We ask this in case the doctor may want to do genetic testing: _____
6. Is he currently employed? ☐ Yes ☐ No What does he do for work? We are particularly interested in knowing if he works with any chemicals/has or had any radiation exposure: _____
7. Does he currently use tobacco?: ☐ Yes ☐ No If yes, how many packs per day?: _____
8. Did he ever use tobacco?: ☐ Yes ☐ No

a. If yes, what years?:_____How many packs per day?: _____ When did he stop?:_____

9. Does he drink alcohol?: ☐ Yes ☐ No If yes, how much? Number of drinks day/week:_____
10. Any illicit drug use? Marijuana?: ☐ Yes ☐ No If yes, please list:_____
11. Any known testicular trauma or prior surgeries: ☐ Yes ☐ No If yes, please explain:_____

    _____
12. Does he have any illnesses?: ☐ Yes ☐ No If yes, please list: _____

    _____
13. Does he take any medications?: ☐ Yes ☐ No If yes, please list: _____

    _____
14. Does he have any children or ever attempted to pursue a pregnancy with another partner?: _____

    _____
15. Has he ever had a semen analysis? ☐ Yes ☐ No If yes, please provide report.

    a) Was the semen analysis it normal?: ☐ Yes ☐ No If not, please explain: _____

    _____

If FEMALE Partner:

Name: _____

Date of birth: _____

1. Is she registered at USF? ☐ Yes ☐ No If not, please call **(813) 259-0692** to have her register.
2. How many years have you been together or married?:_____
3. What is her ethnic background? (Irish, French, Greek, please do not provide her race)? We ask this in case the doctor may want to do genetic testing: _____
4. Is she employed? ☐ Yes ☐ N If yes, what does she do for work? We are particularly interested in knowing if she works with any chemicals/has or had any radiation exposure: _____
5. Does she currently use tobacco? ☐ Yes ☐ No If yes, how many packs per day?: _____
6. Did she ever use tobacco? ☐ Yes ☐ No If yes, what years?:_____
   a) How many packs per day?: _____ When did she stop?:_____
7. Does she drink alcohol?: ☐ Yes ☐ No If yes, how much? Number of drinks day/week:_____
8. Any illicit drug use? Marijuana?: ☐ Yes ☐ No If yes, please list: _____
9. Does she have any illnesses?: ☐ Yes ☐ No If yes, please list: _____

   _____
10. Does she take any medications?: ☐ Yes ☐ No If yes, please list: _____

    _____

We like to inform our patients that the doctor may perform a transvaginal ultrasound at your appointment, although this is not always done at the first visit. We encourage you to bring in any reports that you think would be important (ex. Hysterosalpingogram , Hysteroscopy, most recent PAP...) or have them faxed to our office (fax: 813-259-0882). Thank you for taking the time to look this over and answer questions. We look forward to meeting you and please don't hesitate to contact the office if you have any further questions/concerns.

Our office is located in the South Tampa Center for Advanced Healthcare
2 Tampa Circle, 4th FLR, Tampa, FL 33606. Our phone number is (813) 259-0692.

Thank you and we look forward to partnering with you in your care!

USF IVF AND REPRODUCTIVE ENDOCRINOLOGY
2 TAMPA GENERAL CIRCLE, FLR. 4
Tampa, FL 33606
Phone: 813-250-2130
Fax: 813-259-0882

Authorization for Release of Confidential Information

Periodically, to provide optimal care and review your previous history and treatment, it is important to obtain your medical records from other physicians or hospitals. In a similar fashion, we attempt to keep your physician(s) informed of tests and results that they would like to obtain. By signing this form now, you are giving us permission to send these results to your physician(s) to allow for the best communication between our offices. To help us in this, we would appreciate it if you would sign this release form. We are also requesting your permission to talk to your partner/family member about your results.

Patient Name: _____DOB:_____

Address: _____

Treatment Date (s) to be disclosed/all the following from my record EXCEPT (be specific):_____

_____

☐ I hereby authorize USF IVF to obtain from (Please include your current and any prior Gynecologist or other appropriate doctors along with their address):_____

_____

_____

☐ Release to my current health care providers (e.g. Gynecologist or other appropriate doctors along with their address):_____

_____

☐ Speak with my partner/family member (please list name/relationship): _____

_____

_____

_____ _____
Signature Date

_____
Print name