

Pre-Consultation Questionnaire

Patient _____ Date _____

Partner (if applicable) _____

How did you hear about Dr Nick Lolatgis? _____

Couple Reproductive History

Years married _____ Length of time trying to get pregnant _____

Birth control previously used (please check all that apply)

☐ Pill ☐ IUD ☐ Condom ☐ Vasectomy/Tubal ligation ☐ Other _____

When (years) _____ to _____ For how long? _____

Problems with method of contraceptive _____

Previous marriages? ☐ Yes ☐ No Husband _____ Wife _____

Number of pregnancies from previous marriage (wife) _____

Outcome _____

Length of time to get pregnant _____

Number of pregnancies from previous marriage (husband) _____

Outcome _____

Length of time to initiate a pregnancy _____

Female Profile

Age _____ Allergies _____

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

Do you have regular periods? ☐ Yes ☐ No

Interval between menses (Day 1 of previous cycle to Day 1 of following cycle) _____

Bleeding between periods? ☐ Yes ☐ No Describe _____

Blood flow during periods: ☐ Heavy ☐ Moderate ☐ Light Number of days _____

Clots? ☐ Yes ☐ No Average number of pads/tampons per day _____

Pain with periods? ☐ Yes ☐ No If yes, describe _____

Do you have any bladder (urinary or bowel) symptoms with periods, e.g.,
blood in urine, pain with defecation? ☐ Yes ☐ No

If yes, describe _____

Do you have cyclical mood changes related to your menses? ☐ Yes ☐ No

If yes, describe _____

Nipple discharge (blood, milk, one or both breasts, pain)? ☐ Yes ☐ No

If yes, describe _____

Past Treatments

Have you previously been treated by a gynecologist? Describe in detail (pelvic infection, endometriosis, surgery, ovarian cyst)

Last Pap Smear _____ ☐ Normal ☐ Abnormal

If abnormal, treatment _____

Have you ever had a mammogram? ☐ Yes ☐ No

When (most recent) _____

Patient _____ Date _____

Female Overall

General Health

General Health: ☐ Excellent ☐ Fair ☐ Poor

Do you have or have you ever had the following? (please check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Poor sense of smell |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Gallbladder problems | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Liver problems | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Chronic headaches |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Blood transfusions |
| <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Colitis | <input type="checkbox"/> Vaginitis |
| <input type="checkbox"/> Pelvic infection | <input type="checkbox"/> Diabetes | (trichomaniasis, yeast) |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Anemia | # of episodes _____ |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Nongonoccal urethritis |
| <input type="checkbox"/> Chronic bronchitis | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Parasitic infection |
| <input type="checkbox"/> Measles: regular | <input type="checkbox"/> Breast tenderness | <input type="checkbox"/> Immunization: German |
| <input type="checkbox"/> Measles: German | <input type="checkbox"/> Breast soreness | measles |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Breast discharge | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Neurological problems | <input type="checkbox"/> Ovarian cysts |
| <input type="checkbox"/> Kidney infection | <input type="checkbox"/> Seizures | <input type="checkbox"/> Cancer (specify) |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Epilepsy | _____ |
| <input type="checkbox"/> Hirsutism, acne | <input type="checkbox"/> Visual disturbance | _____ |

Exercise

Please list the forms and frequency of regular exercises (swimming, cycling, running, etc.) and give the age you began

Exercise _____ Average hrs/week _____ Age _____
 Exercise _____ Average hrs/week _____ Age _____
 Exercise _____ Average hrs/week _____ Age _____

Psychological

Have you previously undergone psychological treatment? ☐ Yes ☐ No

If yes, please specify when and nature of treatment _____

Family History

Mother: Living or deceased? _____ Age _____

Health of Mother _____

Father: Living or deceased? _____ Age _____

Health of Father _____

Number of Siblings _____

Family history of the following (please check all that apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Breast Cancer |
| <input type="checkbox"/> History of AIDS | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Other _____ |

Habits

Coffee (cups per day) _____ Cigarettes (packs per day) _____

Alcohol (drinks per day) _____ Marijuana _____

Other _____

Has your weight changed significantly in the past 2 years? ☐ Yes ☐ No

If yes, describe _____

Do you have what you would consider to be an eating disorder? ☐ Yes ☐ No

If so, which ones (please check all that apply): ☐ Binges ☐ Compulsive craving ☐ Purging

Patient _____ Date _____

Female History of Fertility Therapy

Have you been treated for infertility before? ☐ Yes ☐ No

If yes, who was your physician? _____

What cause of infertility was diagnosed? _____

Medications have you taken for infertility (please check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Clomiphene citrate (Seropene [®] , Clomid) | <input type="checkbox"/> Menopur |
| <input type="checkbox"/> Estrogens | <input type="checkbox"/> Repronex |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Progesterone |
| <input type="checkbox"/> Bromocriptine (Parlodel [®]) | <input type="checkbox"/> hCG |
| <input type="checkbox"/> Bravelle | <input type="checkbox"/> Danazol (Danocrine [®]) |
| <input type="checkbox"/> Follistim | <input type="checkbox"/> None |
| <input type="checkbox"/> Gonal F | <input type="checkbox"/> Other (specify) _____ |

Which of the following tests have you had performed?

- | | | |
|--|------------|---------------|
| <input type="checkbox"/> BBT | When _____ | Results _____ |
| <input type="checkbox"/> Post-coital test | When _____ | Results _____ |
| <input type="checkbox"/> Hormonal assays
(FSH, LH, prolactin,
DHEA-S, testosterone,
progesterone) | When _____ | Results _____ |
| <input type="checkbox"/> Endometrial biopsy | When _____ | Results _____ |
| <input type="checkbox"/> Hysterosalpingogram | When _____ | Results _____ |
| <input type="checkbox"/> Ultrasound | When _____ | Results _____ |
| <input type="checkbox"/> Antibodies | When _____ | Results _____ |
| <input type="checkbox"/> Laparoscopy, hysteroscopy | When _____ | Results _____ |
| <input type="checkbox"/> Mycoplasma/Chlamydia | When _____ | Results _____ |
| <input type="checkbox"/> Thyroid tests | When _____ | Results _____ |
| <input type="checkbox"/> Other (please specify) _____ | | |

Have you ever had surgery for tubal reversal? ☐ Yes ☐ No

If yes, specify date and surgeon _____

Have you ever had surgery for lysis of adhesions? ☐ Yes ☐ No

Have you ever had cervical conization or cautery? ☐ Yes ☐ No

Have you ever undergone artificial insemination? ☐ Yes ☐ No

If yes, how many cycles? _____ When? _____

Were you exposed to DES (or any other hormones) before birth?

Obstetrical History

	Year	Duration of Gestation	Sex	Weight	Complications
1)	_____	_____	_____	_____	_____
2)	_____	_____	_____	_____	_____
3)	_____	_____	_____	_____	_____
4)	_____	_____	_____	_____	_____

Patient _____ Date _____

Male Profile

Age _____ Allergies _____
General Health: ☐ Excellent ☐ Fair ☐ Poor
Previous male evaluation for infertility? ☐ Yes ☐ No
If yes, when _____ Doctor _____
Are you now under treatment or have you previously been treated with Clomid, steroids, antibiotics, thyroid replacement or hCG? ☐ Yes ☐ No
If yes, please give details _____
Surgical treatment (please give date):
Varicocele _____ Biopsy _____
Microsurgery _____ Other _____

Genitourinary Diseases

Testicular descent: Did your testes descend normally as a child? ☐ Yes ☐ No
Did you go through puberty at the same time as your peers? ☐ Yes ☐ No
Venereal Disease? ☐ Yes ☐ No Exposure to chemicals? ☐ Yes ☐ No
Genitourinary infections (please check all that apply)
☐ Nonspecific urethritis ☐ Gonorrhea ☐ Excessive exposure to heat
Mumps? ☐ Yes ☐ No
Fever/Viral infections in the previous 3 months (e.g., influenza) _____
Trauma to testicles? ☐ Yes ☐ No Other _____
Past surgery for any disease _____

Past diseases. Please list any disease(s) from which you now suffer or have received treatment in the past _____

Psychological

Have you previously undergone psychological treatment? ☐ Yes ☐ No
If yes, please specify when and nature of treatment _____

Family History

Mother: Living or deceased? _____ Age _____
Health of Mother _____
Father: Living or deceased? _____ Age _____
Health of Father _____
Number of Siblings _____
Family history of the following (please check all that apply):
☐ Infertility ☐ Hypertension ☐ Cancer
☐ Diabetes ☐ Thyroid disease ☐ Breast Cancer
☐ History of AIDS ☐ Hepatitis ☐ Other _____

Habits

Coffee (cups per day) _____ Cigarettes (packs per day) _____
Alcohol (drinks per day) _____ Marijuana _____
Other _____

Patient _____ Date _____

Both Partners

Sexual History

Rate of sexual desire/interest _____
 Average frequency of intercourse (per week) _____
 Lubrication used (if any) _____
 Pain (describe) _____

 Do you douche before or after intercourse? ☐ Yes ☐ No
 Difficulties with reaction and/or ejaculation? ☐ Yes ☐ No
 If yes, please describe _____
 Has there been (or do you anticipate) any difficulty collecting semen samples for evaluation or insemination procedures? _____
 Has infertility affected your sexual responsiveness? _____

Genetic Screening

Questionnaire

1. Will the female partner be age 35 or older when you have children? ☐ Yes ☐ No
2. Have you or your partner (or anyone in either of your families) ever had:
 - a. Neural tube defects - spina bifida ancephaly ☐ Yes ☐ No
 - b. Cystic Fibrosis ☐ Yes ☐ No
 - c. Down Syndrome ☐ Yes ☐ No
 - d. Tay Sachs ☐ Yes ☐ No
 - e. Gaucher's ☐ Yes ☐ No
 - f. Canavan's ☐ Yes ☐ No
 - g. Thalassemia ☐ Yes ☐ No
 - h. Sickle Cell Anemia ☐ Yes ☐ No
 - i. Muscular Dystrophy ☐ Yes ☐ No
 - j. Multiple Sclerosis ☐ Yes ☐ No
 - k. Huntington's Disease ☐ Yes ☐ No
 - l. Lou Gehrig's (ALS) ☐ Yes ☐ No
 - m. Parkinsons Disease ☐ Yes ☐ No
 - n. Alcoholism ☐ Yes ☐ No
 - o. Mental retardation/Fragile X ☐ Yes ☐ No
 - p. Hemophilia ☐ Yes ☐ No
 - q. Baby with birth defects (explain) _____ ☐ Yes ☐ No
 - r. Cleft Lip/Palate ☐ Yes ☐ No
 - s. Adult Polycystic Renal Disease ☐ Yes ☐ No
 - t. Cancer ☐ Yes ☐ No
3. Have you or your partner had a child stillborn? ☐ Yes ☐ No
 If yes, describe _____
4. Do you or your partner (or any close relatives) have any inherited genetic or chromosomal disease, mental retardation and/or birth defects not listed above? ☐ Yes ☐ No
 If yes, describe _____
 Have you ever received counseling for this? ☐ Yes ☐ No
5. Do you or your partner have any close relatives of Jewish ancestry who lived in Eastern Europe (Ashkenazi Jews)? ☐ Yes ☐ No
 If yes, have either you or your partner been screened for Tay Sach's disease? ☐ Yes ☐ No
 If yes, indicate results and who was screened _____

Patient _____ Date _____

**Genetic
Screening**
Questionnaire
(continued)

6. If you or your partner are African-American, have either of you (or any close relatives) ever been screened for sickle cell trait? ☐ Yes ☐ No
If so, was the result positive for Hemoglobin Electrophoresis? ☐ Yes ☐ No
If so, was the result positive for Glucose-6 Phosphate Deficiency? ☐ Yes ☐ No
If yes, indicate results and who was screened _____

7. Do you or your partner have any close relatives descended from Mediterranean countries? ☐ Yes ☐ No
If yes, have you or your partner been screened for thalassemia (Cooley's anemia)? ☐ Yes ☐ No
8. Have you ever been tested to determine if you are immune to Rubella (German measles)? ☐ Yes ☐ No
9. Have you ever been tested to determine if you are immune to Varicella (Chicken pox)? ☐ Yes ☐ No
10. Congenital malformations such as cardiac, neurological, kidneys, liver, adrenal, phenylketonuria, congenital hypothyroidism, homocystinuria, dwarfism, neurofibromatosis, myotonic dystrophy, multiple sclerosis, cystic fibrosis, malignant hyperthermia, premature menopause? ☐ Yes ☐ No
If yes, please indicate which one, where, when and results of tests:

IVF Questionnaire

Please answer the following questions if you have previously been treated with In Vitro Fertilization (IVF) procedure.

Number of Previous cycles _____
Date(s) _____
Location(s) _____
Stimulation
Clomiphene Citrate (Clomid) _____ HMG _____
FSH _____ Other _____
Outcome: Did you complete cycle(s)? ☐ Yes ☐ No
If no, explain reason(s) _____
Number of eggs obtained _____
Were the eggs obtained by laparoscopy/ultrasound? ☐ Yes ☐ No
Did fertilization occur? ☐ Yes ☐ No
Number of embryos replaced (IVF) _____
Outcome _____
Do you have any embryos frozen? ☐ Yes ☐ No If yes, how many? _____
Have you previously had a sperm penetration assay(hamster test, SPA)? ☐ Yes ☐ No
If yes, when _____ where? _____
Results _____

HFF _____ ESP _____ Percoll _____