U.S. Naval Hospital Naples, Italy

Infertility Questionnaire

The following questions make up a screening questionnaire that will help us in caring for you during your pregnancy. Your answers may indicate whether certain tests would be appropriate in helping to evaluate the health of your unborn baby. If you have any questions, please ask your health care provider.

Name________________________________ SSN of sponsor_________________________________

Rank/Rate(active duty)_______ Duty Station__________________Phone# (H)__________ (W)_____________

Age______ HT______ (Pre-pregnancy) WT_______Race______________ Religious Preference____________

Primary Language ____________________Single___Married___Divorced___Widowed___

Name of Baby's Father ____________________________ Rank/Rate____________ Race_______ Age ____

Duty Station ______________________________ Phone # __________________

Fertility History

	Yes	No
1. Have you had an infertility work up in the last year?	_____	_____
2. Have you taken infertility drugs in the past year?	_____	_____
3. Had you been using birth control prior to conception? (i.e. Pill, IUD, foam, condom, diaphragm, sponge, rhythm method) Circle all that apply. When did you stop? ___________________	_____	_____

4. How long have you had unprotected intercourse to become pregnant?
_________months or _________ years
1. How many times per week do you have unprotected intercourse? ______ x / wk

Medical History

	Yes	No
1. Have you ever been hospitalized If so, for what diagnosis ____ ____	_____	_____
2. Do you have any chronic health problems?	_____	_____
3. Do you routinely have headaches, (prior to pregnancy)?	_____	_____
4. Do you have, or have you ever had, seizures or convulsions?	_____	_____
5. Do you have any problems with your vision or eyes? (not including wearing contacts or glasses)	_____	_____
6. Have you ever had problems with your thyroid gland? What?____________________	_____	_____
7. Have you ever had problems with your lungs? (i.e. pneumonia, asthma, bronchitis, tuberculosis)	_____	_____
8. Have you ever had problems with your heart? (i.e. heart murmur, rheumatic heart disease, heart surgery, "heart attack", high blood pressure)	_____	_____

Medical History continued **Yes** **No**

9. Do you have problems with your stomach or intestines, i.e. constipation, diarrhea, hemorrhoids (before pregnancy)? _____ _____

10. Have you ever had a blood transfusion? _____ _____
When? ___________________________

11. Have you been told by a health care provider that you are anemic? _____ _____
When? __________________

12. Are you seeing a health care provider for problems with your muscles or bones? _____ _____

13. Have you had any mental or psychiatric problems that required counseling? _____ _____

14. Do you have any other health problems that we should know about? _____ _____
Explain:____
____
____

15. Have you had or been immunized for:
a. Rubella (German measles or 3 day measles) _____ _____
b. Rubeola (two week, hard, or red measles) _____ _____
c. Varicella (Chicken Pox) _____ _____
d. Hepatitis B _____ _____
e. Hepatits A _____ _____

16. Have you ever had a positive PPD? _____ _____
Were you treated? ________________

Medications
1. Do you take any medications routinely? _____ _____
What and how often? ____
____
____

Allergies **Yes** **No**
1. Do you have allergies to any medications? _____ _____
If yes, which medication and what type of reaction?_______________ _____ _____
____

4. Do you have allergies to any foods?_________________________ _____ _____

5. Do you have a latex allergy? _____ _____

Surgical history
1. Have you ever had any operations or surgeries? _____ _____
What and when? ____
____
____

PATIENT IDENTIFICATION____

Social History **Yes** **No**

1. Do you smoke? _____ _____
How many packs/day? _______ How many years? _______

2. Do you drink alcoholic beverages? _____ _____
How many drinks/week?_________

3. Do you/have you used illicit or illegal drugs _____ _____
if so, what ___________________________
4. Are you currently employed _____ _____
if so, what ___________________________
What type of job? ____

5. Do you have heat in your home? _____ _____

6. Do you have a phone in your home? _____ _____

7. Have you ever been the victim of sexual, physical or emotional abuse? _____ _____

Obstetric History

1. Number of past pregnancies _____

2. Number of miscarriages and/or abortions_____

3. Number of children now living _____
If yes, answer date (chronological order), weight,.method of delivery and any complications.
____
____
____
____

4. Have you ever received Rhogam?_____

Gynecologic & Menstrual History **Yes** **No**

1. Age at first menstrual period _____

2. How often are your periods? Every _____ days, lasting _____ days.

3. Do you usually have severe cramping with your periods? _____

4. What was the first day of your last NORMAL period? ________

5. Have you had the following:
a. unusual breast lumps or discharge from the nipples _____ _____
b. repeated vaginal infections, pelvic inflammatory disease _____ _____
c. abnormal pap smears _____ _____
d. sexually transmitted diseases _____ _____
e. infections of the uterus, tubes or ovaries _____ _____
f. abnormal hair growth pattern, fascial hair, excessive body hair? _____ _____
g. surgery of your tubes, ovaries, uterus or vagina _____ _____
h. pain with intercourse _____ _____
i. use of gels or lubricants during intercourse? _____ _____
j. diagnosis of fibroids, DES exposure, ectopic pregnancy. Circle appropriate _____ _____

PATIENT IDENTIFICATION____

Educational History

1. How many years of school have you completed? ___________
2. How many years of school has your partner completed? ___________
3. Do you plan on taking childbirth preparation classes? ___________

Family History

1. Do you or the father of the baby have any close family members with:

	Yes	No		Yes	No
diabetes	_____	_____	cancer	_____	_____
tuberculosis	_____	_____	high blood pressure	_____	_____
heart attack	_____	_____	heart problems	_____	_____
twins	_____	_____	bleeding problems	_____	_____
cystic fibrosis	_____	_____	Down's syndrome	_____	_____
hemophilia	_____	_____	mental retardation	_____	_____
spina bifida	_____	_____	muscular dystrophy	_____	_____
anencephaly	_____	_____	hydrocephalus	_____	_____

2. Will you be 35 or older when this baby is due? _____ _____

3. Do you or the baby's father have any known birth defects? _____ _____
Please list:_______________________________________

4. Have you or the baby's father had a child born (alive or dead) with a birth defect not listed in the above questions? _____ _____

5. Are there any known inherited or chromosomal disorders in the family? _____ _____

6. Are you and the baby's father related outside of marriage? (such as cousins) _____ _____

Genetic History **Yes** **No**

1. Are you or the father of the baby of African American descent? _____ _____
Have you been tested for sickle cell trait? _____ _____
Were the results positive? _____ _____

2. Are you or the father of the baby of Eastern European Jewish descent? ___ _____
Have you been tested for Tay-Sachs carrier? _____ _____
Were the results positive? _____ _____

3. Are you or the father of the baby of Asian or Mediterranean descent?____ _____
Have you been tested for Thalassemia trait? _____ _____
Were the results positive? _____ _____

4. Any history of Cystic Fibrosis in your or your partner's family? _____ _____

5. Any history of mental retardation in your or your partner's family? _____ _____

6. Are there any other genetic abnormalities in your or your partner's family history? _____ _____

PATIENT IDENTIFICATION____

Male history | **Yes** | **No**

1. How long has he been your partner? __________
2. Has he fathered other children? ___ ___
   a. If yes, how many ____
3. Past medical history______________________________
   ____
   ____
4. Past surgeries? ___ ___
   a. If yes, what type(s) _______________________
      ____
      ____
      ____
5. Has he been exposed to radiation? ___ ___
6. Has he been exposed to hazardous chemicals? ___ ___
   a. If yes, what types? ________________________
      ____
7. Any trauma or surgery to his genitalia/testicles? ___ ___
8. Any history of sexually transmitted diseases? ___ ___
9. Any history of mumps? ___ ___
10. Any problems with ejaculation or erection? ___ ___
11. Is he taking any medications? ___ ___
    a. If yes, what types? ________________________
       ____
       ____

I have completed this History and Physical form to the best of my knowledge. Failure to provide adequate and/or truthful information could adversely affect my physician's ability to treat my infertility and inadvertently have a negative impact on my health and well being.

____ __________
Patient signature Date

I have reviewed the following History and Physical form provided by the patient listed.

____ __________
Physician signature Date

PATIENT IDENTIFICATION____