Heartland Center for Reproductive Medicine

Endocrine/Surgical Questionnaire for Women

General Information

Name _____ Date _____

Address _____

_____

Telephone _____ Home _____ Work _____Cell

Birth date _____ Age_____

Occupation _____

Ethnic Background _____

Height _____ Weight_____

Highest Education_____ Partner's Name _____

Married ☐ Yes ☐ No

Referred by: _____

Reason Referred_____

Gynecologic History

Age of first period _____ Date of first day of last period _____

Usual cycle length _____ days _____ range
(interval from start of one period to start of next)
Usual duration of bleeding _____
Do you have any symptoms at time of ovulation (i.e., pain)?
_____ yes _____ no
Amount of flow _____ Light _____ Moderate _____ Heavy
Is cramping ___ None ___Minimal ___ Moderate ___ Severe
Bleeding between periods?___ Never ___Sometimes ___ Always
Do you skip periods? ___ Never ___ Sometimes ___ Always
Circle symptoms preceding period:

None Breast soreness Irritability

History of: Pelvic Pain_____

Endometriosis _____

Fibroids_____

Gynecologic Surgery _____
_____

Last PAP _____ Breast exam _____ Mammogram _____
Have you ever been treated for: Dates
Syphilis _____
Gonorrhea _____
Chlamydia _____
Genital Warts _____
Do you have a history of genital herpes _____ yes _____ no
Did your mother take any medications while pregnant with you?
_____ yes _____ no _____ don't know _____ What?
Was DES taken _____ yes _____ no

Sexual History

Frequency of sexual intercourse per week _____
Use of lubricants ____ yes ____ no _____
Name of lubricants _____
Does partner ejaculate in the vagina during intercourse ___ yes ___ no
Is intercourse painful to you? _____ yes _____ no
Is intercourse painful to your partner? _____ yes _____ no

Contraceptive History

Birth control pills _____ yes _____ no # of years taken _____
Date stopped birth control pills _____
Were menses regular before birth control pills _____ yes _____ no
Were menses regular after stopping the pills _____ yes _____ no
How long after stopping the pills did menses start _____

Previous use of IUD (intrauterine device) ___ yes ___ no ___ # years
When was IUD removed (date) _____ reason _____
_____

Circle previous use of:

diaphragm condom foam rhythm sponge other

Obstetrical History

Have you been pregnant before? _____ yes _____ no

Do you have children: _____ yes _____ no _____ ages

How long to conceive: _____

RECORD ALL PREGNANCIES							
Pregnancy #	**Year**	**Full term**	**Preterm**	**Miscarriage**	**Terminations**	**Complications**	**Fertility Treatment**

Occupation/Leisure History	**Yes**	**No**	**Dates/Comments**
Exposed to chemicals or x-rays in work or hobby	_____	_____	_____
Please list			**Amount per day or week**
Caffeine	_____	_____	_____
Smoking	_____	_____	_____
Alcohol	_____	_____	_____
Marijuana	_____	_____	_____
Nutritional supplements, herbs, etc.	_____	_____	_____
Drugs	_____	_____	_____

Please describe recreational/sports activities, exercise (frequency, length of time, etc.) _____

Family History

Father's age if alive _____ If no longer living, cause of death _____

Medical problems: _____

Mother's age if alive _____ If no longer living, cause of death _____

Medical problems: _____

Sister(s) ages _____ medical problems:_____

Brother(s) ages _____ medical problems:_____

Is there a family history of:	**Yes**	**No**	**Comments**
Birth defects or genetic diseases	_____	_____	_____
Mental Retardation	_____	_____	_____
Infertility	_____	_____	_____
Early Menopause (before age 40)	_____	_____	_____
Hormone problems	_____	_____	_____
Miscarriages/stillbirths	_____	_____	_____
Pregnancy problems	_____	_____	_____
Cancer: ___ Breast ___Ovarian ___Other	_____	_____	_____
Stroke	_____	_____	_____
Heart Disease	_____	_____	_____
Lung disease	_____	_____	_____
Diabetes	_____	_____	_____
Thyroid/endocrine problems	_____	_____	_____
High blood pressure	_____	_____	_____
Blood clots (deep vein thrombosis, pulmonary embolism)	_____	_____	_____
Any women who have never menstruated	_____	_____	_____
Any men who have never had to shave	_____	_____	_____

Any additional comments you would like to make that you feel may be pertinent and have not already been addressed: _____

Medical/Surgery History	Yes	No	Dates/Comments
Elevated Blood pressure	_____	_____	_____
Blood clots (deep vein thrombosis, pulmonary embolism)	_____	_____	_____
Headaches	_____	_____	_____
Heart murmur	_____	_____	_____
Heart disease	_____	_____	_____
Diabetes	_____	_____	_____
Lung disease	_____	_____	_____
Liver or gall bladder disease	_____	_____	_____
Jaundice	_____	_____	_____
Kidney infections	_____	_____	_____
Hepatitis	_____	_____	_____
Kidney stones	_____	_____	_____
Gout	_____	_____	_____
Urinary tract abnormalities	_____	_____	_____
Thyroid disease	_____	_____	_____
Arthritis	_____	_____	_____
Auto immune diseases (lupus, rheumatoid arthritis, etc.)	_____	_____	_____

Other serious or chronic diseases _____

Any surgery (list type and year) _____

_____

Do you have any allergies (medications, food, latex, iodine, contrast dye): Yes _____ No _____

If yes, list the specific allergies and reactions experienced: _____

_____

Please list any medications you are now taking or have taken in the past. Current: _____ Past: _____

_____ _____

_____ _____

Any history of therapeutic x-ray treatment or anti-cancer drugs? Current: _____ Past: _____

_____ _____

_____ _____

Have you ever been involved in psychotherapy or counseling? Yes _____ No _____

If yes, please indicate why, when, with whom, and any other pertinent information. _____

_____

Please fill in a review of any current or recent symptoms:

	Yes	No		Yes	No		Yes	No
Chronic headaches	____	____	Increased thirst	____	____	Excessive Fatigue	____	____
History of head injury	____	____	Increased sweating	____	____	Tremors	____	____
Convulsion history	____	____	Intolerance to heat	____	____	Desire for extra salt	____	____
Visual problems	____	____	Intolerance to cold	____	____	Excess Loss of scalp hair	____	____
Dizziness	____	____	Difficulty swallowing	____	____	Growth of hair on face	____	____
Rapid weight change	____	____	Change in voice or			or body in new places	____	____
Acne	____	____	hoarseness	____	____	Change in size of clitoris	____	____
Change of appetite	____	____	Difficulty sleeping	____	____	Discharge from nipples	____	____
Headaches	____	____						