Michigan Reproductive Medicine

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Date of appointment at MRM:_____

*Please return this questionnaire as soon as possible so that our physicians can fully review your information in advance of your appointment.

Today's Date: _____

Demographic and Insurance Information

Patient's Information

Last Name: _____First Name:_____Middle:_____

Social Security #: _____

Street Address: _____Suite/Apt #: _____

City: _____State: _____Zip Code: _____

Birth Date: _____ Gender: ☐ Female ☐ Male

Home Phone: ( )_____ Cell: ( )_____

Work: ( )_____

May we leave a message on your voicemail?

Home: ☐ Yes ☐ No Cell: ☐ Yes ☐ No Work: ☐ Yes ☐ No

Email Address: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner

Employment: ☐ Student ☐ Employed ☐ Not Employed ☐ Self Employed ☐ Retired

Employer Name: _____

Occupation (description): _____

Insurance Company Carrier: _____

Insurance Subscriber #: _____ Group #: _____

Policy Holder's Name: ☐ Self ☐ Other (Name & Relationship): _____

Partner's Information (if applicable)

Last Name: _____ First Name: _____ Middle: _____

Social Security #: _____

☐ Address is same as above (complete the following if different)

Street Address: _____ Suite/Apt #: _____

City: _____ State: _____ Zip Code: _____

Birth Date: _____ Gender: ☐ Female ☐ Male

Home Phone: ( ) _____ Cell: ( ) _____

Work: ( ) _____

May we leave a message on your voicemail?

Home ☐ Yes ☐ No Cell: ☐ Yes ☐ No Work: ☐ Yes ☐ No

Employer Name: _____

Occupation (description): _____

☐ Insurance is same as above (complete the following if different)

Insurance Company Carrier: _____

Insurance Subscriber #: _____ Group #: _____

Policy Holder's Name: ☐ Self ☐ Other (Name & Relationship): _____

Emergency Contact (friend or family member not living at your residence):

Last Name: _____ First: _____

Phone #: ( ) _____ Relationship: _____

Referred by: ☐ Self ☐ Friend: _____ ☐ Other: _____

☐ Physician (Dr.'s full name): _____

Specialty (i.e. OB/Gyn, Urology): _____

OB/Gyn Information

Last Name: _____ First Name: _____ Title: ☐ MD ☐ DO ☐ PAC

Street Address: _____ Suite #: _____

City: _____ State: _____ Zip Code: _____

Office Phone #: ( ) _____

Primary Care Physician

Last Name: _____ First Name: _____ Title: ☐ MD ☐ DO ☐ PAC

Street Address: _____ Suite #: _____

City: _____ State: _____ Zip Code: _____

Office Phone #: ( ) _____

Reason for consultation (select *one*):

☐ Fertility Related
☐ Not Fertility Related
☐ Both

Please select *all* that apply:

☐ Abnormal uterine bleeding
☐ Abnormal uterus formation
☐ Cervical stenosis
☐ Diminished (low) ovarian reserve
☐ Donor egg request
☐ Donor sperm insemination request
☐ Ectopic pregnancy
☐ Endometriosis
☐ Excessive hair growth
☐ Fallopian tube problem(s)
☐ Fertility preservation
☐ General infertility
☐ Genetic abnormality
☐ Irregular menstrual periods
☐ Menopause, after age 40
☐ Menopause, before age 40
☐ Never had a menstrual period
☐ No menstrual periods for at least 6 mos
☐ Pelvic pain
☐ Polycystic ovary syndrome (PCOS)
☐ Previous baby, not pregnant since
☐ Previous in vitro fertilization therapy
☐ Previous infertility therapy
☐ Recurrent pregnancy loss
☐ Significant weight gain
☐ Sperm issue
☐ Tubal ligation, not reversed
☐ Tubal ligation, reversed
☐ Uterine fibroid tumors
☐ Vasectomy, not reversed
☐ Vasectomy, reversed
☐ Other: _____

Your Medical History (please fill in everything that applies)

Height: _____ft. ____inches

Weight: _____lbs.

Gynecologic and Pregnancy History

Duration of infertility (approximately): _____years

If you have ever been pregnant, please answer the following starting with your first pregnancy:

	Year of pregnancy	Time to conceive? (# years or months)	Is current partner the father?	Result of infertility therapy?	End in miscarriage?	Ectopic pregnancy?	End in elective abortion?	Live Birth? If yes, date of birth
1			☐yes ☐no	☐yes ☐no	☐yes ☐no	☐yes ☐no	☐yes ☐no	
2			☐yes ☐no	☐yes ☐no	☐yes ☐no	☐yes ☐no	☐yes ☐no	
3			☐yes ☐no	☐yes ☐no	☐yes ☐no	☐yes ☐no	☐yes ☐no	
4			☐yes ☐no	☐yes ☐no	☐yes ☐no	☐yes ☐no	☐yes ☐no	
5			☐yes ☐no	☐yes ☐no	☐yes ☐no	☐yes ☐no	☐yes ☐no	
6			☐yes ☐no	☐yes ☐no	☐yes ☐no	☐yes ☐no	☐yes ☐no	
7			☐yes ☐no	☐yes ☐no	☐yes ☐no	☐yes ☐no	☐yes ☐no	

Date of the first day of your most recent menstrual period (first day of heavy flow): _____

Are your menstrual periods regular (one per month)? ☐ Yes ☐ No

If yes, usual number of days from the 1st day of bleeding to the start of your next period (ex: 28 days)? _____

If no, approximately how many days/months are there between periods? _____

Average number of days you bleed during your period: _____

What was your age when you had your first period? _____ years

Date of your last pap smear:_____ Result: ☐ Normal ☐ Abnormal

If abnormal, what type of treatment was given?_____

Date of your last mammogram:_____ Result: ☐ Normal ☐ Abnormal

If abnormal, what type of treatment was given?_____

Any abnormalities, illnesses or treatments of your female reproductive organs? ☐ Yes ☐ No

If yes, please explain: _____

Has intercourse ever been painful or difficult for you? ☐ Yes ☐ No

If yes, is the pain or difficulty: ☐ current ☐ only in the past ☐ both

How many times per week do you have sexual intercourse (approximately)? _____

Do you have any sexual problems, past or present, you wish to discuss? ☐ Yes ☐ No

If yes, please explain: _____

Previous Contraception (Check any that apply):

☐ None ☐ Birth control pills ☐ Condoms ☐ Diaphragm
☐ IUD ☐ Tubal ligation ☐ Vasectomy ☐ Other:_____

Sexually Transmitted Diseases (Check any that apply):

☐ None ☐ Chlamydia ☐ Genital Herpes ☐ Gonorrhea
☐ PID (pelvic inflammatory disease) ☐ Syphilis ☐ Venereal Warts
☐ Other:_____

Pelvic Pain (Check any that apply):

Do you experience any pelvic pain? ☐ None ☐ Before Period ☐ During Period ☐ After Period

How would you rate your pain? ☐ mild ☐ moderate ☐ severe

Check all that applies to your pelvic pain:
☐ aching ☐ constant ☐ cramping ☐ dull
☐ fainting ☐ intermittent ☐ nausea ☐ sharp
☐ vomiting ☐ with bowel movement ☐ with urination

Does your pain spread to other areas of your body (ex: leg or back)? ☐ yes ☐ no

If yes, where?_____

List anything that aggravates the pain?_____

List anything that relieves the pain?_____

Have you had a previous infertility evaluation? ☐ Yes ☐ No (Check and give details for all that apply):

Procedure/Test	Doctor/Hospital	Date(s)	Results
☐ Temperature chart			
☐ Ovulation predictor kit			
☐ Post coital test			
☐ Endometrial biopsy			
☐ Hysterosalpingogram			
☐ Laparoscopy			
☐ Hysteroscopy			
☐ Sonohysterogram			
☐ Laparotomy			
☐ Ultrasound			
☐ Lab tests			
☐ Other:_____			

Have you had any previous infertility treatment? ☐ Yes ☐ No (Check and give details for all that apply):

Procedure / Treatment	What Fertility Medications were Prescribed (e.g. clomid, Menopur)?	Doctor/Hospital	Date	Number of Cycles
☐ Timed intercourse				
☐ Artificial insemination (IUI)				
☐ In vitro fertilization (IVF)				
☐ Other: _____				

Your Past Medical History

Allergy: ☐ None ☐ Latex ☐ Seasonal ☐ Medications/reaction:_____

Are you a carrier of any genetic abnormalities (cystic fibrosis, SMA, etc)? ☐ Yes ☐ No ☐ Don't know

Describe:_____

Surgeries unrelated to infertility (type/date):_____

Hospitalizations (reason/date):_____

Non-fertility medications (currently, specify):_____

Herbal supplements/remedies:_____

Tobacco smoking? ☐ Never ☐ Currently: How many cigarettes do you smoke per day?_____

☐ In the past: How many years did you smoke?_____ How many years ago did you quit? _____

Substance abuse? ☐ Never ☐ Currently: How long? _____ Substance: _____

☐ In the past: how long? _____ When did you quit? _____ Substance: _____

Exposure to toxic substances? ☐ No ☐ Yes: what type?_____

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

☐ Adult acne	☐ Eating disorder	☐ High cholesterol	☐ Pituitary problem
☐ Arthritis	☐ Endometriosis	☐ HIV	☐ Psychological problems
☐ Asthma	☐ Excessive hair growth	☐ Hypoglycemia	☐ Seizure
☐ Bone problems	☐ Fibroid uterus	☐ Kidney abnormality	☐ Thyroid disease
☐ Breast discharge	☐ Gall bladder disease	☐ Kidney disease	☐ Tuberculosis
☐ Breast tumors	☐ Genetic abnormality	☐ Lupus	☐ Ulcers
☐ Bronchitis	☐ Heart disease	☐ Mumps	☐ Weight problem
☐ Cancer	☐ Hepatitis	☐ Mycoplasma	☐ Other:_____
☐ Colitis	☐ High blood pressure	☐ Nerve disorder	
☐ Diabetes		☐ Ovarian cysts	

Family History: Immediate family with any disorders listed above (list relationship & medical problem):

_____

_____

Male Partner's History (if applicable, please fill in all that apply)

Height: _____ft. ____inches

Weight: _____lbs.

Reproductive history: ☐ No children
☐ Fathered a child with current partner, number _____
☐ Fathered a child with past partner, number _____

Sexually Transmitted Diseases (Check any that apply):
☐ None ☐ Chlamydia ☐ Genital Herpes ☐ Gonorrhea
☐ Syphilis ☐ Venereal Warts ☐ Other:_____

Any previous infertility evaluation? ☐ Yes ☐ No (Check and give details for all that apply):

Procedure/Test	Doctor/Hospital	Date(s)	Results
☐ Semen analysis #1			
☐ Semen analysis #2			
☐ Semen analysis #3			
☐ Urology exam			
☐ Scrotal / Prostate Ultrasound			
☐ Sperm antibody test			
☐ Surgery			
☐ Lab tests			
☐ Other: _____			

Any previous infertility treatment? ☐ Yes (same as partner) ☐ No
☐ Yes (different from partner, check and give details for all that apply):

Procedure / Treatment	What Fertility Medications were Prescribed (e.g. clomid, Menopur)?	Doctor/Hospital	Date	Number of Cycles
☐ Timed intercourse				
☐ Artificial insemination (IUI)				
☐ In vitro fertilization (IVF)				
☐ Other: _____				

Are you taking any male fertility medications? ☐ Yes ☐ No

List male fertility medications (and dose, if known): _____

Who is the prescribing physician? _____

Partner's Past Medical History

Allergy: ☐ None ☐ Latex ☐ Seasonal ☐ Medications/reaction: _____

Are you a carrier of any genetic abnormalities (cystic fibrosis, SMA, etc)? ☐ Yes ☐ No ☐ Don't know

Describe: _____

Surgeries unrelated to infertility (type/date): _____

Hospitalizations (reason/date): _____

Non-fertility medications (currently, specify): _____

Herbal supplements/remedies: _____

Tobacco smoking? ☐ Never ☐ Currently: How many cigarettes do you smoke per day? _____

☐ In the past: How many years did you smoke? _____ How many years ago did you quit? _____

Substance abuse? ☐ Never ☐ Currently: how long? _____ Substance: _____

☐ In the past: how long? _____ When did you quit? _____ Substance: _____

Exposure to toxic substances? ☐ No ☐ Yes: what type? _____

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

☐ Adult acne	☐ Gall bladder disease	☐ Lupus	☐ Testicle/scrotum injury
☐ Arthritis	☐ Genetic abnormality	☐ Minimal body hair	☐ Testicle/scrotum problems
☐ Asthma	☐ Heart disease	☐ Mumps	☐ Thyroid disease
☐ Bone problems	☐ Hepatitis	☐ Mycoplasma	☐ Tuberculosis
☐ Bronchitis	☐ High blood pressure	☐ Nerve disorder	☐ Ulcers
☐ Cancer	☐ High cholesterol	☐ Pituitary problem	☐ Weight problem
☐ Colitis	☐ HIV	☐ Psychological problems	☐ Other: _____
☐ Diabetes	☐ Hypoglycemia	☐ Seizure	
☐ Eating disorder	☐ Kidney abnormality		
☐ Erectile dysfunction	☐ Kidney disease		

Family History: Immediate family with any disorders listed above (list relationship & medical problem):

_____

_____