Your Name:

THE JOHNS HOPKINS HOSPITAL

DIVISION OF REPRODUCTIVE ENDOCRINOLOGY

Please take the time to fill out the following questionnaire

If the reason of your visit is related to <u>Infertility</u> or <u>Recurrent Miscarriage</u> in addition to part A, please fill parts B and C of the form

If you are here for any other reason please fill only part A.

Your Name:_____ Age:_____ Birth date:_____

Address:_____

City:_____ State:_____ Zip Code: _____

Telephone: (home)_____ (work)_____

Your Occupation: _____Your Employer:_____

Your Religion: _____ Ethnic background: _____

Spouse's Name (if applicable):_____

Spouse's Occupation:_____ Date of Marriage (if applicable): _____

Physician whom you will be seeing:_____ Date of visit:_____

Person who referred you:_____

Reason for your clinic visit:_____

Your Name:

Part A:

Please describe the background of your present problem. Include all symptoms, how long you have experienced them, and indicate whether they have changed in severity over time.

_____

_____

_____

_____

Gynecological History:

Menstrual History:

What were the dates of your last two menstrual periods? _____

At what age did you begin to menstruate? _____

What is the average length of your menstrual cycle? (Interval from 1st day of period until day before bleeding of the next cycle):_____

Are you normally **regular** or **irregular** ? (circle one)

If irregular, please describe: _____

How many days do you bleed? _____

Do you have pain during periods? Yes No (circle one)

Do you have any pain between periods? Yes No (circle one)

If so, describe: _____

Do you bleed between periods? Yes No (circle one)

If so, describe frequency and amount of blood loss:_____

When was your last Pap smear? _____

Have you ever been treated for an abnormal Pap smear? Yes No (circle one)

If so, how? _____

Have you ever had a mammogram? Yes No (circle one)

If so, when was your last study? _____

Your Name:

Sexual History:

Are you currently sexually active? Yes No **(circle one)**

Frequency of intercourse: _____times/week or _____times/month _____N/A

Do you bleed during or after intercourse? Yes No

Any pain during or after intercourse? Yes No

Do you use lubricants? Yes No

Do you have any sexual problems? Yes No

Have you ever being diagnosed with

pelvic inflammatory disease (PID) ? Yes No

Have you ever been diagnosed with any of the following:

Syphilis, Gonorrhea, Chlamydia, Genital Herpes, HIV. (circle one)

Do you have any noticeable vaginal discharge? Yes No (circle one)

If so, describe (color, consistency, presence of odor, itching, etc):

_____

If so, describe: _____

Contraception: ____ Never used contraception (continue on to next section)

Please check (▤) any of the following methods of contraception you are currently using and/or have use in the past. Fill in the dates of usage.

Methods	**Dates of Usage**
( ) Birth Control Pills Name:_____	_____
( ) IUD Type:_____	_____
( ) Diaphragm	_____
( ) Condom	_____
( ) Jellies/Foam	_____
( ) Withdrawal	_____
( ) Sterilization _____male _____ female	_____

Other:_____

Your Name:

Obstetrical History: _____ Never been pregnant (continue on to next section)

	Number	**Date(s)**	**Sex/Wt**	**Vag/C-Sect**
Full term Deliveries (>5 lbs. 8 oz.)	_____	_____	_____	_____
Premature Deliveries (<5 lbs. 8 oz.)	_____	_____	_____	_____
Miscarriages	_____	_____	_____	
Induced Abortions	_____	_____	_____	
Ectopic Pregnancies	_____	_____	_____	
Stillbirths	_____	_____	_____	
Newborn Deaths	_____	_____	_____	

Were there any complications during your delivery? Yes No (circle one)

If yes, state which delivery and describe the complication(s):_____

_____

Past History:

Your **general health**: Excellent Good Fair Poor **(circle one)**

Childhood Illnesses: _____ Routine (chickenpox, measles, mumps, etc.)

_____ Unusual (describe):_____

List all your **medical conditions**:

_____

_____

_____

List all your **hospital admissions**: (Reason, Date(s), duration of your hospitalization(s) and name of the hospital(s)):

_____

_____

_____

Your Name:

List all **surgical procedures** you have had, the approximate date(s), and name of the hospital(s):

_____

_____

_____

Are you allergic to any medication? (Specify):

_____

_____

Do you have any other type of allergies?

_____

_____

List current medications (include the name of medication and duration of use)

Medication:	**Date/Duration**	**Medication:**	**Date/Duration**
1._____		4._____	
2._____		5._____	
3._____		6._____	

Are you currently using or have ever used any illicit drugs? Yes No

If yes please circle: Marijuana Cocaine LSD Amphetamines (speed) Sedatives

Other:_____ Frequency and amount of use:_____

Do you drink alcohol? Yes No Approximate drinks per day:_____

Do you currently smoke cigarettes? Yes No

Number packs per day? _____ Number of years?_____

If you are a former smoker, give the approximate dates of smoking and average packs per day:_____

Have you ever had a blood transfusion? Yes No Approx. Date:_____

Have you ever been exposed to industrial chemicals, toxic substances or radiation? Y N

If so, state the substance and extent of exposure:_____

Your Name:

Family History:

Check (☰) all of the following disorders for which you have a family history. Next to each item, state which blood relative (mother/father/sister(s)/brother(s), maternal/paternal grandmother or grandfather, maternal/paternal aunt(s) or uncle(s), cousins) had the disorder. Do not include yourself.

( ) Cancer (specify _____ _____)
( ) Thyroid problems (including goiter)
( ) Hypertension (high blood pressure)
( ) Infertility
( ) Fibroids or endometriosis
( ) No problems
( ) Diabetes
( ) Kidney Disease
( ) Tuberculosis (TB)
( ) Heart Disease
( ) Blood Clotting disorders
( ) Excessive hair growth
( ) Neurological (nerve) disorders

Review of Systems:

Check (☰) any of the following disorders that **you** currently have (or have experienced in the past).

Central Nervous System

( ) No problems
( ) Seizures
( ) Migraine headaches
( ) Paralysis

Eyes, Ears, Nose and Throat

( ) No problems
( ) Wear contact lenses
( ) Eye disorders
( ) Problem with sense of smell

Cardiovascular

( ) No problems
( ) Chest Pain
( ) Palpitations
( ) Diagnosed with Rheumatic Fever
( ) Heart valve disease
( ) High blood pressure
( ) Mitral valve prolapse
( ) Given prophylactic antibiotics before dental work or surgery

Your Name:

Respiratory

( ) No problems
( ) Shortness of breath
( ) Asthma (date of last attack:_____)
( ) Bronchitis
( ) Pneumonia
( ) Blood in sputum

Gastrointestinal

( ) No problems
( ) Nausea/vomiting
( ) Blood in stool
( ) Ulcers
( ) Hepatitis
( ) Constipation
( ) Spastic colon
( ) Poor appetite/anorexia

Genitourinary

( ) No problems
( ) Bladder infections (cystitis)
( ) Kidney infections
( ) Pelvic Pain
( ) No problems

Musculoskeletal

( ) Unusual muscle weakness
( ) Decreased energy/stamina
( ) Rheumatoid Arthritis
( ) Lupus erythematosus (SLE)

Hematologic

( ) No problems
( ) Blood clotting disorder
( ) Sickle Cell Anemia or trait

Endocrine

( ) No problems
( ) Diabetes
( ) Hypoglycemia
( ) Thyroid disorder
( ) Excessive hair growth
( ) Breast Discharge
( ) Rapid weight gain
( ) Rapid weight loss

Skin

( ) No problems
( ) Rash
( ) Problems with skin pigmentation
( ) Acne

Are you suffering from any other conditions not mentioned above?

Yes No

If yes explain: _____

Do you wish to be screened for HIV (AIDS)? Yes No

Are you immune to Rubella (German Measles)? Yes No Don't know

Your Name:

Part B:

If the reason of your visit is related to Infertility or Recurrent pregnancy loss please fill part B and C

How long have you been trying to become pregnant?

_____

Number of pregnancies with your present husband/partner:_____

Number of living children from this marriage/relationship:_____

What cause of infertility has been diagnosed?

_____

Which of the following **tests** have been performed? (Check all that apply)

	DATES	***RESULTS***
BBT Body Temperature chart)		
Semen Analysis		
Post Coital Test		
Female Hormone Studies:		
Endometrial Biopsy		
Hysterosalpingogram (HSG) (x-ray of the womb and tubes)		
Laparoscopy / Hysteroscopy		
Other (Specify)		

-Are you or your spouse a health care worker, school teacher, or daycare worker?

(possible Cytomegalovirus or Parvovirus exposure) Yes No

-Do you or your spouse have cats as pets, take care of cats, or consume raw red meats in your diet? (possible Toxoplasmosis exposure) Yes No

-Do you want to be tested for Cystic fibrosis Yes No

Your Name:

Male partner Medical History:

Please complete the following information <u>about your partner</u> if available

Name: _____ Date of birth: _____ Age: _____
Home telephone number: (___)_____ Best time to reach: _____
Work telephone number: (___)_____ Best time to reach: _____
Occupation: _____
Race: _____ Religious Affiliation:
_____
Ethnic background (i.e., what countries did your mother's and father's ancestors come from?): _____

Current state of health: Excellent Good Fair Poor (**circle one**)

Chronic medical conditions (e.g., diabetes, epilepsy, hypertension, asthma etc:):
_____
_____

Any history of genital infection, trauma or surgery?
_____
____

Current medications:
_____
_____
_____

Allergies:_____

Any use of:
_____ Tobacco_____ Alcohol_____elicit drugs

Does your **<u>partner</u>** have any children from a previous relationship? ❒ Yes ❒ No.
If yes, give ages and gender:

Ages:	**Sex (male or female)**
1._____	_____
2._____	_____
3._____	_____
4._____	_____

Your Name:

Part C:

Genetics Screening Questionnaire

Were any of your children born with birth defects? Yes No (circle one)

If yes, state which delivery and describe the congenital defect:_____

_____

Family History (**of the couple**):

Have either of you or a family member ever seen a genetic counselor or medical geneticist before?

Yes No

If yes, where and for what reason? _____

Are the two of you related by blood? Yes No

Have either of you or any member of either family ever had:

	Female's Family	**Male's Family**
A child with mental retardation?	Yes No	Yes No
A child with Down syndrome or other chromosome problem?	Yes No	Yes No
Learning problems or developmental delay?	Yes No	Yes No
Cleft lip and/or palate?	Yes No	Yes No
Heart defect at birth?	Yes No	Yes No
Spina bifida (open spine), skull defect, or anencephaly?	Yes No	Yes No
Cystic fibrosis?	Yes No	Yes No
Muscle or neuromuscular disease (e.g., muscular dystrophy)?	Yes No	Yes No
Hemophilia?	Yes No	Yes No

Your Name:

Sickle cell anemia, thalassemia or other blood disorder?	Yes No	Yes No
Kidney disorder?	Yes No	Yes No
Huntington disease?	Yes No	Yes No
Three or more miscarriages?	Yes No	Yes No
A stillborn baby?	Yes No	Yes No
A child that died during infancy or childhood?	Yes No	Yes No
Psychiatric illness (e.g., schizophrenia, depression)?	Yes No	Yes No
Cancer at less than 50 years of age?	Yes No	Yes No
Heart disease at less than 50 years of age?	Yes No	Yes No
Infertility?	Yes No	Yes No
Any birth defect or genetic disease not listed above?	Yes No	Yes No

If you answered "Yes" to any of the above questions, please state how the affected individual is related to you and any known details about their condition:

Signature of female: _____ Date: _____

Signature of male: _____ Date: _____

Your Name:

Physician Notes:

Summary of H&P:

Summary of Physical Exam:

Assessment:

Plan:

Total visit time:	……min
Consulting time:	……min