Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

TANFORD HOSPITAL and CLINICS
STANFORD, CALIFORNIA 94305

CLINICS • SFRMC • NEW PRIMARY OVARIAN INSUFFICIENCY PATIENT QUESTIONNAIRE

Please answer the questions to the best of your ability. Leave blank any questions which are not applicable to you or if you do not know the answer. For example, fertility issues may be of concern for some women, but not for all women. If you are uncomfortable with any question, you may also leave it blank.

IDENTIFYING INFORMATION

Date of initial appointment: _____

Name: _____

Address: _____

Telephone Number: Day: _____ Evening: _____

Current Age: _____ Date of Birth: _____ Height: _____ Weight: _____

Ethnicity:
- ❑ American Indian or Alaska Native
- ❑ African American or Black
- ❑ Asian, please specify (e.g.: East Indian, Chinese, Vietnamese) _____
- ❑ Hispanic or Latino
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ White
- ❑ Decline to State
- ❑ Other _____

Partner's Name: _____ Partner's Date of Birth: _____

Partner's Ethnicity _____

Reason for consultation: _____

_____

EMPLOYMENT

Please describe all current employment including job title, description of responsibilities and duration of employment:

_____

_____

GYNECOLOGICAL/HORMONAL SYMPTOM HISTORY

How old were you when you had your first period (or state if you have never had a period)? _____

How frequently do your periods occur now if you are not on any form of hormones or birth control pills (Day one of one cycle to day one of the next cycle)? every _____ days.

Have your menses become irregular? ❑ Yes ❑ No

If yes, when did the menses first become irregular? _____

Please describe the irregularity (frequency of menses, amount of bleeding) _____

_____

How long do your periods last (number of days of bleeding)? _____

Have you ever been treated for irregular menses? ❑ Yes ❑ No

If so, what treatment have you received? _____

When did your last period start (either on your own or with treatment)? _____

Last "natural" menses? _____

Last menses with hormone treatment? _____

Please list years in which oral contraceptives were used (if ever) and indicate whether they were used for contraception or to regulate your menstrual cycle or both: _____

_____

What was the first date (if any) when you were told that there was a concern for low egg supply? _____

What test did the doctor use to make the assessment that your egg supply was low?

- ❑ FSH (please give value and date) _____
- ❑ Other (please specify) _____

Do you experience cramping with your period? ❑ Yes ❑ No

If yes, when during your cycle does the pain occur? (Check all that apply) ❑ Before ❑ During ❑ After

How would you describe the cramps? ❑ Mild ❑ Moderate ❑ Severe

Do you take pain medication for cramps? ❑ Yes ❑ No

What medication do you take for cramps? _____

Do you bleed or spot between periods? ❑ Yes ❑ No

If yes, please describe: _____

When was your last Pap smear? _____ Was it normal? ❑ Yes ❑ No

Have you ever had an abnormal Pap smear result? ❑ Yes ❑ No

If yes, what therapy was required?

❑ Repeat Pap smear ❑ Antibiotics ❑ Colposcopy (microscope evaluation) ❑ Biopsy
❑ Cryotherapy (freezing of cervix) ❑ Laser Therapy ❑ Cone biopsy ❑ Loop Excision (LEEP)
❑ Other _____

Have you ever had any of the following infections involving any part of the reproductive tract (vagina, cervix, uterus, fallopian tubes, ovaries)? Check all that apply:

❑ Yeast ❑ Chlamydia Trichomonas ❑ Gonorrhea ❑ Herpes ❑ Syphilis ❑ Genital Warts

Have you ever had a mammogram? ❑ Yes ❑ No

If yes, when? _____

Result? ❑ Normal ❑ Abnormal

Have you ever had a DEXA (bone density scan)? ❑ Yes ❑ No

If yes, when? _____

Result? _____

Have you ever had a cholesterol profile? ❑ Yes ❑ No

If yes, when? _____

Result? _____

How frequently do you and your partner have intercourse? _____ per week or _____ per month ❑ N/A

Do you have pain with intercourse? ❑ Never ❑ Sometimes ❑ Frequently ❑ Always ❑ N/A

Have you had a significant weight change in the last year? ❑ Yes ❑ No

If yes, please indicate: ❑ weight gain _____lbs ❑ weight loss _____lbs

Do you have any idea why your weight has changed? ❑ Yes ❑ No

If yes, why? _____

Have you experienced any of the following symptoms? Check all that apply:

- ❑ Hot flashes
- ❑ Night sweats
- ❑ Dry-eye symptoms
- ❑ Visual changes
- ❑ Decreased sex drive
- ❑ Vaginal dryness

- ❑ Difficulty sleeping
- ❑ Depression or other mood changes
- ❑ Autoimmune problem (e.g. thyroid, adrenal, lupus, joint problem/arthritis)
- ❑ Gastrointestinal problem
- ❑ Other _____

Please give additional detail about symptoms including when the symptoms started, their severity, and anything else you feel is important.

_____

_____

What treatments have you tried to deal with the symptoms you are having?

_____

OBSTETRICAL HISTORY

Have you ever been pregnant (including elective terminations, miscarriages, birth)? ❑ Yes ❑ No
If yes, please indicate:

Date	Outcomes	How long to conceive?	Infertility therapy?	Complications w/ pregnancy?	Was this conception with your current partner?
			❑ Yes ❑ No		
			❑ Yes ❑ No		
			❑ Yes ❑ No		
			❑ Yes ❑ No		

PAST MEDICAL HISTORY

Do you have or have you ever had (check all that apply):

- ❑ Acne
- ❑ Anemia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Autoimmune disease (e.g. Lupus, Rheumatoid Arthritis)
- ❑ Blood transfusion
- ❑ Breast (nipple) discharge
- ❑ Breast disease
- ❑ Breast tenderness
- ❑ Chicken pox
- ❑ Chronic bronchitis
- ❑ Chronic headaches
- ❑ Cancer? (Specify) _____
- ❑ Colitis
- ❑ Cystic fibrosis
- ❑ Color blindness
- ❑ Dizziness
- ❑ Endometriosis
- ❑ Gallbladder disease
- ❑ Gastrointestinal problems
- ❑ Hair loss
- ❑ Heat/cold intolerance
- ❑ Heart disease
- ❑ Hepatitis
- ❑ Hirsutism (excess hair growth)
- ❑ High blood pressure
- ❑ Hot flashes Immunizations
- ❑ Liver problems
- ❑ Loss of balance
- ❑ Diabetes
- ❑ Kidney problems
- ❑ Measles: German
- ❑ Measles: regular
- ❑ Neurological problems
- ❑ Poor sense of smell
- ❑ Pneumonia
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ Seizures
- ❑ Thyroid problems
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Vision problems

Immunizations

❑ Tetanus
❑ Polio
❑ Varicella (chicken pox)
❑ German Measles (Rubella)
❑ Tuberculosis
❑ Mumps
❑ Hepatitis B date(s)_____

Provide additional information for any problems that you identified:

_____

_____

REVIEW OF SYSTEMS

Do you presently have any problems or symptoms in the following areas? Check YES or NO below.

	Yes or No	Patient Comments:	Physician Comments:
Constitutional (good general health lately)	❑ Yes ❑ No		
Eyes	❑ Yes ❑ No		
Ears/Nose/Mouth/Throat	❑ Yes ❑ No		
Cardiovascular (heart/blood vessels/circulation)	❑ Yes ❑ No		
Respiratory (breathing difficulties)	❑ Yes ❑ No		
Gastrointestinal (stomach/intestines)	❑ Yes ❑ No		
Genitourinary (genitals/sexual function/kidney/bladder)	❑ Yes ❑ No		
Neurological (brain/nervous system)	❑ Yes ❑ No		
Integumentary (skin areas and/or breasts)	❑ Yes ❑ No		
Psychiatric (emotional/mood/memory)	❑ Yes ❑ No		
Musculoskeletal (bones/joints/muscles)	❑ Yes ❑ No		
Endocrine (hormones/metabolism/thyroid)	❑ Yes ❑ No		
Allergic/Immunologic (allergies/immune system)	❑ Yes ❑ No		
Hematologic/Lymphatic (blood or bleeding problems; lymph nodes or "swollen glands")	❑ Yes ❑ No		

If yes, please give explanation: _____

_____

_____

PAST SURGICAL HISTORY

Have you ever had any surgeries in the past? ❑ Yes ❑ No

If yes, please indicate:

Date	Type	Surgery Findings

MEDICATIONS

Are you currently taking hormone therapy? ❑ Yes ❑ No
If yes, please specify:

Medication	Form / Brand	Dose	Days / Month	When Began
Estrogen				
Progesterone				
Oral Contraceptive				

Are your currently taking any other prescription medications? ❑ Yes ❑ No
If yes, please list below:

_____

_____

Please list any hormone therapy you have taken in the past (including name of hormone, form (e.g. patch, pill), over what period of time you took this hormone, when you stopped this hormone and why:

_____

_____

What has been the most acceptable hormone therapy that you have taken (if any)? _____
Are you currently taking any over-the-counter medications? ❑ Yes ❑ No
If yes, please list below:

_____

_____

Are you taking any herbs or supplements or doing acupuncture? ❑ Yes ❑ No
If yes, please list below:

_____

_____

Are you allergic to any medications? ❑ Yes ❑ No
If yes, please indicate name of medication and type of reaction it causes:

_____

_____

SOCIAL HISTORY

Are you currently married or do you have a domestic partner? ❑ Yes ❑ No If yes, how long? _____
Have you previously been married? ❑ Yes ❑ No
Do you smoke? ❑ Yes ❑ No If yes, how many packs per day? _____
Have you smoked in the past? ❑ Yes ❑ No
How many packs per day? _____
For how many years? _____
When did you quit? _____

Do you drink alcohol? ❑ Yes ❑ No If yes, how many alcoholic beverages per week? _____

Have you ever used illicit (illegal) drugs? ❑ Yes ❑ No

If yes, please list _____

What drugs are you currently using if any? _____

Do you exercise regularly? ❑ Yes ❑ No

If yes, please indicate type of exercise and estimate hours/week spent in this activity.

Type of Exercise	Hours per Week

Do you follow a particular food diet? ❑ Yes ❑ No

❑ Vegetarian ❑ Diet plan name: _____ ❑ Other _____

What is your calcium intake per day? _____

Supplement (number of mg): _____

If yes, when did you begin taking? _____

Glasses of milk per day _____

Amount of cheese per day _____

Amount of yogurt per day _____

Other sources per day _____

Do you take a daily multivitamin? ❑ Yes ❑ No

Do you take a Vitamin D supplement (or Vitamin D with the calcium)? ❑ Yes ❑ No

FAMILY HISTORY

At what age did your mother experience menopause? _____

How old are your sisters? _____

At what age did your sister(s) experience menopause? _____

Do you have any aunts who have experienced early menopause? ❑ Yes ❑ No

What is your father's height? _____

What is your mother's height? _____

Has anyone if your immediate family had a history of infertility or difficulty conceiving? ❑ Yes ❑ No

If yes, please describe: _____

Have any of these illnesses occurred in your family? If yes, please indicate family members relationship to you.

	Relationship to you:		Relationship to you:
Alzheimer's disease		Hearing loss	
Amenorrhea (no periods)		Infertility/difficulty conceiving	
Autism		Irregular menses (before age 40)	
Autoimmune disease		Late 1st menstrual period (after age 16)	
Breast cancer		Learning disability	
Colon cancer		Menopause	
Lung cancer		Mental retardation	
Ovarian cancer		Migraines	
Prostate cancer		Multiple miscarriages	
Skin cancer		Neurologic disease	
Cancer, other		Obesity	
Consanguinity		Osteoporosis	
Diabetes		Parkinson's	
Endometriosis		Polycystic ovarian syndrome	
Fragile X associated tremor/ataxia syndrome		Premature menopause/Primary Ovarian Insufficiency	
Fragile X syndrome		Rheumatoid arthritis	
Fibroid tumor of uterus (myoma)		Stroke	
Gynecologic surgery		Thyroid problem	
Heart disease		Twin pregnancy	
High blood pressure		Other	
High cholesterol			

FERTILITY EVALUATION (if applicable)

Are you currently attempting to conceive? ❑ Yes ❑ No

Would you like to attempt to conceive in the future? ❑ Yes ❑ No

When was the last time that you used contraception

- ❑ Currently using
- ❑ Never used
- ❑ Last used in (year/date) _____

Do you have a current partner? ❑ Yes ❑ No

If you are trying to conceive with a heterosexual partner, how long have you and your partner been attempting to achieve pregnancy? _____

If you do not have a current heterosexual partner, how long have you tried to conceive in the past or with donor sperm? _____

Have you ever conceived a pregnancy with a different partner? ❑ Yes ❑ No
Have you been treated for infertility previously? ❑ Yes ❑ No
If yes, where/when? _____
Was the cause for infertility identified? _____
Which of the following tests have been performed?

❑ Basal body temperature
❑ Postcoital test
❑ Hormonal tests
❑ Thyroid test
❑ Infection test (Mycoplasma, Chlamydia)
❑ Endometrial biopsy
❑ Ultrasound
❑ Hysterosalpingogram (dye, x-ray test)
❑ Laparoscopy
❑ Hysteroscopy
❑ Sonohysterogram
❑ Antibody tests

Have you ever taken any of the medications listed below:

❑ Clomiphene Citrate (Clomid, Serophene)
❑ Injectable Gonadotropins (Bravelle, Menopur)
❑ Steroids (Medrol, Prednisone, Dexamethasone)
❑ Bromocriptine (Parlodel or Dostinex)
❑ Antibiotics
❑ Progestins (Provera, Cycrin)
❑ hCG (Pregnyl) Novarel
❑ Testosterone or "Male"hormone
❑ GnRH agonist (Lupron, synarel, Zoladex)
❑ Aspirin
❑ Danazol (Danocrine)
❑ Estrogens (Estrace, Estraderm, Vivelle, Luveris, Gonal-F, Follistim, Repronex)
❑ Progesterone (Suppositories, Injections, Crinone, Prometrium, Endometrin)

Have you ever had ovulation induction (medication to develop eggs) or intrauterine inseminations?
❑ Yes ❑ No

If you have had intrauterine insemination, the specimen was provided by: (check all that apply)
❑ Partner ❑ Donor

Date	Location	Medication Used	# of Follicles	IUI?	Pregnant?	Outcome
				❑ Yes ❑ No	❑ Yes ❑ No	
				❑ Yes ❑ No	❑ Yes ❑ No	
				❑ Yes ❑ No	❑ Yes ❑ No	
				❑ Yes ❑ No	❑ Yes ❑ No	

Have you ever attempted in vitro fertilization with your own eggs? ❑ Yes ❑ No
If yes, please specify below (if known)

Date	Location	# Vials/Units of med/day	# Egg Retrieved	ICSI?*	# Eggs Fertilized	# Embryos Transferred	Pregnancy?	Outcome
				❑ Yes ❑ No			❑ Yes ❑ No	
				❑ Yes ❑ No			❑ Yes ❑ No	
				❑ Yes ❑ No			❑ Yes ❑ No	
				❑ Yes ❑ No			❑ Yes ❑ No	

* Intracytoplasmic sperm injection

Have you ever attempted in vitro fertilization with donor eggs? ❑ Yes ❑ No
If yes, please specify below (if known)

Date	Location	Anonymous or known Donor	# Egg Retrieved	ICSI?*	# Eggs Fertilized	# Embryos Transferred	Pregnancy?	Outcome
				❑ Yes ❑ No			❑ Yes ❑ No	
				❑ Yes ❑ No			❑ Yes ❑ No	
				❑ Yes ❑ No			❑ Yes ❑ No	
				❑ Yes ❑ No			❑ Yes ❑ No	

* Intracytoplasmic sperm injection

Patient Signature **Print Name** **Date** **Time**

Person completing form is other than patient: _____ Relationship to patient: _____

Print Name **Signature** **Date** **Time**

Instructions to Attending Physician:
Your signature below indicates that you have reviewed the information contained in the entire questionnaire and that you have reviewed the pertinent or key finding(s) with the patient and/or family. Key finding(s) must be summarized in your progress note, however, the questionnaire should be referenced for additional details.

Date Time

Attending Physician Signature Print Name Pager Number