Patient Name

TANFORD HOSPITAL and CLINICS STANFORD, CALIFORNIA 94305



CLINICS • SFRMC • NEW PRIMARY OVARIAN INSUFFICIENCY
PATIENT QUESTIONNAIRE
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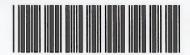
Addressograph or Label - Patient Name, Medical Record Number

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.

<u>IDENTIFYING</u>				
Date of initial a	appointment:			
Name:				
Address:				
Telephone Nui	mber: Day:	Evening	:	
Current Age:	Date of Birth:	Heig	ght:	Weight:
Ethnicity:	American Indian or A	Alaska Native / (e.g.: East Indian, Chine	African An	merican or Black
	☐ Hispanic or Latino	☐ Native Hawaiian or (Other Pacific I	Islander
		Decline to State		
Partner's Name	e:	Partner's [Date of Birth:	
Partner's Ethni	icity			
Reason for co	nsultation:			
		t including job title, descr	ription of resp	onsibilities and duration
Please described of employmen GYNECOLOG How old were	ICAL/HORMONAL SYM you when you had your	IPTOM HISTORY first period (or state if you	u have never l	had a period)?
Please described of employmen GYNECOLOG How old were How frequently	ICAL/HORMONAL SYM you when you had your y do your periods occur	IPTOM HISTORY first period (or state if you now if you are not on any	u have never l	had a period)?
Please describe of employmen GYNECOLOG How old were How frequently pills (Day one	ICAL/HORMONAL SYM you when you had your y do your periods occur of one cycle to day one	IPTOM HISTORY first period (or state if you now if you are not on any of the next cycle)? every	u have never l	had a period)?
Please described of employment of employment of employment of the	you when you had your y do your periods occur of one cycle to day one nses become irregular?	IPTOM HISTORY first period (or state if you now if you are not on any of the next cycle)? every Yes No	u have never l y form of horm days	had a period)?
Please described of employment of employment of employment of employment of employment of the employment of the employment of the employment of the employment of employment of employment of the employment of empl	it: ICAL/HORMONAL SYM you when you had your y do your periods occur of one cycle to day one nses become irregular? when did the menses firs	IPTOM HISTORY first period (or state if you now if you are not on any of the next cycle)? every	u have never l / form of horm days	had a period)? nones or birth control s.
GYNECOLOG How old were How frequently pills (Day one Have your mel If yes, w Please	it: ICAL/HORMONAL SYM you when you had your y do your periods occur of one cycle to day one nses become irregular? when did the menses firs describe the irregularity	IPTOM HISTORY first period (or state if you now if you are not on any of the next cycle)? every. Yes No t become irregular? (frequency of menses, amer of days of bleeding)?	u have never ly form of horm days	had a period)? nones or birth control s. ding)
GYNECOLOG How old were How frequently pills (Day one Have your me If yes, w Please How long do y Have you ever	you when you had your of one cycle to day one nses become irregular? when did the menses first describe the irregularity your periods last (number been treated for irregularity)	IPTOM HISTORY first period (or state if you now if you are not on any of the next cycle)? every Yes No t become irregular? (frequency of menses, and or of days of bleeding)?	u have never ly form of horm days	had a period)? nones or birth control s. ding)
GYNECOLOG How old were How frequently pills (Day one Have your men If yes, we Please of How long do your Have you ever	ical/Hormonal sym you when you had your y do your periods occur of one cycle to day one nses become irregular? when did the menses firs describe the irregularity your periods last (number been treated for irregular	first period (or state if you now if you are not on any of the next cycle)? every. Yes No t become irregular? (frequency of menses, amer of days of bleeding)?	u have never he form of horm days	had a period)? nones or birth control s. ding)
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GYNECOLOG How old were How frequently pills (Day one If yes, w Please How long do y Have you ever If so, what trea When did you Last "na Last me	you when you had your y do your periods occur of one cycle to day one nses become irregular? when did the menses first describe the irregularity your periods last (number been treated for irregular thanks at period start (either atural" menses?	first period (or state if you now if you are not on any of the next cycle)? every. Yes No t become irregular? (frequency of menses, amer of days of bleeding)?	u have never here form of horm days nount of bleed ment)?	had a period)?nones or birth control s. ding) whether they were

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Addressograph or Label - Patient Name, Medical Record Number 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 __ Do you have any idea why your weight has changed? Yes No 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

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Au	uressograph of Laber - Patient Na	ame, Medical Record Numbe	f		171116111	COLONIONNINE	Page 3 of
□ Depres□ Autoim	ty sleeping ssion or other mo imune problem (intestinal probler	e.g. thyroid, ac	drenal, lupus, jo	pint proble	m/arthrit	is)	
Please given and anyth	e additional deta ing else you feel	ail about symp	toms including	when the	symptor	ns started, their s	everity,
What treat	tments have you	tried to deal w	rith the sympto	ms you are	e having	?	
Have you	RICAL HISTORY ever been pregn ase indicate:		elective termin	ations, mis	carriage	es, birth)? 🔲 Yes	□ No
Date	Outcomes	How long to conceive?	Infertility therapy?	Complication pregnance		Was this concep your current par	
			Yes No				
			Yes No				
			☐ Yes ☐ No				
			Yes No				
PAST ME	DICAL HISTORY	<u>/</u>					
Do you ha	ive or have you e	ever had (chec	k all that apply):			
Acne		Dizzine			☐ Kid	ney problems	
Anemia		Endon	netriosis			asles: German	
☐ Append		A STATE OF THE PARTY OF THE PAR	adder disease		Measles: regular		
Arthritis			intestinal probl		Neurological problems		
Autoimmune disease (e.g. Lupus, Rheumatoid Arthritis)					Poor sense of smell		
Blood transfusion					Pneumonia		
☐ Breast (nipple) discharge ☐ Heat/cold intolerance				Rheumatic fever			
☐ Breast disease ☐ Heart disease ☐ Hepatitis				Scarlet fever			
				Seizures Thyroid problems			
☐ Chicken pox ☐ Hirsutism (excess hair growth ☐ Chronic bronchitis ☐ High blood pressure			i giowiii)	☐ Thyroid problems☐ Tuberculosis			
	headaches		shes Immuniza	tions	Ulc		
200	? (Specify)				- Contraction	on problems	
Colitis		Liver p	roblems		☐ ¥131	on problems	
☐ Cystic f	ibrosis		f balance				
☐ Color b	lindness	Diabet	es				

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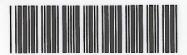


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Address	ograph of caber - Patient Name, N	Medical Record Number	FAI	IEMI GOESTIONNAII	Page 4 of 9		
☐ Tetanus☐ Polio				ubella)			
Provide addi	tional information	for any problems that y	ou identified:				
DEVIEW OF	01/077110						
Do you preso		obleme or eventome in	the following or				
Do you prose	critiy have any pro	oblems or symptoms in					
Constitutions	al (good general h	analth lotalui	Yes or No		Physician Comments		
Eyes	i (good general i	lealth lately)	Yes No				
Ears/Nose/M	outh/Throat		Yes No				
		essels/circulation)	Yes No				
	breathing difficult		Yes No				
	nal (stomach/inte		Yes No				
		function/kidney/bladder	Yes No				
	(brain/nervous sy						
	y (skin areas and		Yes No				
	emotional/mood/n		Yes No				
	etal (bones/joints/	3,	Yes No				
	ormones/metabo		Yes No				
		s/immune system)	Yes No				
Hematologic/	Lymphatic (blood	d or bleeding problems:					
lymph nodes	or "swollen gland	ds")	Yes No				
If yes, please	give explanation	•					
	CAL HISTORY	ion in the next D.V.					
If yes, please	indicate:	ies in the past? Yes	Ŭ No				
Date	Туре	Surgery Fin	dinge				
	Type	Surgery Fill	ungs				
	+						

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MEDICATIONS				
	aking hormone therapy	? 🔲 Yes 🔲 No		
If yes, please speci				
Medication	Form / Brand	Dose	Days / Month	When Began
Estrogen				
Progesterone				
Oral Contraceptive				
Are your currently t	aking any other prescrie list below:	iption medications?	Yes No	
	one therapy you have tand			
	most acceptable horm aking any over-the-cour elow:			· · · · · · · · · · · · · · · · · · ·
Are you taking any If yes, please list be	herbs or supplements elow:	or doing acupunct	ure? Yes No	
	any medications? 🔲 Y ate name of medication	ANY STATE OF THE S	on it causes:	
SOCIAL HISTORY Are you currently n				
Do you smoke? Have you smoked	narried or do you have by been married? Yes Yes No If yes, how in the past? Yes Sacks per day?	es 🔲 No w many packs per o 🕽 No	day?	
Do you smoke? Have you smoked How many p	ly been married? 🔲 Ye Yes 🔲 No If yes, how	es 🔲 No w many packs per o 🕽 No	day?	

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Do you drink alcohol? Yes No If y	yes, how many alcoholic beverages per week?	
Have you ever used illicit (illegal) drugs?	_	
If ves. please list	3 100 3 110	
What drugs are you currently using	g if any?	
Do you exercise regularly? Yes No		
If yes, please indicate type of exercise an	d estimate hours/week spent in this activity.	
Type of Exercise	Hours per Week	
Do you follow a particular food diet? Y	′es □ No	
	Other	
What is your calcium intake per day?	d otici	
Supplement (number of ma):		
If ves, when did you begin tak	king?	
Glasses of milk per day	g.	
Amount of cheese per day		
Amount of yogurt per day		
Other sources per day		
Do you take a daily multivitamin? Yes	□ No.	
	/itamin D with the calcium)?	
	res [No	
FAMILY HISTORY		
At what age did your mother experience n	nenopause?	
How old are your sisters?		
At what age did your sister(s) experience i	menopause?	
Do you have any aunts who have experier	nced early menopause? Tyes No	
What is your father's height?		
What is your mother's neight:		
Has anyone if your immediate family had a	a history of infertility or difficulty conceiving? Y	es 🗍 No
If yes, please describe:	, , , , , , , , , , , , , , , , , , , ,	

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

Relationship 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 Fragile X syndrome	Premature menopause/Primary Ovarian Insufficiency 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? You would you like to attempt to conceive in the fut the was the last time that you used contrace 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 heterobeen attempting to achieve pregnancy? If you do not have a current heterosexual past or with donor sperm?	ture? Yes No ption osexual partner, how long have you a	

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Yes

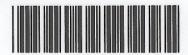
No Have you been treated for infertility previously? ☐ Yes ☐ No If yes, where/when? Was the cause for infertility identified? Which of the following tests have been performed? ☐ Basal body temperature ☐ Infection test (Mycoplasma, Chlamydia) Laparoscopy ☐ Postcoital test ■ Endometrial biopsy Hysteroscopy ☐ Hormonal tests ☐ Ultrasound ☐ Sonohysterogram ☐ Thyroid test Hysterosalpingogram (dye, x-ray test) ☐ Antibody tests Have you ever taken any of the medications listed below: ☐ Clomiphene Citrate (Clomid, Serophene) ☐ hCG (Pregnyl) Novarel ☐ Injectable Gonadotropins (Bravelle, Menopur) ☐ Testosterone or "Male"hormone ☐ Steroids (Medrol, Prednisone, Dexamethasone) ☐ GnRH agonist (Lupron, synarel, Zoladex) ☐ Bromocriptine (Parlodel or Dostinex) ☐ Aspirin ☐ Antibiotics □ Danazol (Danocrine) ☐ Progestins (Provera, Cycrin) ☐ 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 ☐ No ☐ Yes ☐ Yes ☐ No Have you ever attempted in vitro fertilization with your own eggs?

Yes
No If yes, please specify below (if known) # Vials/Units # Egg # Eggs # Embryos Date Pregnancy? Location ICSI?* Outcome of med/day Retrieved Fertilized Transferred 🔲 Yes 🔲 No 🗌 Yes 🔲 No Yes No Yes 🗌 No Yes No Yes No 🔲 Yes 🔲 No Yes 🗌 No

* Intracytoplasmic sperm injection

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		empted in viticity below (if		on with donor	eggs?	Yes 🔲 No		
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	
Persor	n completi	ng form is ot	her than p	patient:	Rel	ationship to	patient:	
Print N	lame		Signat	ture		Date	Tir	ne
Your si questic family. be refe	gnature be onnaire and Key finding	d that you hav g(s) must be s additional de	that you he reviewed summarize	ave reviewed to the pertinent of the per	or key fine	ding(s) with	the patient an	d/or
Date		Time						

Print Name

Attending Physician Signature