Gondra Center
for Reproductive Care & Advanced Gynecology

New Patient Questionnaire							
Patient Last, First Name:		DOB:		Age:		Date:	
Partner Last, First Name:		DOB:		Age:			

Jewish- Ashkenazi ☐ Jewish-Sephardic ☐ French Canadian ☐ Mediterranean ☐ Cajun ☐ Middle Eastern ☐
Latina/o ☐ African American ☐ American Indian ☐ Native Alaskan/American ☐ Asian ☐ Native Hawaiian ☐
White ☐ PLEASE check all that apply.

Occupation:			Emergency Contact:
Email:		Circle - Married or Single	Name
Home Phone #:		Cell phone #:	Telephone
Pharmacy Name:		Pharmacy Address:	

MEDICATIONS: *Please list any medications you take, including over-the-counter.*

Medicine	Dose	How often?	Medicine	Dose	How often?

REVIEW of SYSTEMS

Weight Increase ⇧ Decrease ⇩	Pelvic Pain Y ☐ N ☐	Irregular cycles Y ☐ N ☐
Abnormal vaginal bleeding Y ☐ N ☐	Bowel changes Y ☐ N ☐	Painful periods Y ☐ N ☐
Abnormal hair growth Y ☐ N ☐		
How long have you been having unprotected sexual intercourse______	How long have you been trying to conceive? _________	Have you ever had a problem conceiving with another partner? Y ☐ N ☐

MEDICAL /FAMILY HISTORY - Please check if you or a blood-relative have had any of the following:

	Myself	*Family*		*Myself*	*Family*		*Myself*	*Family*
Anemia	☐	☐	Mental illness	☐	☐	Liver disease	☐	☐
High Blood Pressure	☐	☐	Depression	☐	☐	Gall bladder	☐	☐
High Cholesterol	☐	☐	Anxiety	☐	☐	Blood clots	☐	☐
Heart Disease	☐	☐	Eating disorder	☐	☐	Blood transfusion	☐	☐
Stroke	☐	☐	Migraine headaches	☐	☐	Breast cancer	☐	☐
Diabetes	☐	☐	Urinary tract infection	☐	☐	Colon cancer	☐	☐
COPD/Emphysema	☐	☐	Lupus	☐	☐	Ovarian cancer	☐	☐
Asthma	☐	☐	Seizures	☐	☐	Other cancer, Specify:		
Thyroid problems	☐	☐	History of TB disease	☐	☐	Genetic Disease	☐	☐

ALLERGIES

If you have any allergies, please list and indicate reaction.

SURGICAL HISTORY

Please list and surgeries, including the year

HOSPITALIZATION HISTORY

Please list any hospitalizations, including year.

Prior Fertility Testing and SEXUAL HISTORY

Ultrasound Y ☐ **N** ☐	**Fertility Pills Y** ☐ **N** ☐
HSG (tubes tested) Y ☐ **N** ☐	**Fertility injections (IUI) Y** ☐ **N**
Surgery Y ☐ **N** ☐	**Insemination (IUI) Y** ☐ **N** ☐
Fertility Blood Work-up (Labs) Y ☐ **N** ☐	**In vitro fertilization (IVF) Y** ☐ **N** ☐

Is/Are your partners male ☐ female ☐ both ☐

PERSONAL/SOCIAL HISTORY	Y or N				
Do you use tobacco products?	☐ ☐	How much?			
Do you drink alcohol?	☐ ☐	How many per week?			
Do you drink caffeine?	☐ ☐	How much daily?			
Do you exercise?	☐ ☐	# Times/week:		Type:	
Do you use illicit drugs?	☐ ☐	Which drugs?			

Have you been a victim of physical, verbal, sexual or emotional abuse? **Y** ☐ **N** ☐

GYNECOLOGICAL HISTORY

Have you been vaccinated for Human Papilloma Virus? **Y** ☐ N ☐

Last Pap Smear:	Last Mammogram:	
Last Colonoscopy Year:	Cone / Leep / Cervical Procedures Year? _____	
Any personal history of:	Abnormal Pap Smear **Y** ☐ N ☐	Sexually Transmitted Diseases **Y** ☐ N ☐
Uterine Fibroids **Y** ☐ N ☐	Endometriosis **Y** ☐ N ☐	Infertility **Y** ☐ N ☐

MENSTRAUL HISTORY

First day of last period?	Age at first menstrual period?
How often do you get your menses?	Number of days that you bleed?

Describe the amount of menstrual flow (per day): Tampons _____ Pads_______

How many tampons or pads do you use on your heaviest day? Do you bleed after intercourse? **Y** ☐ N ☐

Do you bleed between your periods? **Y** ☐ N ☐ **Do you experience pain with your period? Y** ☐ N ☐

Do you have pain with bowel movements during your period? **Y** ☐ N ☐

OBSTETRICAL HISTORY

Number of: Pregnancies: Vaginal Birth: Living Children: C-Section(s):

Miscarriages: Ectopic: Abortions: