CENTER FOR HUMAN REPRODUCTION - CHR

21 East 69th Street, New York, N.Y., 10021 *Telephone: 212.994 4400; Fax: 212.994 4499*

PATIENT QUESTIONNAIRE

(Please complete entire questionnaire prior to initial consultation and e-mail to _____)

Name Female _____ Occupation _____

Name Male _____ Occupation _____

Appointment with CHR physician: ☐ **Norbert Gleicher, MD**
☐ **Vitaly Kushnir, MD**
☐ **David H. Barad, MD, MS**
☐ **Other: _____**

On ___ /___ /___

My permanent residence is in: _____

I am able to conduct a consultation in English ☐
I require translations services for _____ (language)

I was referred to CHR by: ☐ **former CHR patient**
☐ **my insurance**
☐ **my own research**
☐ **the Web**
☐ **a physician: _____ _____**
Name ***Phone***

I/We tried to conceive since ___ / ___ / ___
I/We never tried to conceive ☐
I/We have been in fertility treatment since ___ / ___ / ___
I/We never have been in fertility treatment before ☐
I/We have never started an IVF cycle ☐
I/We have started ____ IVF cycles before. Amongst those ____ have reached retrieval and ____ have reached embryo transfer.

I/WE WAS/WERE PREVIOUSLY ADVISED THAT MY PRINCIPAL INFERTILITY PROBLEM(s) IS/ARE:

_____

MY/OUR LAST TREATMENT RECOMMENDATION RECEIVED WAS:

_____

FEMALE HISTORY

PLEASE IGNORE THIS SECTION IN ABSENCE OF A FEMALE PARTNER

Please tell us

your birth date: ___ / ___ / ____; and age: ____ years;

your height in feet and inches: ____ feet ____ inches; or in cms: _____;

your weight in pounds: _____; or in kg: _____;

How often have you been pregnant?

Confirmed by ultrasound? _____

but miscarried: _____

before fetal heart: _____

after fetal heart: _____

Delivered a baby: ____

Any complications? _____

but had only a chemical pregnancy: _____

Some questions about your menstrual period:

How old were you at first menstrual period? _____ years;

How many days are between one menstrual period and the next? _____ days;

Is your menstrual pattern REGULAR ☐ or IRREGULAR ☐

When did your last menstrual period (LMP) start? ___ / ___ / ___;

Date of your last PAP smear: ___ / ___ / ___; NORMAL ☐ ABNORMAL ☐ NEVER ☐

Date of your last mammogram: ___ / ___ / ___; NORMAL ☐ ABNORMAL ☐ NEVER ☐

Have parents, grandparents or siblings of yours been diagnosed with:

Breast cancer? YES ☐ NO ☐; If YES, who? _____; What age? ___ years

Ovarian cancer? YES ☐ NO ☐; IF YES, who? _____; What age? ___ years

Have you ever had any of the following? **If YES, please explain:**

Surgeries: _____

Psych treatments: _____

Hospitalizations: _____

Any medical treatments for longer than 2 weeks: _____

Other medical conditions of significance: _____

Skin rashes: _____

Unexplained medical symptoms: _____

Environmental or food allergies: _____

Medication allergies: _____

Any evidence of neurologic problems: _____

COMMENTS: _____

Are you currently on any medications? **If YES, please list: _____**

_____

Are you up to date with your vaccinations schedule?

Influenza	**☐YES**	**☐NO**	**☐DON'T KNOW**
Tetanus, diphtheria, whooping cough	**☐YES**	**☐NO**	**☐DON'T KNOW**
Measles, Mumps, Rubella (MMR)	**☐YES**	**☐NO**	**☐DON'T KNOW**
Pneumococcus	**☐YES**	**☐NO**	**☐DON'T KNOW**
Hepatitis A	**☐YES**	**☐NO**	**☐DON'T KNOW**
Hepatitis B	**☐YES**	**☐NO**	**☐DON'T KNOW**
Meningococcus	**☐YES**	**☐NO**	**☐DON'T KNOW**

Are there medical or genetic problems in your family? **If YES, please explain:**

Your father: _____

Your mother: _____

Your siblings: _____

Others: _____

Where is your family from in the world?

Your father's family: _____

Your mother's family: _____

Do you consider yourself: **☐AFRICAN ☐ASIAN ☐CAUCASIAN ☐ Other: _____**

Is your ethnicity: **☐American Indian ☐ Arab ☐Black ☐ Chinese ☐Hispanic**
☐Indian (Asian) ☐Indonesian ☐Japanese ☐Jewish-Ashkenazi
☐Jewish Sephardic ☐Pakistani ☐Philippine ☐White
☐Other: _____

Tell us whether you

Smoke? ☐YES ☐NO ☐QUIT (when _____) If YES, how many? ____
Drink more than socially ☐YES ☐NO
Use illegal and/or prescription drugs? ☐YES ☐NO

are ☐single ☐have a boyfriend ☐are engaged ☐common law ☐married
☐in same-sex relationship

EXTRA COMMENTS:

MALE HISTORY

PLEASE IGNORE THIS SECTION IN ABSENCE OF A MALE PARTNER

Please tell us

your birth date: ___ / ___ / ____; and age: ____ years;

your height in feet and inches: ____ feet ____ inches; or in cms: _____;

your weight in pounds: _____; or in kg: _____;

Are you currently on any medications? **If YES, please list: _____**

Are you up to date with your vaccinations schedule?

Influenza	**☐YES**	**☐NO**	**☐DON'T KNOW**
Tetanus, diphtheria, whooping cough	**☐YES**	**☐NO**	**☐DON'T KNOW**
Measles, Mumps, Rubella (MMR)	**☐YES**	**☐NO**	**☐DON'T KNOW**
Pneumococcus	**☐YES**	**☐NO**	**☐DON'T KNOW**
Hepatitis A	**☐YES**	**☐NO**	**☐DON'T KNOW**
Hepatitis B	**☐YES**	**☐NO**	**☐DON'T KNOW**
Meningococcus	**☐YES**	**☐NO**	**☐DON'T KNOW**

Have you ever been hospitalized, significantly injured, had surgery, received a medical treatment for longer than 2 weeks, suffer from unexplained symptoms, have been

diagnosed with a disease (even if currently untreated), including psychiatric conditions? If YES, please explain in detail below:

Have you ever been told that your semen was abnormal? YES☐ NO☐

Have you ever consulted an Urologist for infertility? YES☐ NO☐

*If so what is the Urologist's name*_____

Have you ever suffered from sexual dysfunction? YES☐ NO☐

Are there medical or genetic problems in your family? **If YES, please explain:**
(A GENETIC PROBLEM IS DEFINED AS EITHER BIRTH OF A CHILD WITH BIRTH DEFECTS OR OCCURRENCE OF A DISEASE IN MORE THAN ONE GENERATION)

Your father: _____

Your mother: _____

Your siblings: _____

Others: _____

Where is your family from in the world?

Your father's family: _____

Your mother's family: _____

Do you consider yourself: **☐AFRICAN ☐ASIAN ☐CAUCASIAN ☐ Other: _____**

Is your ethnicity: **☐American Indian ☐ Arab ☐Black ☐ Chinese ☐Hispanic ☐Indian (Asian) ☐Indonesian ☐Japanese ☐Jewish-Ashkenazi ☐Jewish Sephardic ☐Pakistani ☐Philippine ☐White ☐Other: _____**

Tell us whether you

Smoke? ☐YES ☐NO ☐QUIT (when _____) If YES, how many? ____
Drink alcohol more than socially ☐YES ☐NO
Use illegal and/or prescription drugs? ☐YES ☐NO

EXTRA COMMENTS:

HISTORY OF FERTILITY TREATMENTS

What was your highest FSH ever measured? **_____ mIU/mL; When? ___ / ___ / ___**

What was your lowest AMH ever measured? **_____ ng/mL; When? ___ / ___ / ___/**

Do you have embryos or eggs frozen at another IVF center? **If YES, how many, and at which center?**

_____

PRIOR FRESH IVF CYCLE HISTORY

PLEASE LIST YOUR IVF CYCLE IN ORDER FROM 1 - X, AND TELL US FOR EACH CYCLE THE APPROXIMATE DATE STARTED, THE CENTER WHERE PERFORMED (IF POSSIBLE THE NAME OF TREATING PHYSICIAN), WHETHER THE CYCLE REACHED EGG RETRIEVAL, HOW MANY EGGS WERE OBTAINED, HOW MANY FERTILIZED, WHETHER YOU HAD AN EMBRYO TRANSFER, IF NOT, WHY NOT, HOW MANY EMBRYOS WERE TRANSFERRED, WHETHER AND HOW MANY EMBRYOS WERE CRYOPRESERVED, AND WHAT YOU WERE TOLD ABOUT THE QUALITY OF TRANSFERRED EMBRYOS. PLEASE DO NOT LIST HERE FROZEN-TAHAWED IVF CYCLES.

1st_____

2nd_____

3rd_____

4th_____

5th_____

6th_____

7th_____

8th_____

9th_____

10th_____

Did any of your IVF cycles result in freezing of embryos? **If YES, which cycles (refer to above cycle numbers), and list how many embryos were frozen in that cycle.**

_____

_____

Did any of your IVF cycles involve culturing your embryos to blastocyst stage (day-5)?
If YES, which cycles (refer to above cycle numbers)

_____

Did any of your IVF cycles involve the use of preimplantation genetic diagnosis or screening (PGD/PGS)? **If YES, which cycles (refer to above cycle numbers)**

_____

Were any of your IVF cycles accompanied by complications, hospitalizations or other unusual events? **If YES, please describe (and refer to above cycle numbers).**

_____

ADDITIONAL COMMENTS

Thank you for completing our questionnaire
The CHR

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