Reprosave
PRESERVING YOUR FUTURE FERTILITY

CLINICAL QUESTIONNAIRE

Please complete this questionnaire as accurately as possible. Feel free to keep a copy for your records. We very much look forward to your upcoming consultation.

Name of Female _____ DOB _____ Age _____

Telephone: (H) _____ (W)_____ (FAX) _____

(Cell)_____ Email Address_____

Address Street _____ City _____

State_____ Zip _____

Social Security Number: _____ Spouse_____

How were you referred to REPROSAVE.?

Friend ____ Relative ____ Seminar ____ Internet ____ Other _____

Physician: _____

Date of Consultation _____

OBSTETRICAL HISTORY

How long have you been trying to have a baby? _____ years

Have you ever been pregnant before? Yes _____ No _____

Date	Current/ Prior Partner	Live Birth (Y/N)	Miscarriage/ Abortion/ Ectopic	Wks	Fetal Heart (Y/N)	D&C (Y/N)	Mode of Delivery	Sex	Wt.	Complications/ Comments

GYNECOLOGIC HISTORY

When was the first day of your last period? _____

Are your periods regular? Yes _____ No _____

Age at first period? _____ #Days between periods? _____ #Days of bleeding? _____

Amount of bleeding: Light _____ Medium _____ Heavy _____

Have you ever needed medication to bring on your period? Yes _____ No _____

Pain with menstruation? Yes _____ No _____

Degree of pain: Mild _____ Moderate _____ Severe _____

Pain relieved by over the counter medications? Yes _____ No _____

Starts with the onset of bleeding? Yes _____ No _____

Begins a few days prior to the onset of bleeding? Yes _____ No _____

Persists more than 48 hours? Yes _____ No _____

Do you have pain with ovulation----------Yes_____ No_____

Do you experience pain with sexual intercourse? Yes _____ No _____

Pain is mostly on the exterior? Yes _____ No _____

Pain is mostly internal (deep penetration)? Yes _____ No _____

Do you experience painful ovulation? Yea _____ No _____

Are you experiencing a vaginal discharge? Yes _____ No _____

Associated with itching or burning? Yes _____ No _____

Associated with an unusual odor? Yes _____ No _____

Do you have a Gynecologist? Yes _____ No _____

When was you last Pap Smear? _____

Result? _____

Have you ever had an abnormal Pap Smear? Yes _____ No _____

If yes, what follow up was needed? _____

Have you ever had a Mammogram? Yes _____ No _____

Have you ever had a sexually transmitted disease?

(i.e. Chlamydia, Gonorrhea, Syphilis, Herpes) Yes _____ No _____

When? _____ Was it treated? Yes _____ No _____

Have you ever had Pelvic Inflammatory Disease (PID)? Yes _____ No _____

When? _____

Were you Hospitalized? Yes _____ No _____

Do you experience milk or discharge from your breasts? Yes _____ No _____

Have you ever used an IUD? Yes _____ No _____

Have you ever used the Oral Contraceptive Pill? Yes _____ No _____

How many years? _____

When did you last use it? _____

PREVIOUS SURGERIES

Have you ever had surgery?

Procedure	Date	Indication	Outcome

MEDICAL CONDITIONS

Do you have a history of any of the following conditions?

Condition	Yes/No	Comments
German measles (Rubella)		
Migraine		
Prolonged dizziness		
Glasses/ contact lenses		
Thyroid problems		
Pneumonia		
Tuberculosis		
Asthma		
Bronchitis		
Other lung conditions		
Heart attack		
Heart murmur		
Rheumatic fever		
Other heart conditions		
High blood pressure		
Gastric/duodenal ulcer		
Hepatitis		
Cirrhosis		

Intestinal bleeding		
Bleeding tendency		
Problems with anesthesia		
Diabetes		
Kidney stones		
Kidney infection		
Other kidney disorders		
Bladder infection		
Rheumatoid arthritis		
Other forms of arthritis		
Lupus erythematosis		
Paralysis		
Neurologic disorders		
Thrombophlebitis		
Varicose veins		
Breast tumor (benign)		
Breast Cancer		
Ovarian cancer		
Uterine cancer		
Other Cancer		
Other		

DRUG ALLERGIES

Are you allergic to any medications that you know of? Yes _____ No _____

Medication	Reaction

CURRENT MEDICATIONS

Are you currently taking any medications? Yes _____ No _____

Medication	Dose	Frequency

FAMILY HISTORY

Is there a history of any of the following conditions in the family?

Condition	Yes/ No	Comments
Diabetes		
Heart disease		
High blood pressure		
Kidney disease		
Multiple births		
Mental retardation		
Birth defects		
Inherited diseases		

Rheumatoid arthritis		
Thyroid disease		
Lupus erythematosis		
Blood disorders		
Breast cancer		
Ovarian cancer		
Uterine cancer		
Other cancer		
Sickle cell disease		
Cystic fibrosis		
Tay Sachs		
Thalassemia		
Other		

SOCIAL HISTORY

Occupation: _____

Do you use tobacco? Yes _____ No _____ #Packs/day _____
Do you use alcohol? Yes _____ No _____ #Drinks/wk _____
Are you currently married? Yes _____ No _____
How long? _____yrs
Have you been married before? Yes _____ No _____
Problems conceiving in that relationship? Yes _____ No _____
How frequently do you have intercourse? _____ per wk / mon
Do you use a lubricant? Yes _____ No _____

COMMENTS

Please describe the nature of your problem.

_____

_____

_____

_____

PREVIOUS INFERTILITY EVALUATION

Have you had or used any of the following tests or procedures?

Test/ Procedure	Date	Result
Blood Tests (Non immunologic)		
FSH (Cycle day 3)		
Estradiol (Cycle day 3)		
LH (Cycle day 3)		
Progesterone (7 days after ovulation)		
TSH		
Prolactin		
DHEAS		
Testosterone		

17 Hydroxy-Progesterone		
Blood type and Rh status		
Rubella		
HIV		
Hepatitis B surface antigen		
Hepatitis C antibody		
RPR/ VDRL (Syphilis)		
Blood tests (Immunologic)		
Antinuclear antibodies (ANA)		
Antiphospholipid antibodies (APA)		
Antipaternal leukocyte antibodies (APLA)		
Natural Killer (NK) cell assay		
Immunophenotype		
DQ Alpha		
Antithyrogobulin antibodies (ATA)		
Antimicrosomal antibodies (AMA, TPO)		
Antisperm antibodies		
IgA		
Cervical Cultures		
Chlamydia		
Gonorrhea		
Ureaplasma/ Mycoplasma		
Routine aerobic/ anaerobic		
General Assessment		
Pap smear		
Mammogram		
Physical exam		
Basal Body Temperature chart (BBT)		

Urine Ovulation predictor (LH kit)		
Post coital test (PCT)		
Endometrial biopsy		
Semen Analysis		
Pelvic Assessment	**Date**	**Result**
Pelvic exam		
Vaginal ultrasound		
Hysterosalpingogram (HSG) (Dye Test)		
Fluid ultrasound		
Hysteroscopy		
Laparoscopy		
Laparotomy		
Other		

PREVIOUS INFERTILITY TREATMENT

Have you ever used any of the following medications or treatments?

Medication	Date	Dose	# Cycles	Comment
Clomiphene Citrate (Oral)				
Perganol, Humagon, Repronex, Metrodin, Fertinex, Gonal F, Follistim (Injectable)				
HCG (Profasi)				
Progesterone				
Aspirin				
Heparin				
Prednisilone (Medrol)				

Prednisone				
Dexamethasone				
Intravenous Immunoglobulin (IVIG)				
Leukocyte Immunization Therapy (LIT)				
Treatment				
Timed Intercourse				
Intrauterine Insemination				
In Vitro Fertilization (IVF)				
Gamete Intrafallopian Tube Transfer (GIFT)				
Zygote Intrafallopian Tube Transfer (ZIFT)				
Ovum Donation (OD)				
Gestational Surrogacy (SUR)				
OD + SUR				
Other				

IF YOU HAVE UNDERGONE IVF, ANSWER THE FOLLOWING QUESTIONS:

GENERAL QUESTIONS:	**RESPONSE**
1. What date were the most recent cycle day three (CD-3) blood tests for FSH and plasma estradiol (E2) level and what were the respective values?	*Date:* *Values : FSH:____ U/ml* *E2 ____ pg/ml*
2. How many IVF cycles, using your own eggs vs. an egg donor have you undergone?	*Own eggs:* *Donor eggs:*

3. How many frozen embryo transfers (FETs) have you undergone?	
4. When did each cycle (using fresh or frozen embryos) take place?	*(Mo/Yr) 1._____ 2._____ 3._____ 4._____ 5._____ 6._____*
5. What were the outcomes in each case (negative pregnancy test; positive pregnancy test but no ultrasound confirmation of a gestational sac [i.e., chemical pregnancy]; ultrasound confirmation of a gestational sac [i.e., clinical pregnancy]; ectopic pregnancy; miscarriage; live birth or perinatal death)?	1. 2. *3.* *4.* 5. *6.*
6. Which were single and which were multiple pregnancies (when applicable)? (use the number in 5- above to designate The cycle concerned)	*1.* *2.* *3.* *4.* *5.* *6.*

QUESTIONS PERTAINING TO YOUR MOST RECENT FRESH IVF ATTEMPT	**RESPONSE**
1. When did you undergo your most recent IVF?	*(Month/Year)*
2. How many ampules of gonadotropins (e.g., Pergonal, Humegon; Folistim; Gonal F or Repronex) were injected on the 1st, 2nd and 3rd day of the cycle of treatment?	*Amps day 1_____* *Amps day 2_____* *Amps day 3_____*
3. Did you use your own eggs or that of an egg donor?	
4. Did you use a gestational surrogate?	
5. How many follicles were observed by ultrasound examination?	
6. What was the peak plasma E2 level on the day of HCG administration (whether given to you or to the ovum donor)?	
7. What was the thickness of the endometrial lining prior to egg retrieval?	*____mm*
8. For how many days were gonadotropins administered?	*____days*

9. What was the blood estradiol (E2) concentration on the day of HCG administration (ie;2 days prior to the egg retrieval)	_____*pg/ml*

10. Was GnRH agonist (e.g., lupron) started five (5) or more days before initiating gonadotropin therapy (i.e., the "long protocol") or less than three (3) days prior to gonadotropin administration (i.e., "flare protocol")?	
11. How many eggs were harvested?	
12. Was intracytoplasmic sperm injection (ICSI) used to fertilize the eggs?	
13. How many embryos were produced?	
14. Were embryos/blastocysts transferred three (3) days or (5) days following egg retrieval?	
15. How many fresh ,Day-3 embryos Vs Day-5 embryos (blastocysts) were transferred at ET?	
16. How many times had each transferred embryo divided (number of cells) at the time of ET? *	*1.___ 2.___* *3___ 4___* *5.___ 6.___*
17. What was the embryological assessment of the quality of each fresh embryo transferred (poor, average, or good)?	
18. What was the outcome of the IVF cycle (negative pregnancy test; positive pregnancy test but no ultrasound confirmation of a gestational sac (i.e., chemical pregnancy); ultrasound confirmation of a gestational sac (i.e., clinical pregnancy; ectopic pregnancy; healthy pregnancy, still ongoing; miscarriage; live birth or perinatal death)?	
19. If a clinical pregnancy occurred, was it a single pregnancy, twin pregnancy or a higher multiple than twins?	

*****Only applies to embryos transferred three (3) days following ET

Please continue with the questions on the next page (page #11)

Additional Questions:		
While some of the questions asked may not seem applicable to your individual situation or medical care, they have been included on the questionnaire to address a wide spectrum of issues related to reproductive health care. Thank you for your cooperation.	**Responses** **YES**	**NO**
1. Have you ever received intravenous pituitary derived human growth hormone?		
2. Have you received non-therapeutic injected drug use within the preceding five years?		
3. Have you ever had a blood transfusion?		
4. Have you been exposed in any capacity to infected blood in the last 12 months?		
5. Have you had any tattoos or body piercings within the last 6 months?		
6. Have you been bitten by an animal suspect of rabies within the last 6 months?		
7. Do you or have you had a sexual partner who takes injectable drugs?		
8. Have you engaged in prostitution at any time since 1977?		
9. Have you been sexually involved with anyone who has engaged in prostitution?		
10. Have you been sexually involved with anyone known to have a hepatitis infection?		
11. Have you had close contact with anyone with viral hepatitis in the last 12 months?		
12. Have you been sexually involved with anyone known to be HIV positive?		
13. Have you ever received intravenous Factor VIII or Factor IX concentrate which was not heat treated or otherwise virally inactivated?		

14. Have you ever had a blood transfusion?		
15. Have you ever been exposed to radiation or toxic chemicals such as lead, mercury and gold? If yes, please specify in the box on the right.		
16. Have you ever been arrested or been an inmate in a correctional facility for more than 72 consecutive hours within the preceding 12 months? If yes, please explain in the box provided on the right.		
17. Have you ever been rejected as a blood donor due to reasons of Infectious disease? If yes, please explain in the box provided on the right.		