

Center for Reproductive Medicine and Surgery

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www.reproductive-medicine.com

Your Name: _____

(please print first name, middle initial and last name)

Partner's Name: _____

(if applicable)

(please print first name, middle initial and last name)

Date of appointment with Dr. Mersol-Barg*: _____

*Please return this questionnaire as soon as possible so that Dr. Mersol-Barg can fully review your information in advance of your appointment.

Your Presenting Issue

(please check only one)

Fertility Related Not Fertility Related Both

Please check all that apply, below:

- | | |
|--|--|
| <input type="checkbox"/> General infertility | <input type="checkbox"/> Previous tubal sterilization |
| <input type="checkbox"/> Fallopian tube problem(s) | <input type="checkbox"/> Previous infertility therapy |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Previous in vitro fertilization therapy |
| <input type="checkbox"/> Fibroid tumors of the uterus | <input type="checkbox"/> Cervical stenosis |
| <input type="checkbox"/> Pelvic pain | <input type="checkbox"/> Abnormal uterine bleeding |
| <input type="checkbox"/> Previous ectopic pregnancy | <input type="checkbox"/> Never had a menstrual period |
| <input type="checkbox"/> Recurrent pregnancy loss | <input type="checkbox"/> No menstrual periods for at least 6 mos |
| <input type="checkbox"/> Previous baby, not pregnant since | <input type="checkbox"/> Irregular menstrual periods |
| <input type="checkbox"/> Genetic abnormality | <input type="checkbox"/> Menopause before age 40 |
| <input type="checkbox"/> Significant weight gain | <input type="checkbox"/> Menopause |
| <input type="checkbox"/> Polycystic Ovary Syndrome | <input type="checkbox"/> Previous vasectomy |
| <input type="checkbox"/> Excessive hair growth | <input type="checkbox"/> Sperm issue |

Your Demographic and Insurance Information

Identifying Information

Today's Date: _____

Your Name: _____

Date of Birth: _____ Social Security #: _____

Address: _____

Phone: Home: () _____ Work: () _____

May we contact you at work? Yes No

May we leave a message on your home answering machine? Yes No

Your insurance company: _____

Insurance policy #: _____ Insurance group #: _____
(if applicable)

Your employer: _____

Your occupation (title, brief description on line below):

Male Partner's Name: _____

(if applicable)

Date of Birth: _____ Social Security #: _____

Address: _____

(if different from above)

Phone: Home: () _____ Work: () _____

(if different from above)

May we contact you at work? Yes No

May we leave a message on your home answering machine? Yes No

Male partner's insurance company: _____

(if different from above)

Male partner's insurance policy #: _____ Insurance group #: _____

(if different from above)

(if applicable)

Male partner's employer: _____

Male partner's occupation (title, brief description on line below)

Relative or friend to notify in case of emergency (not living at your residence)

Name: _____ Relation: _____ Phone #:() _____

You were referred by:

Physician: _____ Self Other: _____
(please print Dr.'s full name) (please print name or group)

Your Primary Care Physician

Your Gynecologist

(if different from your primary care physician)

Dr.'s full name, please note if M.D. or D.O.

Dr.'s full name, please note if M.D. or D.O.

Dr.'s street address

Dr.'s street address

Dr.'s city, state and zip code
() _____

Dr.'s city, state and zip code
() _____

Dr.'s office phone number

Dr.'s office phone number

Your Medical History (please fill in everything that applies)

Current height: _____ Current weight: _____

Gynecologic and Pregnancy History

Duration of infertility (approximately): _____ years

If you have ever been pregnant, please answer the following starting with your first pregnancy:

End in elective abortion?	End in miscarriage?	Ectopic pregnancy?	Result of infertility therapy?	Is current partner the father?	Time to conceive? (# years or months)	When? (give year of pregnancy)	Live Birth? If yes, give month and year of birth
1) <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
2) <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
3) <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
4) <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
5) <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
6) <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
7) <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			

Date of the first day of your most recent menstrual period (first day of heavy flow): _____

Are your menstrual periods regular (once per month)? Yes No

If yes, what is the usual number of days from the 1st day of bleeding to the start of your next period (ex: 28 days)? _____

If no, approximately how many days/months are there between periods? _____

How many days do you bleed during your period (on average)? _____

What was your age when you had your first period? _____ years.

Date of your last pap smear: _____ Result of pap smear: Normal Abnormal

If abnormal, what type of treatment was given? _____

Any abnormalities, illnesses or treatments of your female reproductive organs? Yes No

If yes, please explain: _____

Has intercourse ever been painful or difficult for you? Yes No

If yes, is the pain or difficulty current? Yes No Was it only in the past? Yes No

How many times per week do you have sexual intercourse (approximately)? _____

Have you ever used lubricants for intercourse? Yes No. If yes, are you currently using them? Yes No If you have ever used lubricants, which one(s)? _____

Are there any sexual problems, past or present, you wish to discuss? Yes No

Previous contraception (Check any that apply):

- None IUD Birth control pills Diaphragm
 Condoms Tubal ligation Vasectomy Other _____

Sexually transmitted diseases (Check any that apply):

- None Chlamydia Gonorrhea Genital herpes
 Venereal warts PID (pelvic infection with pain) Other: _____

Pelvic Pain (Check any that apply):

- Before period During period After period
 Mild Moderate Severe Constant Intermittent
 Cramping Sharp Dull Aching Nausea
 Vomiting Fainting With intercourse When bowels move With urination

Does your pain spread to other areas of your body (ex: leg or back)? Yes No

If yes, where? _____

List anything that aggravates the pain? _____

List anything that relieves the pain? _____

Have you had a previous infertility evaluation? Yes No (Check and give details for all that apply):

Procedure/Test	Doctor/Hospital	Date	Results
<input type="checkbox"/> Temperature chart			
<input type="checkbox"/> Ovulation predictor kit			
<input type="checkbox"/> Post coital test			
<input type="checkbox"/> Hysterosalpingogram			
<input type="checkbox"/> Endometrial biopsy			
<input type="checkbox"/> Laparoscopy #1			
<input type="checkbox"/> Laparoscopy #2			
<input type="checkbox"/> Hysteroscopy			
<input type="checkbox"/> Laparotomy			
<input type="checkbox"/> Surgery for abnormal pap smear			
<input type="checkbox"/> Lab tests			
<input type="checkbox"/> Other: _____			

Have you had any previous infertility treatment? Yes No (Check and give details for all that apply):

Procedure/Treatment	Doctor/Hospital	Date	Number of cycles
<input type="checkbox"/> Clomid			
<input type="checkbox"/> Injectable medication Name of medicine: _____			
<input type="checkbox"/> Artificial insemination			
<input type="checkbox"/> In vitro fertilization			
<input type="checkbox"/> Other: _____			

Your Past Medical History

Allergy: None Latex Medications/reaction: _____

Are you immune to rubella (German measles)? Yes No Don't know

Surgeries unrelated to infertility (type/date): _____

Hospitalizations (reason/date): _____

Non-fertility medications (currently, specify): _____

Herbal supplements/remedies: _____

Tobacco smoking? Never Currently In the past

If you quit smoking, how many years did you smoke? _____ How many years ago did you stop smoking? _____

Substance abuse? Never Currently: how long? _____ Substance: _____

In the past: how long? _____ When did you quit? _____ Substance: _____

Exposure to toxic substances? Yes No. If yes, type: _____

Other: _____

Do you have or have you ever had the following medical problems (check all that apply)?

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Ovarian cysts | <input type="checkbox"/> Gall bladder disease | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Fibroid uterus | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Kidney abnormality |
| <input type="checkbox"/> Pituitary gland problem | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Colitis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Bone problems |
| <input type="checkbox"/> Hypoglycemia (low blood sugar) | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Psychological problems |
| <input type="checkbox"/> Acne in adult years | <input type="checkbox"/> Breast tumors | <input type="checkbox"/> Weight problem | <input type="checkbox"/> Nerve disorder |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Syphilis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Excess hair growth | <input type="checkbox"/> Mycoplasma | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Mumps | <input type="checkbox"/> Breast discharge | <input type="checkbox"/> Other: _____ |
| | <input type="checkbox"/> Genetic abnormality | <input type="checkbox"/> High cholesterol | |

Family History: Immediate family with any disorders listed above (list relationship & specific disorder):

Male Partner's History (please fill in all that apply)

Current height: _____ Current weight: _____

Any previous infertility evaluation? Yes No (Check and give details for all that apply):

Procedure/Test	Doctor/Hospital	Date	Results
<input type="checkbox"/> Semen analysis #1			
<input type="checkbox"/> Semen analysis #2			
<input type="checkbox"/> Semen analysis #3			
<input type="checkbox"/> Exam by urologist			
<input type="checkbox"/> Scrotal/prostate ultrasound			
<input type="checkbox"/> Sperm antibody test			
<input type="checkbox"/> Surgery			
<input type="checkbox"/> Lab tests			
<input type="checkbox"/> Other: _____			

Any previous infertility treatment? Yes No (Check and give details for all that apply):

Procedure/Treatment	Doctor/Hospital	Date	Number of cycles
<input type="checkbox"/> Clomid			
<input type="checkbox"/> Injectable medication Name of medicine: _____			
<input type="checkbox"/> Artificial insemination			
<input type="checkbox"/> In vitro fertilization			
<input type="checkbox"/> Other: _____			

Past Medical History

Allergy: None Latex Medications/reaction: _____

Surgeries unrelated to infertility (type/date): _____

Hospitalizations (reason/date): _____

Non-fertility medications (currently, specify): _____

Herbal supplements/remedies: _____

Tobacco smoking? Never Currently In the past

If you quit smoking, how many years did you smoke? _____ How many years ago did you stop smoking? _____

Substance abuse? Never Currently: how long? _____ Substance: _____

In the past: how long? _____ When did you quit? _____ Substance: _____

Exposure to toxic substances? Yes No. If yes, type: _____

Reproductive history: No children

Fathered a child: with current partner, number _____. with past partner, number _____.

Other: _____

Do you have or have you ever had the following medical problems (check all that apply)?

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Testicle/scrotum injury | <input type="checkbox"/> Gall bladder disease | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Minimal body hair | <input type="checkbox"/> Erectile dysfunction | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Genetic abnormality |
| <input type="checkbox"/> Pituitary gland problem | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Colitis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Bone problems |
| <input type="checkbox"/> Hypoglycemia (low blood sugar) | <input type="checkbox"/> Chlamydia | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Psychological problems |
| <input type="checkbox"/> Testicle/scrotum problems | <input type="checkbox"/> Genital herpes | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Nerve disorder |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Syphilis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Mycoplasma | <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Other: _____ |
| | <input type="checkbox"/> Mumps | <input type="checkbox"/> HIV | |

Family History: Immediate family with any disorders listed above (list relationship & specific disorder):
