

PLEASE COMPLETE & BRING TO YOUR 1<sup>st</sup> VISIT



Office Use: Patient Label

Center for Infertility & Reproductive Surgery
NEW PATIENT QUESTIONNAIRE

APPOINTMENT: \_\_\_\_\_ AM / PM PROVIDER: \_\_\_\_\_
Date Time

PATIENT:

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_ E-mail: \_\_\_\_\_

Preferred Name and/or Pronoun: \_\_\_\_\_ Cell number: \_\_\_\_\_

Primary Care Provider's Name & Location: \_\_\_\_\_

How did you hear about the Center for Infertility & Reproductive Surgery? \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

PARTNER: (if applicable)

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_ MRN: \_\_\_\_\_

Occupation: \_\_\_\_\_

Past medical history: \_\_\_\_\_

Past surgeries: \_\_\_\_\_

# of children in this relationship: \_\_\_\_\_ In other relationships: \_\_\_\_\_

Medications: \_\_\_\_\_

# alcoholic beverages per week: \_\_\_\_\_ Cigarettes per day: \_\_\_\_\_

REPRODUCTIVE HISTORY:

Please list all pregnancies in order with dates & outcomes (boy, girl, miscarriage, stillbirth) and specify if different partner(s) than present partner.

Blank lines for listing pregnancies with dates and outcomes.

Have you ever seen another physician for reproductive issues? Y / N

If yes, Physician's name, date and location: \_\_\_\_\_

First day of your last menstrual period: \_\_\_\_\_ Age at 1st menstrual period: \_\_\_\_\_

How often are your menstrual periods? \_\_\_\_\_ # Days of menstrual period: \_\_\_\_\_

How long have you been trying to become pregnant? \_\_\_\_\_

Have you ever experienced: (Please circle)

- Abdominal/pelvic pain with periods? Y / N Pain during sexual intercourse? Y / N
Abdominal/pelvic pain without periods? Y / N Bleeding/spotting between periods? Y / N
Discharge from breasts? Y / N Changes in scalp or body hair? Y / N
Significant change in weight? Y / N Change in weight in past year? Y / N

Problems with diet and/or nutrition? Y / N

Are there any problems with sexual performance (erectile dysfunction, low libido)? Y / N \_\_\_\_\_

Do you use personal lubricants? Y / N If yes, what do you use? \_\_\_\_\_

Have you used birth control? Y / N If yes, which types? \_\_\_\_\_

**DIAGNOSTIC TESTING:**

- Blood Tests:  FSH \_\_\_\_\_  Endometrial Biopsy: \_\_\_\_\_
- TSH \_\_\_\_\_  Hysterosalpingogram (HSG, Tubogram): \_\_\_\_\_
- Estradiol \_\_\_\_\_  Laparoscopic findings: \_\_\_\_\_
- Prolactin \_\_\_\_\_  Hysteroscopic findings: \_\_\_\_\_
- Progesterone \_\_\_\_\_  Semen Analysis: \_\_\_\_\_
- German Measles \_\_\_\_\_  Other: \_\_\_\_\_
- Chicken Pox \_\_\_\_\_

**PREVIOUS FERTILITY TREATMENT:** (Please check all that apply)

- Intrauterine Insemination (IUI)  Menopur, Repronex, etc.  Birth Control Pills  Assisted Hatching
- IUI + Clomid or Serophene  Lupron  Danazol  IVF
- IUI + Gonal-F, Follistim, Bravelle  Synarel  GIFT  ICSI

**PAST GYNECOLOGICAL HISTORY:**

Date of last pap smear: \_\_\_\_\_ Have you ever had an abnormal pap smear? Y / N

If yes, when and what treatment did you have? \_\_\_\_\_

Date of last mammogram: \_\_\_\_\_ Results: \_\_\_\_\_

Have you ever been diagnosed with a sexually transmitted disease (i.e. Herpes, Venereal Warts, Chlamydia, Gonorrhea, Syphilis, Hepatitis B, Hepatitis C, HIV)?  
Y / N \_\_\_\_\_

Have you ever had pelvic inflammatory disease? Y / N / Don't Know

Did your mother take DES while pregnant with you? Y / N / Don't Know

**PAST MEDICAL HISTORY:** (Please check all that apply and explain)

- Anemia \_\_\_\_\_  High Blood Pressure \_\_\_\_\_
- Anxiety \_\_\_\_\_  Jaundice/ Hepatitis \_\_\_\_\_
- Arthritis \_\_\_\_\_  Kidney problems \_\_\_\_\_
- Bowel problems (constipation, diarrhea, colitis, etc.) \_\_\_\_\_  Leaking of urine with coughing, sneezing, or stress \_\_\_\_\_
- Breast problems \_\_\_\_\_  Migraines \_\_\_\_\_
- Breathing problems/Asthma \_\_\_\_\_  Migraines with Visual changes \_\_\_\_\_
- Cancer \_\_\_\_\_  Neurological (brain) disorders \_\_\_\_\_
- Depression \_\_\_\_\_  Skin Disorders \_\_\_\_\_
- Diabetes \_\_\_\_\_  Stomach problems (hernia, ulcer, heartburn) \_\_\_\_\_
- Eating Disorder \_\_\_\_\_  Thyroid problems \_\_\_\_\_
- Headaches \_\_\_\_\_  Urinary tract infections (UTI) \_\_\_\_\_
- Heart Disease \_\_\_\_\_  Varicose veins \_\_\_\_\_
- \_\_\_\_\_  Other \_\_\_\_\_

**PAST SURGERIES & DATES:** [If Gynecologic Surgery please bring a copy of your Operative Note to your appointment]

\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES:** (Please list all known allergies (i.e. medications, latex) and your reactions) \_\_\_\_\_

**MEDICATIONS:** (Please list all medications you are currently taking, the dosage, and how many times a day you take each)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FAMILY MEDICAL HISTORY:** (please list age of family members and medical problems)

Mother: \_\_\_\_\_ Maternal Grandmother: \_\_\_\_\_  
\_\_\_\_\_  
Father: \_\_\_\_\_ Maternal Grandfather: \_\_\_\_\_  
\_\_\_\_\_  
Brothers: \_\_\_\_\_ Paternal Grandmother: \_\_\_\_\_  
\_\_\_\_\_  
Sisters: \_\_\_\_\_ Paternal Grandfather: \_\_\_\_\_  
\_\_\_\_\_

**HEALTH HABITS:**

Do you smoke? Y / N Have you ever smoked? Y / N If yes, how often? \_\_\_\_\_ # alcoholic beverages perweek: \_\_\_\_\_  
Do you or have you ever used recreational drugs? Y / N If yes, which drugs: \_\_\_\_\_

**SOCIAL HISTORY:**

Marital Status: \_\_\_\_\_ How long have you been with your current partner? \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Current and/or recent life stressors: \_\_\_\_\_

**PERSONAL SAFETY QUESTIONS:**

- Do you have a history of falls and/or have problems with your balance while walking? Y / N
- Do you understand how to prevent the spread of germs? Y / N
- Have you ever felt threatened or unsafe in a relationship? Y / N
- If you are having surgery or a procedure, do you understand how we will keep you safe? Y / N
- Do you currently feel safe at home? Y / N

**In order to provide you with optimal care it is important for us to understand all of the issues, physical and emotional, that you are facing. You will provide us, as part of your health care team, with written permission to access any notes written by any mental health providers you may have seen by signing this form. While you retain the right to revoke this consent at any time by informing us of such revocation, doing so may impact our ability to provide you with reproductive services.**

\_\_\_\_\_  
Patient Signature Date Time AM / PM

*All questions have been answered to the best of my ability. I understand this form will become part of my medical record.*

\_\_\_\_\_  
Patient Signature Date Time AM / PM

*I have reviewed the above information with the patient.*

\_\_\_\_\_  
Provider Signature CID # Date Time AM / PM

**Comments:**

\_\_\_\_\_  
\_\_\_\_\_

# BRIGHAM HEALTH



BRIGHAM AND  
WOMEN'S HOSPITAL

Department of Obstetrics and Gynecology  
Center for Infertility and Reproductive Surgery

## PATIENT/GUARANTOR STATEMENT

1. I acknowledge that it is my responsibility to understand my health plan coverage, in or out of network status, obligation to obtain the appropriate authorization and/or referral for my visit as well as pay applicable copays, deductibles and cost sharing associated with my health plan.
2. I acknowledge that it is my responsibility to ensure that the service I am about to receive is a benefit covered by my health insurance member agreement. If the service is not a covered benefit, I will be responsible for payment of these services and any bills accrued during/related to this stay/visit prior to the start of treatment.
3. I acknowledge that payment is required in advance of treatment.
4. I acknowledge that I am financially responsible for non covered expenses as well as expenses that will apply to my deductible by my health plan.
5. I acknowledge that any deposit, which has been required by the time of my admission/visit, is only an ESTIMATE.
6. I acknowledge that my ESTIMATE is based on the similar charges of other patients with like diagnosis, treatments and/or procedures.
7. I acknowledge that the ESTIMATE includes the fees for physicians and ancillary services rendered during the course of my hospital stay/visit. These services include but are not limited to, admitting physician, internist, anesthesiologists, surgeons, pathologist or radiologists.
8. I acknowledge that the bill I receive could be higher or lower than the ESTIMATE, depending on the services and treatments that I require. A refund or request for additional payment will be processed depending on your ESTIMATE.
9. I acknowledge that Brigham and Women's Hospital has reserved the right to apply any excess payment for this admission/visit toward any other open liabilities I may have. Either for other services rendered by the hospital, or the physician services rendered to me by the hospital's medical staff.
10. This waiver is good for one year from the date of signature.

PATIENT'S SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

WRITTEN NAME: \_\_\_\_\_

PATIENT'S MRN: \_\_\_\_\_

Department of Ambulatory Obstetrics and Gynecology  
75 Francis Street, Boston, Massachusetts 02115