BMH MEDICAL GROUP
a Department of Brattleboro Memorial Hospital

# FOUR SEASONS OB/GYN & MIDWIFERY
# INFERTILITY QUESTIONNAIRE

| | | |
|---|---|---|
| **Last Name:** | **First Name:** | **Middle Initial:** |

**Date of Birth:** **Gender Identity:** **Preferred Name:**

**Relationship status:** ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐Other

**Pronouns:** ☐ She/Her ☐ He/Him ☐ They/Them ☐ Other (Please list):

**Partner Name:** **Partner's DOB:**

**Is English your primary language?** ☐ Yes ☐ No If no, what is?

**Primary Care Provider:** **Practice Name:**

**Preferred Pharmacy:**

## CURRENT PRESCRIPTION AND OVER THE COUNTER MEDICATIONS

| Medication Name | Dosage | Doses/day | Reason you take this medication | Refill needed? |
|---|---|---|---|---|
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My signature acknowledges my understanding that the medical providers of BMH Medical Group are not obligated to prescribe any medications or any dosages of medications that they feel are not in my best interest.

**Signature** **Date**

## MEDICAL ALLERGIES
Include medications, latex, iodine

| Allergen Name | What type of allergic reaction do you have? |
|---|---|
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## INFERTILITY SCREENING

How long have you been trying to conceive?

Have you ever been evaluated for infertility? □ yes □ no

*If yes, when and where were the tests performed?*

| | | | |
|---|---|---|---|
| *If yes, what infertility tests were performed?* | □ ovulation tests | □ Hysterosalpingography (HSG) | □ Hormone testing |
| | □ ovarian reserve testing | □ Ultrasound | □ other |

| | |
|---|---|
| Have you undergone treatment for infertility? | □ yes □ no |
| *If yes, when and where were the tests performed?* | |
| *If yes, what treatment(s) were performed?* | □ IUI □ IVF □ Medication □ Other |

Do you have any financial concerns relating to infertility treatment? □ yes □ no

Are there specific questions or concerns you want answered at this visit?

## OBSTETRIC HISTORY

**BIRTHS**

| DATE | HOSPITAL | WEEKS | WEIGHT | SEX | OUTCOME (circle one) | COMPLICATIONS/COMMENTS ABOUT PREGNANCY OR DELIVERY |
|---|---|---|---|---|---|---|
| ***e.g: 1988*** | ***BMH*** | ***37*** | ***8lb, 2 oz*** | ***F*** | vaginal c-section | ***(i.e. shoulder dystocia, gestational diabetes, preeclampsia)*** |
| | | | | | vaginal c-section | |
| | | | | | vaginal c-section | |
| | | | | | vaginal c-section | |
| | | | | | vaginal c-section | |
| | | | | | vaginal c-section | |

**OTHERS**

| DATE | WEEKS | TYPE (check type and circle details) | | |
|---|---|---|---|---|
| | | □ **Miscarriage** (D&C Yes/No) | □ **Abortion** (D&C or Pills) | □ **Ectopic** (treatment: meds or surgery) |
| | | □ **Miscarriage** (D&C Yes/No) | □ **Abortion** (D&C or Pills) | □ **Ectopic** (treatment: meds or surgery) |
| | | □ **Miscarriage** (D&C Yes/No) | □ **Abortion** (D&C or Pills) | □ **Ectopic** (treatment: meds or surgery) |
| | | □ **Miscarriage** (D&C Yes/No) | □ **Abortion** (D&C or Pills) | □ **Ectopic** (treatment: meds or surgery) |

## GYNECOLOGIC HISTORY

| | |
|---|---|
| Number of partners in the past 12 months? | 5 or more lifetime sexual partners? □ Yes □ No |
| Age of first period: | Date of last menstrual period (day period started): |
| Frequency of menses: | |
| □ Regular/ monthly (every _____days, last for _____days) | |
| □ Irregular: explain: | |
| Change in menstrual bleeding patterns? □ Yes □ No | |
| Bleeding between periods? □ Yes □ No | |
| Bleeding after intercourse? □ Yes □ No | |
| How heavy are your periods? | |
| □ Normal, not heavy | |
| □ Moderately heavy but not concerning | # of pads/tampons/cups on the heaviest day: |
| □ Very heavy and concerning | # of pads/tampons/cups on the heaviest day: |
| How painful are your periods? | |
| □ None | □ Mild pain, over the counter meds work |
| □ Moderate | □ Severe pain, prescription meds, miss work/school |

Do you have any of the following problems or concerns:

□ Unusual vaginal odor □ unusual vaginal discharge □ DES exposure □ painful intercourse

□ leaking of fluid from the breasts □ heat or cold intolerance □ increased facial hair □ acne

□ unexplained weight loss □ unexplained weight gain □ fatigue □ weakness

Do you have any concerns about the following sexually transmitted diseases?

□ Chlamydia □ Gonorrhea □ Herpes □ Warts □ PID

Have you ever had an abnormal pap smear? □ Yes □ No *If yes, when:*_____

*If yes, how was it treated?*

History of sexual or physical abuse? □ Yes □ No

*Have you spoken to someone about this?* □ Yes □ No

**Contraception**

Please mark the what has been used in the past:

| | | | |
|---|---|---|---|
| □ | None (you do nothing to prevent pregnancy) | □ | Birth Control Pills/ Patch |
| □ | Cooper/Paragard IUD (insert date ) | □ | NuvaRing |
| □ | Hormonal IUD (insert date _____)<br>*Type*: Mirena Liletta Kyleena Skyla | □ | Withdrawal |
| □ | Nexplanon/Implant | □ | Tubal Sterilization<br>*Type:* |
| □ | Condoms | □ | Vasectomy: |
| □ | Depo-Provera | □ | Rhythm/ Natural Family Planning |
| □ | Other: | □ | Diaphragm |

**Family History**

Do any family members have any of the following:

| | | |
|---|---|---|
| □ High blood pressure | □ Heart attacks | □ High cholesterol |
| □ Diabetes | □ Thyroid disease | □ Bleeding problems |
| □ Birth defects | □ Down Syndrome | □ Sickle Cell disease |
| □ Breast Cancer | □ Ovarian Cancer | □ Colon Cancer |
| □ Hepatitis | □ Recurrent Pregnancy Loss | □ Other inherited diseases |

## MALE PARTNER HEALTH HISTORY*: IF APPLICABLE*

Previous pregnancy: □ Yes □ No

**CURRENT PARTNER PRESCRIPTION AND OVER THE COUNTER MEDICATIONS**

| Medication Name | Dosage | Doses/day | Reason you take this medication | Refill needed? |
|---|---|---|---|---|
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Medical History: *please check any health issues in the chart below*

| C | P | ***Cardiovascular*** | C | P | ***Cancer*** | C | P | ***Urinary*** |
|---|---|---|---|---|---|---|---|---|
| □ | □ | High blood pressure | □ | □ | Colon | □ | □ | Frequent UTIs |
| □ | □ | High cholesterol | □ | □ | Prostate | □ | □ | Kidney stones |
| □ | □ | Heart disease (CAD/MI) | □ | □ | Thyroid | □ | □ | Kidney infection |
| □ | □ | Deep vein thrombosis | □ | □ | Other: | □ | □ | Other: |
| □ | □ | Pulmonary embolism | | | ***Digestive/GI*** | □ | □ | ***Psychological*** |
| □ | □ | Anemia | □ | □ | Reflux/GERD | □ | □ | Depression |
| | | ***Endocrine*** | □ | □ | Crohn's/ulcerative colitis | □ | □ | Anxiety |
| □ | □ | *Hypo*thyroidism (low) | □ | □ | Liver disease/Hepatitis | □ | □ | ADHD |
| □ | □ | *Hyper*thyroidism (high) | □ | □ | Irritable bowel syndrome | | | Alcoholism |
| □ | □ | Diabetes □ Type 1 □ Type 2 | □ | □ | Gallbladder disease | □ | □ | Eating disorder |
| | | ***Musculoskeletal*** | □ | □ | Liver disease/Hepatitis | □ | □ | Substance use disorder |
| □ | □ | Arthritis | □ | □ | Ulcers | □ | □ | |
| □ | □ | Osteoporosis | □ | □ | Gallbladder disease | □ | □ | ***Other:*** |
| | | ***Respiratory*** | | | ***Neurological*** | □ | □ | |
| □ | □ | Asthma | □ | □ | Migraines (aura? □ yes □ no) | □ | □ | |
| □ | □ | COPD | □ | □ | Epilepsy | □ | □ | |
| | | | □ | □ | Multiple sclerosis | □ | □ | |

## PARTNER SURGICAL HISTORY

| DATE | HOSPITAL | SURGERY |
|---|---|---|
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I acknowledge that I have completed this form to the best of my ability. I realize that any information that I provide on this form will become part of my permanent medical record. I understand that any misrepresentations of my health history may result in an alteration of my current treatment plan, as deemed appropriate by my BMH Medical Group healthcare provider.

**Signature:** **Date:**

**Name (print):** **Relationship to Patient:**