

**PATIENT QUESTIONNAIRE**

**Division of Reproductive Endocrinology St. Luke's-Roosevelt Hospital Center**  
**Martin D. Keltz, M.D. Daniel E. Stein, M.D.**

This questionnaire provides your physician(s) with medical information which will help him to formulate an appropriate medical plan. The included information is part of your medical record and is confidential.

Full Name \_\_\_\_\_ Date \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_  
Address \_\_\_\_\_ Home Telephone ( ) \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work Telephone ( ) \_\_\_\_\_

Name of Spouse or Partner (if applicable) \_\_\_\_\_  
Telephone number of Spouse or Partner ( ) \_\_\_\_\_

Referring Physician: Full Name \_\_\_\_\_ Specialty \_\_\_\_\_  
Address \_\_\_\_\_ Telephone ( ) \_\_\_\_\_

Please describe the reason(s) for today's visit and any pertinent background information (including previous evaluations, medications used, previous physicians and any previous tests performed):

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

**OBSTETRICAL HISTORY** Total number of times you have been pregnant: \_\_\_\_\_

	Number	Dates (month/year)	Sex (M,F)	Vaginal/C-Section
Full Term Deliveries: (> 37 weeks)	_____	_____	_____	_____
		_____	_____	_____
Premature Deliveries: (< 37 weeks)	_____	_____	_____	_____
		_____	_____	_____
Miscarriages:	_____	# weeks pregnant _____	D&C done? (circle Y or N)	
Abortions:	_____	Stillborns _____	(Provide details below – e.g. cause(s))	
Ectopic Pregnancies	_____	(Provide details below – e.g. how it (they) were treated)		

Please list any complications with any of your pregnancies (including birth defects, stillborns, ectopic pregnancies):

\_\_\_\_\_  
Have you ever been advised by a previous physician to avoid pregnancy in the future? \_\_\_\_\_  
Have you ever been advised by a previous physician to avoid a vaginal delivery in the future? \_\_\_\_\_

**MENSTRUAL HISTORY** First day of Last Period: \_\_\_\_\_ Age of first period \_\_\_\_\_  
First day of Prior Period: \_\_\_\_\_ # of days you bleed: \_\_\_\_\_

Typical number of days from first day of bleeding in one cycle to first day of bleeding in next cycle: \_\_\_\_\_

Do you consider your periods Regular/Irregular? \_\_\_\_\_ Do you frequently miss periods? \_\_\_\_\_

Do you bleed: LIGHTLY \_\_\_\_ MODERATELY \_\_\_\_ HEAVILY \_\_\_\_ Do you pass clots? \_\_\_\_\_

Do you bleed between periods? \_\_\_\_\_ Are your periods painful? \_\_\_\_\_

Does the pain precede the period ? \_\_\_\_\_ Does the pain end when the period ends ? \_\_\_\_\_

**SEXUAL HISTORY** Are you involved in a sexual relationship? \_\_\_\_ Is your partner of a different sex or same sex? \_\_\_\_\_

If applicable, please list your frequency of intercourse. \_\_\_\_\_ times per week \_\_\_\_\_ times per month

Do you encounter pain, bleeding or other problems before, during or after intercourse? If yes, please describe:

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

**GYNECOLOGY HISTORY** List any forms of contraception you have ever used (type(s), duration of use)

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

Have you had abnormal pap smears in the past? \_\_\_\_\_ Date & result of last pap smear? \_\_\_\_\_

Have you had a colposcopy and/or biopsies performed on your cervix? \_\_\_\_\_

Have you ever experienced any breast discharge? (if yes, please describe): \_\_\_\_\_

Have you or have you ever been infected with any of the following?:

Pelvic Inflammatory Disease (PID) \_\_\_\_\_ Chlamydia \_\_\_\_\_  
Gonorrhea \_\_\_\_\_ Syphilis \_\_\_\_\_  
Hepatitis B or C \_\_\_\_\_ HIV \_\_\_\_\_

If you answered yes to any of the above, please state when you were diagnosed, how you were treated and if you were hospitalized:

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

Please List ALL surgeries you have had (include dates and hospitals where the operations occurred):

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

**MEDICAL HISTORY** Please list all serious illnesses you have ever suffered from (list dates of all hospitalizations):

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

Please list any and all medications you are presently taking (include doses if possible):

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

Please list and describe any allergies you have to medications:

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

Do you have any allergies to rubber or latex products? \_\_\_\_\_

Do you have any allergies to peanuts or sesame seeds or oils? \_\_\_\_\_

Have you ever had any of the following illnesses or been vaccinated for them?

- Rubella (German Measles) \_\_\_\_\_
- Measles \_\_\_\_\_
- Chicken Pox (Varicella) \_\_\_\_\_
- Hepatitis B \_\_\_\_\_

Do you smoke (if yes, how many cigarettes per day and for how many years)? \_\_\_\_\_

Do you drink alcohol (if yes, what kind, how much and how often)? \_\_\_\_\_

Do you use any recreational/illicit drugs (if yes, what kind, how much and how often)? \_\_\_\_\_

Current Height \_\_\_\_\_ Current Weight \_\_\_\_\_ Have you had recent weight gain or loss (please describe)?

\_\_\_\_\_

Do you exercise (what type, how often)? \_\_\_\_\_

Have you experienced significant: hair loss (scalp) \_\_\_\_\_ hair growth \_\_\_\_\_ thirst \_\_\_\_\_ urination \_\_\_\_\_

**PARTNER'S HISTORY** (all questions apply only to *male* partners)

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Number of children from this relationship \_\_\_\_\_ Number of children from another relationship \_\_\_\_\_

Has partner ever impregnated another woman (what was outcome)? \_\_\_\_\_

Has partner ever had any medical illnesses, neurological illnesses or sexually transmitted infections ( list in detail)?

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

Has partner had any surgical procedures? (Please describe)

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

Is partner on any medications? (Please list)

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

Has partner had a semen analysis performed? (If yes, provide date(s) and results):

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

Does partner have any difficulties with ejaculation or obtaining and erection? (please describe)

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

Has partner ever consulted with a urologist (who? when? for what reason?)

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

Has partner been recently (within 3 months) exposed to any of the following? (Please describe)

Excessive heat (e.g. ovens, hot tubs, high fevers) \_\_\_\_\_

Toxic chemicals (including chemotherapy) \_\_\_\_\_

Radiation \_\_\_\_\_

Cigarette Smoke \_\_\_\_\_

Alcohol \_\_\_\_\_

**FAMILY HISTORY**

List any of the following conditions which may have occurred in a sibling, child, parent, grandparent, parent’s sibling or first cousin:

	<b><u>Patient’s Family</u></b>	<b><u>Partner’s Family</u></b>
Birth defects	_____	_____
Recurrent miscarriages	_____	_____
Heart Disease	_____	_____
Diabetes	_____	_____
Infertility	_____	_____
Other	_____	_____

**Ob/Gyn Associates of SLR**  
**Division of Reproductive Endocrinology and Infertility**

Reproductive Endocrinology is a highly specialized field which requires extensive testing to achieve favorable results.

Many of the procedures which need to be performed are not routinely reimbursed by insurance coverage.

If you are covered by an HMO or PPO, your coverage will be verified by a staff member. I will inform the staff which procedures need to be performed so that preauthorization for those services can be requested. Many of the procedures which we may consider necessary may not be covered by your plan; therefore, you will be required to pay for such services. A bill will be provided to you so that payment can be made when the service is performed.

If you are covered by a commercial policy, your coverage will be verified by our staff. It is requested that payment be made at the time service is rendered. A receipt will be generated which you may use for insurance submission. We will gladly submit a claim for you, if you prefer.

Any exceptions to these guidelines must be arranged in advance of treatment.

We welcome the opportunity to participate in your care.

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I have read the terms outlined above, and I agree to assume all financial responsibility for procedures which are deemed necessary to my treatment and are performed by OB/GYN Associates of SLR.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date