

Reproductive Gynecology Inc.

Akron: 95 Arch St. Ste 250 Akron, OH 44304 P: (330-375-7722) F: (330-253-6708)
Columbus: 540 N. Cleveland Ave. Ste 100 Westerville, OH 43082 P: (614-895-3333) F: (614-895-3338)
Canton: 2600 W. Tuscarawas Ste 560 Canton, OH 44708 P: (330-452-6010) F: (330-454-8538)

Richard W. Moretuzzo, MD
Stephen B. Mooney, MD
Summer L. James, MD

David M. Nash, MD
Priya B. Maseelall, MD

RGI Patient Questionnaire

Date: _____

Patient Name _____
Last First Middle

Date of Birth _____ Age _____ Social Security # _____

Address _____
Street Apt. or POB#

City State Zip Code

Home Phone _____ Work Phone _____

Cell Phone _____ Pharmacy Name _____

Email _____ Pharmacy Phone _____

Partner Name _____
Last First Middle

Date of Birth _____ Age _____ Social Security # _____

Current Gynecologist _____ Office Phone _____

Primary Care Physician _____ Office Phone _____

*It is very important that you take the time to fill out the * questions accurately.*

MENSTRUAL HISTORY

	YES	NO
Age at first period _____ Date of last period _____		
Are your periods regular?	<input type="checkbox"/>	<input type="checkbox"/>
What is the usual number of days between periods? Minimum _____ Maximum _____		
What is the usual duration of your bleeding? Minimum _____ Maximum _____		
Do you have PMS?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe		
Do you have painful menses?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe		
Do you take pain medication for cramps?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify: _____		
Do you bleed or spot between periods?	<input type="checkbox"/>	<input type="checkbox"/>
If you've ever taken oral contraceptives, were your periods regular after stopping the pill? ..	<input type="checkbox"/>	<input type="checkbox"/>
Did your mother have any difficulty with contraception or pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>
Did your mother take diethylstilbestrol (DES) when she was pregnant with you?	<input type="checkbox"/>	<input type="checkbox"/>
At what age did your mother begin menopause? _____		
Is there a family history of infertility?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, who/ relationship: _____		
Is there a history of hormonal disorders in your family?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, who/ relationship/type: _____		
Is there a family history of birth defects?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, who/ relationship: _____		
Is there a family history of habitual pregnancy loss?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, who/ relationship: _____		
Have you ever used an intrauterine device (IUD)?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify type/# of years: _____		
Have you ever had a sexually transmitted disease (STD)?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, describe: _____		
Is intercourse painful?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe		
Do you use lubricants for intercourse?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, which brand: _____		
Do you douche before or after intercourse?	<input type="checkbox"/>	<input type="checkbox"/>

How many times per week do you and your partner have intercourse? _____

* How many months has it been since you discontinued methods of birth control? _____

* How many months have you been trying to get pregnant? _____

Have you used Basal Body Temperature (BBT)? YES NO

If yes, what day did you ovulate: _____

Have you used an Ovulation Predictor Kit (OPK)?

If yes, what day did you ovulate: _____

Do you take vitamins?

If yes, what kind and how much: _____

How many cups of coffee or caffeinated beverages do you drink each day? _____

Have you been exposed to any toxins?

If yes, what kind and how much: _____

Patient Ethnic Origin:

- White Non-Hispanic White Hispanic Black Non-Hispanic Black Hispanic
- Asian Non-Hispanic Asian Hispanic Native American
- Unknown/Other, please specify: _____

PREGNANCY DATA

* How many prior pre-term (< 37 weeks) births have you had? _____

* How many prior full-term (> 37 weeks) births have you had? _____

* How many pregnancies (including miscarriages) have you had? _____

* How many miscarriages have you had? _____

Please fill in chart below:

Pregnancy	Year	End in Abortion, Miscarriage or Ectopic Pregnancy?	Infertility therapy required to conceive?	How long to conceive? (months)	37 weeks or more?	Baby born alive?	Is current partner the father?
First							
Second							
Third							
Fourth							

Fifth							
-------	--	--	--	--	--	--	--

Additional Comments: _____

SURGICAL HISTORY

Have you ever been surgically sterilized? YES NO

How many operations have you had? _____

Date	Procedure	Hospital	Surgeon	Findings

MEDICAL HISTORY

Weight _____ Height _____ Blood Type (if known) _____

List the forms and frequency of regular, vigorous exercise (swimming, cycling, running), and age you began:

Exercise _____ Hrs/Week _____ Exercise _____ Hrs/Week _____

Have you lost more than 20 lbs. of weight in the last year? YES NO

Do you follow a particular food diet or have any specific dietary habits? YES NO

If yes, specify: _____

Have you ever had an eating disorder (anorexia or bulimia)? YES NO

If yes, specify: _____

Do you have any allergies to medications? YES NO

If yes, specify: _____

List any vaccinations you have received

Specify: _____

Do you or have you ever had (check **all** that apply):

- | | | |
|---|---|---|
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> Breast Tenderness |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Breast Soreness |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hirsutism (Excess Hair Growth) | <input type="checkbox"/> Breast Milky Discharge |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Neurologic problems |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Gallbladder Problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Pelvic Infection | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Visual Disturbances |

- | | | |
|---|---|--|
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Poor Sense of Smell |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> Colitis | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Measles: Regular | <input type="checkbox"/> Anemia | <input type="checkbox"/> Chronic Headaches |
| <input type="checkbox"/> Measles: German | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Blood Transfusions |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Parasitic Infection |
| <input type="checkbox"/> Nongonococcal Urethritis | <input type="checkbox"/> Ovarian Cysts | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Cervical Cancer | <input type="checkbox"/> Ovarian Cancer |
| <input type="checkbox"/> Vaginitis | <input type="checkbox"/> Other Cancer | <input type="checkbox"/> Allergies |
| Trichomoniasis or Yeast | Specify: _____ | Specify: _____ |
| # per year: _____ | | |

Within the last year, have you taken any prescription medications? Please note in the chart below.

Medication	Diagnosis	Dosage/Frequency	Duration

Are you taking any over-the-counter medications on a regular basis? Please note in the chart below.

Medication	Diagnosis	Dosage/Frequency	Duration

Do you or have you ever used (check **all** that apply):

- Alcohol – How many glasses per week do you usually drink? Wine ____ Beer ____ Cocktails ____
- Cigarettes – Number of packs per day _____ Number of years _____
- Illicit or Recreational Drugs (Marijuana, Cocaine, etc.) – If you would feel more comfortable not writing anything down, please discuss this directly with your physician. Specify:

HISTORY OF FERTILITY THERAPY

Have you been treated for infertility before? YES NO

If yes, who was your physician: _____

Address: _____

Diagnosed cause of infertility:

Have you taken any of the following medications? (Check **all** that apply)

- Thyroid medication (e.g. Synthroid) Bromocriptine (e.g. Parlodel)

Which of the following tests have you had performed? (Check **all** that apply and results if known)

- | | | | | |
|--|------|-------------|----------|-------|
| <input type="checkbox"/> Postcoital Test | Date | ___/___/___ | Results: | _____ |
| <input type="checkbox"/> Day3 FSH, Estradiol | Date | ___/___/___ | Results: | _____ |
| <input type="checkbox"/> Endometrial Biopsy | Date | ___/___/___ | Results: | _____ |
| <input type="checkbox"/> Hysterosalpingogram | Date | ___/___/___ | Results: | _____ |
| <input type="checkbox"/> Antisperm Antibodies | Date | ___/___/___ | Results: | _____ |
| <input type="checkbox"/> Laparoscopy | Date | ___/___/___ | Results: | _____ |
| <input type="checkbox"/> Hysteroscopy | Date | ___/___/___ | Results: | _____ |
| <input type="checkbox"/> Mycoplasma/Chlamydia Cultures | Date | ___/___/___ | Results: | _____ |
| <input type="checkbox"/> Thyroid Tests | Date | ___/___/___ | Results: | _____ |
| <input type="checkbox"/> Rubella | Date | ___/___/___ | Results: | _____ |
| <input type="checkbox"/> HIV | Date | ___/___/___ | Results: | _____ |
| <input type="checkbox"/> PAP Smear | Date | ___/___/___ | Results: | _____ |
| <input type="checkbox"/> Mammogram | Date | ___/___/___ | Results: | _____ |
| <input type="checkbox"/> Sickle Cell | Date | ___/___/___ | Results: | _____ |
| <input type="checkbox"/> Tay Sachs | Date | ___/___/___ | Results: | _____ |
| Other – Specify: _____ | Date | ___/___/___ | Results: | _____ |

INFERTILITY CYCLE HISTORY

Clomiphene Citrate

Dates	# of Cycles	Max Starting Dose	Max Follicles	# with Insemination	# of Cycles Resulting in Pregnancy

* Number of prior Gonadotropin Cycles: _____

Gonadotropin (Follistim, Gonal-F, etc.)

Dates	# of Cycles	Max Starting Dose	Max Estradiol	Max Follicles	# with Insemination	# of Cycles Resulting in Pregnancy

--	--	--	--	--	--	--

* Number of prior Fresh ART (IVF) Cycles: _____

* Number of prior Frozen ART (IVF) Cycles: _____

IVF History

	Cycle 1		Cycle 2		Cycle 3		Cycle 4		Cycle 5		Cycle 6	
Date												
IVF Center												
Frozen Embryo Cycle	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 <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Max Start Dose												
Max Estradiol												
# Eggs Retrieved												
# Eggs Fertilized												
ICSI?	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 <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
# Embryos Transferred												
Embryo Age (day 2, 3 or 5)												
Pregnancy?	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 <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Delivered?	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 <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>

Family History (indicate Relation to You for all that apply)

Disorder	Relation to You	Disorder	Relation to You
Breast Cancer		Fanconi Anemia	
Ovarian Cancer		Familial Dysautonia	
Colon Cancer		Muscular Dystrophy	
Diabetes		Neurologic (brain/spine)	
Thyroid Problems		Neural Tube Defects	
Heart Disease		Dwarfism	
Blood Clots		Developmental Delay	
Obesity		Learning Problems	
Psychiatric Problems		Polycystic Kidney Disease	
Tuberculosis		Heart defect from birth	
Endometriosis		Down Syndrome	
Infertility		Other chromosome defects	
Menopause before 40		Marfan syndrome	
Birth Defects		Hemophilia	
Cystic Fibrosis		Sickle Cell Anemia	
Tay-Sachs Disease		Thalassemia	
Canavan Disease		Galactosemia	
Bloom Syndrome		Deafness/Blindness	

Gauchers Disease		Color Blindness	
Niemann-Pick Disease		Hemochromatosis	

Other (specify) _____

Review of Systems

(Please indicate any conditions below that apply to you)

General

- Recent weight gain or loss
- Anorexia/Bulimia
- Lack of Energy
- Fever/Chills
- Other: _____
- None

Endocrine/Hormonal

- Diabetes Hair Loss
- Thyroid gland problems
- Rapid weight loss or gain
- Excessive hunger/thirst
- Temperature Intolerance – feeling hot or cold
- Other: _____
- None

Genito-Urinary

- Bladder infections
- Kidney Infections
- Vaginal infections
- Frequent urination Leaking urine
- Blood in urine
- Herpes
- Other: _____
- None

Musculoskeletal

- Unusual muscle weakness
- Decreased energy/stamina
- Rheumatoid Arthritis
- Lupus Erythematosus
- Myasthenia gravis
- Other: _____
- None

Mental Health Problems

- Depression
- Anxiety disorder
- Schizophrenia
- Other: _____
- None

Head, Eyes, Ears, Nose, Throat

- Dizziness Loss of smell
- Headaches Blurred Vision
- Blurred Vision Hearing Loss
- Chronic Nasal Congestion
- Other: _____
- None

Breasts

- Discharge (clear__ bloody__ milky__)
- Lumps Pain Cancer
- Abnormal Mammogram
- Reduction
- Augmentation/Breast Implants (saline? ___ silicone? ___)
- Other: _____
- None

Gastrointestinal

- Nausea/Vomiting Ulcers
- Hepatitis Diarrhea
- Blood in stools Constipation
- Irritable Bowel Syndrome
- Change in bowel habits
- Colitis (ulcerative or Crohn's)
- Other: _____
- None

Hematologic

- Blood clotting disorder/Blood clot
- Sickle cell Anemia Thrombophlebitis
- Blood transfusions (dates/reasons _____)
- Easy Bruising
- Swollen glands/lymph nodes
- Other: _____
- None

Respiratory

- Shortness of breath
- Asthma Bronchitis
- Pneumonia Tuberculosis
- Bloody cough
- Other: _____
- None

Neurological Problems

- Weakness/Loss of balance
- Seizures/Epilepsy
- Headaches
- Migraine headaches
- Numbness Memory Loss
- Other: _____
- None

Skin/Extremities

- Unexplained rash/inflammation
- Acne
- Skin Cancer
- Burn Injury
- Moles changing in appearance
- Excess hair growth
- Other: _____
- None

Cardiovascular

- Palpitations/Skipped beats
- Chest pain Heart Attack
- Stroke Murmurs
- High Blood Pressure
- Rheumatic fever
- Mitral valve prolapsed (Need antibiotics before dental procedures? Yes__ No__)
- Other: _____
- None

MALE DATA, if applicable

Name: _____
First Last

Marriage #: _____

Pregnancies Conceived with a Previous Partner

Number of pregnancies conceived with current partner: _____

Number of pregnancies conceived with previous partners: _____

Date of Pregnancy	Pregnancy Outcome		
	Delivered	Aborted	Miscarried

Urologist: _____ Phone: _____

Address: _____

Male Ethnic Origin:

- White Non-Hispanic
 White Hispanic
 Black Non-Hispanic
 Black Hispanic
 Asian Non-Hispanic
 Asian Hispanic
 Native American
 Unknown/Other, please specify: _____

Have you ever had a semen analysis (sperm count) performed? YES NO

Date of Semen Analysis	Location of Analysis	Count (Million/ml)	Motility	Grade	Morphology

Do you have any medical problems unrelated to your fertility?

Nature of Problem (Diagnosis)	Treatment	Physician

MALE SURGICAL HISTORY

Have you ever had surgery? If yes, please specify:

Date	Hospital	Procedure	Findings	Surgeon

Do you take any medications? If yes, please specify:

Medication	Diagnosis	Dosage/Frequency	Duration

Do you or have you ever used (check **all** that apply):

- Alcohol – How many glasses per week do you usually drink? Wine ____ Beer ____ Cocktails ____
- Cigarettes – Number of packs per day _____ Number of years _____
- Illicit or Recreational Drugs (Marijuana, Cocaine, etc.) – If you would feel more comfortable not writing anything down, please discuss this directly with your physician. Specify:

Do you or have you ever had any difficulties with (check **all** that apply):

- Erection If yes, please explain:

- Ejaculation If yes, please explain:

- | | YES | NO |
|---|--------------------------|--------------------------|
| Have your genitals ever been exposed to excessive heat? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any serious injuries to your genitals? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any infections of your penis, testicles or prostate gland? | <input type="checkbox"/> | <input type="checkbox"/> |
| Is there any history of birth defects in your family? | <input type="checkbox"/> | <input type="checkbox"/> |
| Is there any history of recurrent miscarriage in your family? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have any allergies to medications? | <input type="checkbox"/> | <input type="checkbox"/> |

If yes, specify: _____

