NEW PATIENT INTAKE FORM

Welcome to Mount Sinai Fertility!

This questionnaire should be completed prior to the initial consultation and will help us get to know you better. Please complete the form to the best of your ability. There may be some parts of the form which are not relevant to you. Each person who will be involved in this process should complete a separate form.

Date: _____

CONTACT INFORMATION

First Name: _____ Middle Name: _____ Last Name: _____

Preferred Name: ○ Same as above ○ _____

Preferred Pronoun: ○ She ○ He ○ They ○ Other: _____

Birth Date (MM/DD/YY): _____ Age: _____ Occupation: _____

Relationship Status: _____ Ethnicity: _____

Gender: ○ Female ○ Intersex ○ Male ○ Trans- Female to Male ○ Trans- Male to Female ○ Other: _____

Sexual Orientation: ○ Bisexual ○ Gay ○ Heterosexual -"Straight" ○ Lesbian ○ Queer ○ Two-Spirit
○ Other: _____

Street Address: _____

City: _____ Prov: _____ Postal Code: _____ Country: _____

Phone number (where we can leave a confidential voicemail message): _____

Email address: _____

PARTNER INFORMATION (if applicable)- Your Partner should also complete a separate New Patient Intake Form.

First Name: _____Middle Name: _____ Last Name: _____

Preferred Name: ○ Same as above ○ _____ Birth Date (MM/DD/YY): _____

Phone number (where we can leave a confidential voicemail message): _____

Email address: _____

NEW PATIENT INTAKE FORM

PHYSICIAN INFORMATION

Referring physician

Name: _____ Phone: _____ Fax: _____

Family physician ☐ same as referring physician

Name: _____ Phone: _____ Fax: _____

Specialist (ex. gynaecologist, urologist, psychiatrist) ☐ same as referring physician

Name: _____ Phone: _____ Fax: _____

Specialty: _____ Date of last visit: _____

Specialist (ex. gynaecologist, urologist, psychiatrist) ☐ same as referring physician

Name: _____ Phone: _____ Fax: _____

Specialty: _____ Date of last visit: _____

REASON FOR VISIT (check all that apply)

☐ Infertility ☐ Recurrent Pregnancy Loss ☐ Egg Freezing ☐ Donor Sperm

☐ Gestational Carrier ☐ Preimplantation Genetic Testing ☐ Embryo Freezing ☐ Donor Egg

☐ Other (please describe):_____

_____

Questions you would like answered at this visit:

_____

_____

Do you have benefits that cover fertility medications? ◯ Y ◯ N ◯ Not sure

For more information about the medications used at our clinic, including DIN numbers, please go to http://mountsinaifertility.com/patient-resources/medications/

NEW PATIENT INTAKE FORM

MEDICAL HISTORY

Past or current medical problems or treatments: ☐ None

_____

_____

Past or current mental health concerns: ☐ None

_____

_____

Past surgeries or procedures: ☐ None

_____

_____

Have you ever had problems with anesthesia / sedation? ◯ N ◯ Y – Please explain:

_____

_____

Allergies to medications: ◯ None ◯ _____

Allergies to foods: ◯ None ◯ _____

Current medications (including non-prescription): ☐ None

_____

_____

Current supplements, vitamins, herbal remedies etc.: ☐ None

_____

_____

Do you smoke cigarettes? ◯ N ◯ Y – How many per day? _____ How many years? _____

◯ Quit - When? _____

Do you use e-cigarettes? ◯ N ◯ Y – How many per day? _____ How many years? _____

Do you smoke marijuana? ◯ N ◯ Y – How often? _____ How many years? _____

Do you drink alcohol? ◯ N ◯ Y – How many drinks per week? _____

Do you use cocaine, heroin or other drugs? ◯ N ◯ Y – Please describe: _____

How many caffeinated beverages to you drink per day? _____

NEW PATIENT INTAKE FORM

FERTILITY HISTORY

Have you been trying to become pregnant? ◯N ◯Y – for how long? _____

Have you ever tried to get pregnant in a previous relationship? ◯N ◯Y – for how long? _____

Have you ever seen fertility specialist(s) in the past? ◯N ◯Y – Name(s)? _____

Have you ever had fertility treatment in the past? ◯N ◯Y

Oral medication and timed intercourse: ◯N ◯Y – # of cycles? _____

Oral medication and insemination: ◯N ◯Y – # of cycles? _____

Daily injectable medication & insemination: ◯N ◯Y – # of cycles? _____

In vitro fertilization (IVF): ◯N ◯Y – # of fresh cycles? _____ Frozen cycles? _____

Other: _____

SEXUAL HISTORY

Are you currently sexually active? ◯N ◯Y – with: ◯Men ◯Women ◯Both

How many times do you have intercourse per week? _____ Do you use lubricants? ◯N ◯Y

Do you have pain with intercourse? ◯N/A ◯Never ◯Rarely ◯Sometimes ◯Always

Do you struggle with any of the following? (check all that apply)

☐ Sexual desire (libido) ☐ Sexual arousal ☐ Orgasm ☐ Other: _____

Do you have difficulty with erections? ◯N/A ◯N ◯Y

Do you have difficulty with ejaculation? ◯N/A ◯N ◯Y

Have you had any of the following infections? (check all that apply) ☐ None

☐ Chlamydia ☐ Herpes ☐ Syphilis ☐ HIV / AIDS

☐ Gonorrhea ☐ HPV / Genital Warts ☐ Hepatitis

PREGNANCY HISTORY (Please complete your pregnancy history in this and previous relationships)

Number of: Total Pregnancies: _____ Miscarriages: _____

Tubal / ectopic pregnancies _____ Abortions: _____

Full Term Deliveries: _____ Preterm deliveries: _____

Date of Delivery / End of Pregnancy	Outcome / Complications	Months to Conceive	Treatment used to Conceive	Current Partner
				◯Y ◯N
				◯Y ◯N
				◯Y ◯N
				◯Y ◯N
				◯Y ◯N
				◯Y ◯N

NEW PATIENT INTAKE FORM

MENSTRUAL / GYNECOLOGIC HISTORY ☐ Not applicable

Number of days between the start of one menstrual period and the start of the next one: _____

Number of days of bleeding: _____ Age when you had your first period: _____

First day of your last 3 periods: _____, _____, _____ ☐ N/A (no periods)

Have you been tracking ovulation? ◯N ◯Y – How (check all that apply)?

☐ Home ovulation (LH) kit ☐ Basal body temperature ☐ Phone app ☐ Other: _____

Do you have bleeding in between periods? ◯N ◯Y

Do you need medication to bring on a period? ◯N ◯Y

Are your periods very heavy? ◯Never ◯Rarely ◯Sometimes ◯Always

Are your periods very painful? ◯Never ◯Rarely ◯Sometimes ◯Always

Do you notice excessive facial / body hair? ◯N ◯Y

Past contraception use (check all that apply) ☐ None

☐ Birth control pill / patch / ring When? _____

☐ IUD- When? _____ ☐ Condoms- When? _____

☐ Other: _____ When? _____

Have you ever had a pelvic exam or pap test? ◯N ◯Y – Date of last Pap Test: _____ ◯Not sure

Have you ever had an abnormal pap test? ◯N ◯Y

Have you ever had any of the following because of an abnormal pap tests? (check all that apply)

☐ Colposcopy ☐ Cryosurgery (freezing) ☐ Laser treatment ☐ Conization (cone biopsy) ☐ LEEP

Have you had negative experiences in the past related to pelvic exams or pap tests, including avoiding them?

◯N ◯Y – Please explain: _____

For more information about pap tests and cervical cancer screening in Ontario, please visit:
https://www.cancercare.on.ca/cms/One.aspx?portalId=1377&pageId=9550
To schedule a pap test, please contact your family physician.

UROLOGIC HISTORY ☐ Not applicable

Have you had a semen analysis? ◯N ◯Y – ◯Normal ◯Abnormal

Do you have a history of undescended testicles? ◯N ◯Y – ◯one side ◯both sides

Have you had an injury to your testicles requiring hospitalization? ◯N ◯Y

Do you have scrotal / testicular pain? ◯N ◯Y Have you had mumps since puberty? ◯N ◯Y

Have you had bladder/penis surgery as a child? ◯N ◯Y Have you had hernia surgery? ◯N ◯Y

Have you had varicocele surgery? ◯N ◯Y Do you use hot tubs regularly? ◯N ◯Y

Are you exposed to prolonged heat, radiation or toxic chemicals at your workplace? ◯N ◯Y

Have you had a vasectomy? ◯N ◯Y – has it been reversed? ◯N ◯Y – When? _____

NEW PATIENT INTAKE FORM

FAMILY HISTORY ☐ Unknown

Condition		Relationship to you (ex. maternal aunt, paternal grandfather)	Details of Condition
Infertility	◯N ◯Y		
Endometriosis	◯N ◯Y		
Recurrent miscarriages	◯N ◯Y		
Menopause before age 40	◯N ◯Y		
Birth defects	◯N ◯Y		
Developmental delay	◯N ◯Y		
Genetic diseases	◯N ◯Y		
Sickle Cell Anemia	◯N ◯Y		
Thalassemia	◯N ◯Y		
Down Syndrome	◯N ◯Y		
Breast cancer	◯N ◯Y		
Ovarian cancer	◯N ◯Y		
Colon cancer	◯N ◯Y		
Other cancer	◯N ◯Y		
Diabetes	◯N ◯Y		
Blood clots	◯N ◯Y		
Other	◯N ◯Y		

THANK YOU FOR COMPLETING THE QUESTIONNAIRE.