

## 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: _	
Name on Health Card (if different from	n above):		
Pronoun Used: She He	They		
Birth Date (MM/DD/YY):	Age:	_ Occupation:	
Relationship Status:	Ethnicity:		
Gender: Female Intersex	Male Trans Ti Male Fe		
Sexual Orientation: Bisexual Gay	y Heterosexual Les	bian Queer	Two-Spirit
Street Address:			
City:	Prov: Postal Cod	de:	Country:
Phone number (where we can leave a	confidential voicemail m	nessage):	
Email address:			
PARTNER INFORMATION (if applicab	<u>le)-</u> Your Partner should al	so complete a separa	te New Patient Intake Form.
First Name:	Middle Name:	Last Name: _	
Name on Health Card (if different from	m above):		
Pronoun Used: She He	They		
Birth Date (MM/DD/YY):	Age:	_ Occupation:	
Phone number (where we can leave a	confidential voicemail m	nessage):	
Fmail address:			



# **PHYSICIAN INFORMATION**

Referring physician			
Name:	Phone:	Fax: _	
Family physician ☐ sam	e as referring physician		
Name:	Phone:	Fax: _	
Specialist (ex. gynaecolo	ogist, urologist, psychiatrist)   same as	referring physician	
Name:	Phone:	Fax: _	
Specialty:		_ Date of last visit:	
Specialist (ex. gynaecolo	ogist, urologist, psychiatrist) □ same as	referring physician	
Name:	Phone:	Fax: _	
Specialty:		_ Date of last visit:	
REASON FOR VISIT (che	eck all that apply)		
☐ Infertility	☐ Recurrent Pregnancy Loss	☐ Egg Freezing	☐ Donor Sperm
☐ Gestational Carrier	☐ Preimplantation Genetic Testing	☐ Embryo Freezing	☐ Donor Egg
Not listed (Please des	cribe):		
Questions you would lik	e answered at this visit:		
Do you have benefits th	at cover fertility medications?	□ N □ Not sure	

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



**MEDICAL HISTORY** 

#### **NEW PATIENT INTAKE FORM**

Past or current medicate	al problems or treatments:	□ None

Past or current mental healtl	h concerr	ns: 🗆 None	
Past surgeries or procedures	: 🗆 Non	e	
Have you ever had problems	with ane	esthesia / sedation?	Y – Please explain:
Do you smoke cigarettes?	□ <b>N</b>	☐ Y — How many per day?	
Do you use e-cigarettes?	$\square$ N		
Do you smoke marijuana?	$\square$ N	☐ Y – How often?	How many years?
Do you drink alcohol?	$\square$ N	☐ Y – How many drinks per week?	
Do you use cocaine, heroin o	or other d	rugs? 🗆 N 🗆 Y – Please desci	ibe:
How many caffeinated bever	ages to y	ou drink per day?	

Please complete the Personal Medication List on page 7 and bring the completed form with you on your first visit to Mount Sinai Fertility. This needs to be completed even if you are not on any medication.

I have completed the Personal Medication List



# **FERTILITY HISTORY**

Have you been trying	to become pregnant?		□ IN	$\square$ Y – for now long	3:
Have you ever tried t	o get pregnant in a previous rela	ationship?	? 🗆 N	☐ Y – for how long	<u> </u>
Have you ever seen f	ertility specialist(s) in the past?	$\square$ N	□ Y – Naı	me(s)?	
Have you ever had fe	rtility treatment in the past?	$\square$ N	Y		
Oral medicat	ion and timed intercourse:	$\square$ N	□ Y – # o	f cycles?	
Oral medicat	ion and insemination:	$\square$ N	□ Y – # o	f cycles?	
Daily injectal	ole medication & insemination:	$\square$ N	□ Y – # o	f cycles?	
In vitro fertili	zation (IVF):	$\square$ N	□ Y – # o	f fresh cycles?	Frozen cycles?
Other:					
SEXUAL HISTORY  Are you currently sex	cually active? No Yes –	with:	Men	Women Both	:
	mes do you have intercourse pe	r week?		Do you use lubi	ricants? $\square$ N $\square$ Y
Do you have pain wit				 Rarely □ Sometin	
	any of the following? (check all			,	.,
	ire (libido) □ Sexual arousal			☐ Other:	
Do you have difficult	y with erections?	$\square$ N	□Y		
Do you have difficult	y with ejaculation? □ N/A	$\square$ N	$\square$ Y		
Have you had any of	the following infections? (check	all that a	pply)	□ None	
☐ Chlamydi	a Herpes	☐ Syp	ohilis	☐ HIV / AIDS	;
☐ Gonorrhe	ea 🗆 HPV / Genital Wart	:s □ He	patitis		
PREGNANCY HISTOR	Y (Please complete your pregn	ancy histo	ory in th	is and previous relat	ionships)
Number of: Total	Pregnancies:		Misca	rriages:	
Tuba	I / ectopic pregnancies		Abort	ions:	
Full 1	Ferm Deliveries:		_ Prete	rm deliveries:	
Date of Delivery / End of Pregnancy	Outcome / Complications	Month Conce		Treatment used to Conceive	o Current Partner
Life of Fregulaticy		Conce	EIVE	Conceive	
					□ Y □ N
					□ Y □ N
					□ Y □ N
					□ Y □ N
		1			$\sqcap Y \sqcap N$



MENSTRUAL / GYNECOLOGIC HISTORY	□ Not a	pplicable			
Number of days between the start of one mens	trual per	iod and the	start of the next o	ne:	
Number of days of bleeding:		Age when y	ou had your first p	eriod:	
First day of your last 3 periods:	<i>,</i>			□ N/A (no pe	riods)
Have you been tracking ovulation?	$\square$ N	☐ <b>Y</b> – <b>How</b>	(check all that app	ly)?	
$\square$ Home ovulation (LH) kit $\square$ Basal boo	ly tempe	rature $\square$	Phone app 🛛 Ot	her:	
Do you have bleeding in between periods?	$\square$ N	$\square$ Y			
Do you need medication to bring on a period?	$\square$ N	$\square$ 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?	$\square$ N	$\square$ Y			
Past contraception use (check all that apply)	□ None				
☐ Birth control pill / patch / ring	When?				
□ IUD- When?	□ Cond	oms- When $\widehat{:}$			
□ Other:	When?				
Have you ever had a pelvic exam or pap test?	□ N □ Y – Date of last Pap Test: □ Not su				
Have you ever had an abnormal pap test?	$\square$ N	$\square$ Y			
Have you ever had any of the following bec	ause of a	n abnormal	pap tests? (check	all that apply)	
☐ Colposcopy ☐ Cryosurgery (freezi	ng) 🗆 Las	er treatmen	t 🗆 Conization (co	ne biopsy) 🗆 LE	EP
Have you had negative experiences in the p	ast relate	ed to pelvic	exams or pap tests	s, including avoid	ling them?
□ N □ Y – Please explain: _					
For more information about pap to	ests and o	cervical cand	er screening in On	tario, please visi	it:
https://www.cancercare.o					
To schedule a pap	test, piea	se contact y	our family physicia	an.	
UROLOGIC HISTORY ☐ Not applicab	ole				
Have you had a semen analysis?	□ <b>N</b>	□ Y – □ Nor	mal 🗆 Abnormal		
Do you have a history of undescended testicles			side 🗆 both sides		
Have you had an injury to your testicles requiri					
Do you have scrotal / testicular pain?			re you had mumps	since nuherty?	$\square$ N $\square$ Y
Have you had bladder/penis surgery as a child?			e you had hernia s		
Have you had varicocele surgery?			you use hot tubs re		$\square$ N $\square$ Y
Are you exposed to prolonged heat, radiation o				- ,	_ IV _ L I
Have you had a vasectomy? $\square$ N $\square$ Y – has it be		·	·	· • □ ·	



FAMILY HISTORY ☐ Unknown

Condition		Relationship to you (ex. maternal	Details of Condition (include age of
		aunt, paternal grandfather)	onset)
Infertility	$\square$ N $\square$ Y		
Endometriosis	□N□Y		
Recurrent	□ N □ Y		
miscarriages			
Menopause before	$\square$ N $\square$ Y		
age 40			
Birth defects	$\square$ N $\square$ Y		
Developmental delay	□N □Y		
Genetic diseases	□N □Y		
Sickle Cell Anemia	□N □Y		
Thalassemia	$\square$ N $\square$ Y		
Down Syndrome	$\square$ N $\square$ Y		
Breast cancer	$\square$ N $\square$ 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.



# PERSONAL MEDICATION LIST AND RECONCILIATION FORM

Name:	
DOB: (DD-MMM-Y	Y):

Please tell us about any medications (prescription and non-prescription), vitamins, and supplements you currently take.
Bring your completed form to your first visit at Mount Sinai Fertility. Both partners (if applicable) should each complete a separate form.
Please inform your doctor of any changes to your medications which arise while you are a patient at MSF so your doctor can update this form.
Medications related to your fertility treatment cycle will be recorded separately in your patient chart.

# **ALLERGIES OR SENSITIVITIES:**

MEDICATIONS, VITAMINS, SUPPLEMENTS:					To be Completed by the Clinic			
Name	Dose	Route (oral, patch, injection)	Frequency (daily, twice a day)	Date Started (DD-MMM-YY)	MD/NP Initials	Date Stopped (DD-MMM-YY)	MD/NP Initials	NOTES

To be Completed by the Clinic List Updated By:								
	Initials:	Signature:	Date: dd/mm/yyyy	Print Name:	Initials:	Signature:	Date: dd/mm/yyyy	