

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)

- | | | | |
|--|--|--|--------------------------------------|
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Recurrent Pregnancy Loss | <input type="checkbox"/> Egg Freezing | <input type="checkbox"/> Donor Sperm |
| <input type="checkbox"/> Gestational Carrier | <input type="checkbox"/> Preimplantation Genetic Testing | <input type="checkbox"/> Embryo Freezing | <input type="checkbox"/> Donor Egg |

Not listed (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/>

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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:

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? _____

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

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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? No Yes – 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
				<input type="checkbox"/> Y <input type="checkbox"/> N
				<input type="checkbox"/> Y <input type="checkbox"/> N
				<input type="checkbox"/> Y <input type="checkbox"/> N
				<input type="checkbox"/> Y <input type="checkbox"/> N
				<input type="checkbox"/> Y <input type="checkbox"/> N
				<input type="checkbox"/> Y <input type="checkbox"/> 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 (include age of onset)
Infertility	<input type="checkbox"/> N <input type="checkbox"/> Y		
Endometriosis	<input type="checkbox"/> N <input type="checkbox"/> Y		
Recurrent miscarriages	<input type="checkbox"/> N <input type="checkbox"/> Y		
Menopause before age 40	<input type="checkbox"/> N <input type="checkbox"/> Y		
Birth defects	<input type="checkbox"/> N <input type="checkbox"/> Y		
Developmental delay	<input type="checkbox"/> N <input type="checkbox"/> Y		
Genetic diseases	<input type="checkbox"/> N <input type="checkbox"/> Y		
Sickle Cell Anemia	<input type="checkbox"/> N <input type="checkbox"/> Y		
Thalassemia	<input type="checkbox"/> N <input type="checkbox"/> Y		
Down Syndrome	<input type="checkbox"/> N <input type="checkbox"/> Y		
Breast cancer	<input type="checkbox"/> N <input type="checkbox"/> Y		
Ovarian cancer	<input type="checkbox"/> N <input type="checkbox"/> Y		
Colon cancer	<input type="checkbox"/> N <input type="checkbox"/> Y		
Other cancer	<input type="checkbox"/> N <input type="checkbox"/> Y		
Diabetes	<input type="checkbox"/> N <input type="checkbox"/> Y		
Blood clots	<input type="checkbox"/> N <input type="checkbox"/> Y		
Other	<input type="checkbox"/> N <input type="checkbox"/> Y		

THANK YOU FOR COMPLETING THE QUESTIONNAIRE.

