Braverman Reproductive Immunology

Clinical Questionnaire

Please complete this questionnaire as accurately as possible. Feel free to keep a copy for your records. We very much look forward to your upcoming consultation.

Name of Female _____ DOB_____ Age_____

Name of Partner _____DOB_____ Age_____

Address _____

Telephone (H) _____ (W) _____ (Fax) _____

(Cell)_____ Email Address _____

Social Security #_____ partner's social security #_____

How were you referred to Braverman Immunologic and Reproductive Medical Services?

Friend_____Relative_____Seminar_____Internet_____Other_____

Physician: _____

OBSTETRICAL HISTORY

How long have you been trying to have a baby? _____years

Have you ever been pregnant before? Yes _____ No_____

Date	Current/prior partner	Live Birth (Y/N)	Misscarriage/Abortion Ectopic	Wks	Fetal Heart (Y/N)	D&C (Y/N)	Mode of Delivery	Gender	Wt

If you had a D&C did you have genetic studies? Yes_____ No_____

With your pregnancies did you experience?

High Blood Pressure _____ Toxemia/preclampsia _____Bleeding_____

Gestational Diabetes_____ Other_____

Any Treatments_____

GYNECOLOGICAL HISTORY

When was the first day of your last period?

_____

Are your periods regular? Yes _____ No_____

Age at first period _____ # of days between periods? _____ # days of bleeding _____

Amount of bleeding: Light _____ Medium _____ Heavy_____

Have you ever needed medication to bring on your period? Yes _____ No_____

Pain with menstruation? Yes _____ No _____

Degree of pain: Mild _____ Moderate _____ Severe_____

Pain relieved by over the counter medications? Yes _____ No_____

Starts with the onset of bleeding? Yes _____ No_____

Begins a few days prior to the onset of bleeding? Yes _____ No_____

Persists more than 48 hours? Yes _____ No_____

Do you have pain with ovulation? Yes _____ No_____

Do you experience pain with sexual intercourse? Yes _____ No_____

Pain is mostly on the exterior? Yes _____No_____

Pain is mostly internal (deep penetration)? Yes _____No_____

Are you experiencing a vaginal discharge? Yes _____No_____

Associated with itching or burning? Yes _____No_____

Associated with an unusual odor? Yes _____ No_____

Do you have a gynecologist? Yes _____ No_____

Name of Gynecologist _____

When was your last pap smear? _____

Result? _____

Have you ever had an abnormal pap smear? _____

Have you ever had a Mammogram? Yes _____ No_____

When was most recent? _____

Have you ever had a sexually transmitted disease?

(i.e. Chlamydia, Gonorrhea, Syphilis, Herpes) Yes _____ No_____

When? _____ Was it treated? Yes _____ No_____

Have you ever had Pelvic Inflammatory Disease (PID)? Yes _____No_____

When? _____

Were you hospitalized? Yes_____No_____

Do you experience milk or discharge from your breasts? Yes _____ No_____

Have you ever used an IUD? Yes _____ No_____

Have you ever used the Oral Contraceptive Pill? Yes _____ No_____

How many years? _____

When did you last use it? _____

Patients Height _____ Weight_____

PREVIOUS SURGERIES

Have you ever had surgery? Yes _____ No_____

Procedure	Date	Indication	Outcome

DRUG ALLERGIES

Are you allergic to any medications that you know of? Yes _____ No _____

Medication Reaction

CURRENT MEDICATIONS

Are you currently taking any medications? Yes _____ No_____
Please include any supplemental vitamins or herbs

Medication Dose Frequency

FAMILY HISTORY

Is there a history of any of the following conditions in the family?

Condition	Yes/No	Comments
Diabetes (AODM)		
Heart Disease		
High Blood Pressure		
Kidney Disease		
Multiple Births		
Mental Retardation		
Birth Defects		
Inherited Diseases		
Blood Disorders		
Breast Cancer		
Ovarian Cancer		
Uterine Cancer		
Other cancer		
Sickle cell disease		
Cystic Fibrosis		
Tay Sachs		
Thalassemia		
Family History of Miscarriages		
Blood Clots		
Strokes		

Autoimmune Disorders such as:

Rheumatoid Arthritis _____
Lupus _____
Multiple Sclerosis _____
Myasthenia Gravis _____
Autoimmune Neuropathies _____
Guillain-Barre _____
Crohns Disease _____
Ulcerative Colitis _____
Sjogrens Syndrome _____
Antiphospholipid Syndrome _____
Thyroid Disease/Hashimotos/Graves _____
Autoimmune Ureitis _____
Primary Biliary Cirrhosis _____
Autoimmune Hepatitis _____
Autoimmune Hemolytic Anemia _____
Pernicious Anemia _____
Autoimmune Thrombocytopenia _____
Type I Insulin Diabetes _____
Autoimmune Adrenal Diseases _____
Psoriasis _____
Temporal Artertis _____
Dermalomyositis Scleroderma _____
Wegeners Granulomatosis _____
Dermatitis Herpetiformis _____
Pemphigus Vulgaris _____
Vitiligo _____
Polymyositis _____
Spondyloarthropathies _____
Behcets Disease _____

SOCIAL HISTORY

Occupation _____

Do you use tobacco? Yes _____ No_____ #packs/day _____
Any History of Drug use? Yes _____ No_____
Do you use Alcohol? Yes _____ No _____ #drinks/week _____
Are you currently married? Yes _____ No_____
How long? _____ years
Have you been married before? Yes _____ No_____
Problems conceiving in that relationship? Yes _____ No _____
How frequently do you have intercourse? _____per wk/month
Do you use a lubricant? Yes _____ No_____

COMMENTS

Please describe the nature of your problem.

MALE HISTORY Occupation _____

Have you initiated any pregnancies in the past? Yes _____ No_____
Number of pregnancies? _____
Number with current partner? _____
When was the most recent pregnancy? _____
Have you been evaluated by a Urologist? Yes _____ No_____

Diagnosis:_____
Have you ever had a semen analysis? Yes _____ No_____
Result: Date _____
Count (million cell/ml) _____
Motility (%) _____
Morphology (% normal forms) _____
Other _____
Are you allergic to any medications? Yes _____ No_____
Medication: _____ Reaction: _____
Are you taking any medications?
Medication _____ Dose _____ Frequency _____
Do you use Tobacco? Yes_____ No_____ #packs/wk _____
Do you use Alcohol? Yes _____No_____ #drinks/wk_____
Do you use a hot tub? Yes _____No_____ #times/wk_____
Any history of drug use? Yes _____ No_____

Have you had any of the following tests or procedures?

Test/Procedure	Date	Result	Comment
Blood Tests			
FSH			
LH			
Testosterone			
TSH			
Antisperm Antibodies			
Semen Tests			
Hamster Egg penetration			
Fructose			
Semen Culture			
Surgery			
Vasectomy			
Vasectomy reversal			
Testicular biopsy			
Varicocele Ligation			
Hernia Repair			
Undescended testicle			
Removal of Testicle			
Other			

PREVIOUS INFERTILITY EVALUATION

Have you ever had or used any of the following tests or procedures?

Test/Procedure	Date	Result
Blood Test (non immunological)		
FSH (cycle day 3)		
Estradiol (cycle day 3)		
LH (cycle day 3)		
Progesterone (7 days after ovulation)		
TSH		
Prolactin		
DHEAS		
Testosterone		
17 Hydroxy-progesterone		
Blood type and Rh status		
Rubella		
HIV		
Hepatitis B surface antigen		
Hepatitis C antibody		
RPR/VDRL (Syphilis)		

Blood Tests (immunologic)
Antinuclear antibodies (ANA) _____
Antiphospholipid antibodies (APA) _____
Antipaternal Leukocyte Antibodies (APLA)
_____
Natural Killer (NK) cell assay _____
Immunophenotype _____
DQ Alpha _____
Antithyrogobulin antibodies (ATA) _____
Antimicrosomal antibodies (AMA, TPO) _____
Antisperm antibodies _____
IgA _____

Cervical Cultures
Chlamydia _____
Gonorrhea _____
Ureaplasma/Mycoplasma _____
Routine aerobic/anaerobic _____

General Assessment
Physical Exam _____
Basal Body Temperature chart (BBT) _____
Urine Ovulation Predictor (LH kit) _____
Post coital test (PCT) _____
Endometrial biopsy _____

MEDICAL CONDITIONS

Do you have a history of any of the following conditions?

Condition	Yes/No	Comments
German Measles (Rubella)		
Migraines		
Prolonged Dizziness		
Glasses/contact lenses		
Thyroid problems		
Pneumonia		
Tuberculosis		
Asthma		
Bronchitis		
Other lung conditions		
Heart Attack		
Heart Murmur		
Rheumatic Fever		
Other Heart conditions		
High blood pressure		

Gastric/duodenal ulcer _____
Hepatitis _____
Cirrhosis _____
Intestinal Bleeding _____
Bleeding tendency _____
Problems with anesthesia _____
Diabetes (AODM/IDDM) _____
Kidney Stones _____
Kidney infections _____
Other kidney disorders _____
Bladder infection _____
Rheumatoid Arthritis _____
Other forms of arthritis _____
Lupus Erythematosis _____
Paralysis _____
Neurological disorders _ _____
Thrombophlebitis _____
Varicose Veins _____
Breast tumor (benign) _____
Breast cancer _____
Ovarian Cancer _____
Uterine Cancer _____
Other cancer _____
History of miscarriages _____

Have you ever had a positive ANA? Yes _____ No_____
Have you ever been told you have an autoimmune disease? Yes _____ No _____
If Yes, which one? _____
Have you ever had a blood clot or told you were at risk for blood clots? Yes _____ No_____
Do you experience flu like symptoms with implantation, transfer or
Implantation failure? Yes_____ No_____
Do you experience stabbing pelvic pains or intense cramps
with insemination or embryo transfers? Yes _____ No_____

IF YOU HAVE UNDERGONE IVF, ANSWER THE FOLLOWING QUESTIONS:

General Questions:	Response:
What date were the most recent cycle day 3 (cd3) blood tests for FSH and plasma estradiol (E2) level and what were the respective values?	Date: _____ Values: FSH _____ U/ml E2 _____ pg/ml
How many IVF cycles, using your own eggs vs. an egg donor have you undergone?	Own eggs: _____ Donor eggs: _____
How many frozen embryo transfers (FETs) have you undergone?	_____
When did each cycle (using fresh or frozen embryos) take place?	Mo/year 1_____ 2_____ 3_____ 4_____

What were the outcomes in each case (negative pregnancy test: positive pregnancy test but no ultrasound confirmation of a gestational sac (i.e. chemical pregnancy): ultrasound confirmation of gestational sac (i.e clinical pregnancy): ectopic pregnancy; miscarriage; live birth or perinatal death

1 _____
2 _____
3 _____
4 _____
5_____

Which were single and which were multiple pregnancies (when applicable)? Use the number above to designate the cycle concerned.

1 _____
2 _____
3 _____

QUESTIONS PERTAINING TO YOUR MOST RECENT FRESH IVF ATTEMPT

When did you undergo your most recent IVF? Month/year _____

How many ampules of gonadotropins (e.g. pergonal, Humegon, Follistim, Gonal F or Repronex) were injected on the 1st, 2nd and 3rd day of the cycle treatment?

Amps day 1 _____
Amps day 2 _____
Amps day 3 _____

Did you use your own eggs or that of a donor? _____

Did you use a gestational surrogate? _____

How many follicles were observed by ultrasound exam? _____

What was the peak plasma E2 level on the day of HCG administration (whether given to you or ovum donor)? _____

What was the thickness of the endometrial lining prior to egg retrieval? _____mm

For how many days were gonadotropins administered? _____ days

What was the blood estradiol (E2) concentration on the day of HCG administration (ie 2 days prior to the egg retrieval) _____pg/ml

Was GnRH agonist (eg lupron) started five or more days Before initiating gonadotropin therapy (ie the "long protocol") Or less than three days prior to gonadotropin administration (ie "flare protocol")? _____

How many eggs were harvested? _____

Was Intracytoplasmic sperm injection (ICSI) used to Fertilize the eggs? Yes _____ No_____

How many embryos were produced? _____

Were embryos/blastocycsts transferred three days or five Days following egg retrieval? _____

How many fresh Day 3 embryos vs Day 5 embryos

(blastocysts were transferred at ET)? _____

How many times had each transferred embryo divide (number of cells) at the time of ET? _____

What was the embryological assessment of the quality of Each fresh embryo transferred (poor, average, good)? _____

What was the outcome of the IVF cycle (negative pregnancy Test; positive test but no ultrasound confirmation of a Gestational sac (ie chemical pregnancy); ultrasound Confirmation of a gestational sac (ie clinical pregnancy); Ectopic pregnancy; healthy pregnancy, still ongoing; Miscarriage; live birth or perinatal death? _____

If a clinical pregnancy occurred, was it a single pregnancy, Twin pregnancy or a higher multiple than twins? _____

Pelvic Assessment	**Date**	**Result**
Pelvic Exam		
Vaginal sono		
Hysterosalpingogram (HSG)		
Fluid Ultrasound		
Hysteroscopy		
Laparoscopy		
Laparotomy		
Other		

PREVIOUS INFERTILITY TREATMENT

Have you ever used any of the following medications or treatments?

Medication	**Date**	**Dose**	**# Cycles**	**Comment**
Clomiphene Citrate (oral)				
Perganol, Humagon, Repronex, Menopur, Fertinex, Gonal F, Follistim (injectable)				
HCG (Profasi)				
Progesterone				
Aspirin				
Heparin				
Prednisilone (Medrol)				
Dexamethasone				
Intravenous Immunoglobulin (IVIG)				
Leukocyte Immunization Therapy (LIT)				
Intralipids				

Treatment

Timed Intercourse _____
Intrauterine Insemination _____
In Vitro Fertilization (IVF) _____
Gamete Intrafallopian Tube Transfer (GIFT) _____
Zygote Intrafallopian Tube Transfer (ZIFT) _____
Ovum Donation (OD) _____
Gestational Surrogacy (SUR) _____
OD + SUR _____
Other _____