JIM THOMPSON, M.D.
201 Cedar Street SE, Suite 51-20 • Albuquerque, NM 87106
PH: 505-248-0000 • Fax: 505-842-0000
Infertility • Reproductive Endocrinology
NMFertility.com

Dear Patient:

Welcome to our office. We want to thank you for choosing The Fertility Center of New Mexico for your healthcare needs. We have a dedicated team of professionals who are available and committed to serving you. Our goal is to provide you with the highest quality services in a timely manner.

Included in this packet are forms that need to be printed and filled out by you and your partner (if applicable). Please bring the *completed* paperwork to your appointment along with picture ID and your insurance card(s).

A Medical Records Release form is enclosed to assist you in obtaining any relevant records from other providers for your appointment. Complete and forward to providers as needed.

Please plan to arrive 15 minutes prior to your scheduled appointment time.

(Presbyterian Hospital offers Valet Parking for your consideration and convenience.)

A representative from our office will call you prior to the appointment to discuss your benefits as they relate to care in this office.

A $75.00 deposit was collected at the time you scheduled your appointment. This will be applied to your charges. We require a 48-hour notice to cancel or reschedule this appointment or the deposit will be forfeited.

We look forward to meeting you.

If you need any additional assistance, please do not hesitate to call.

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NEW PATIENT HISTORY QUESTIONNAIRE - FEMALE

A. IDENTIFYING DATA Date this form completed __________ Appointment Date _________

Name ____ Age _____ Birth Date _____________ SS# ___________________
Height _________ Weight ____________
Home Address ____City/State _________________ Zip __________

Best daytime contact #________________________ (home/cell/other) OK for detailed message? O Yes O No

Other contact # ______________________________ (home/cell/other) OK for detailed message? O Yes O No

OK to discuss lab results or plan of care with your partner? O Yes O No E-Mail Address ___________________________

Type of relationship: Married or Significant Other Duration of Relationship _____ Duration of Infertility _____
Are you and your partner sexually intimate? O Yes O No

Biological sex: Female Male (please circle)

Preferred Gender: Cis-Female Cis-Male Trans-Female Trans-Male Other (please circle)

Self-reported ethnicity:
O Refused O Unknown O Not asked
O White O Hispanic or Latino O Black or African American
O Asian O American Indian or Alaska Native
O Native Hawaiian or other Pacific Islander

Partner's name ____________________________________ Age ___ Birth Date _________ SS# _________________

Partner Identity Known: Yes No (anonymous sperm donor) Biological sex: Female Male (please circle)

Preferred Gender: Cis-Female Cis-Male Trans-Female Trans-Male Other (please circle)

Self-reported ethnicity:
O Refused O Unknown O Not asked
O White O Hispanic or Latino O Black or African American
O Asian O American Indian or Alaska Native
O Native Hawaiian or other Pacific Islander

Sperm source: Yes No (please circle) Intended Parent: Yes No (please circle)

Female's Employer ____ Work Phone _________________

Partner's Employer ____ Work Phone _________________

Emergency Contact ____ **Phone** _________________

Insurance Carrier – Primary: ____ Group # _____________
Identification # ______________________________ Plan # ____________________
Secondary: ____ Group # _____________
Identification # ______________________________ Plan # ____________________

Reason for your visit today? ____
____
Primary Care Physician or GYN/OB Physician ___________________________________
Referred by _______________________________________

By signing below, I confirm that the information above is, to the best of my knowledge, true and accurate. I am aware that TFCNM is a specialty clinic, and the short-term, focused nature of the care I receive at the clinic does not afford for long-term follow-up. I understand that I need to have a primary-care provider (PCP), and that routine care, such as PAP smears, breast exams, annual exams, and physicals need to be performed and followed by my PCP or gynecologist.

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO PHYSICIAN

____ ____________
Signature (Insured or authorized person) **Date**

B. PREGNANCY HISTORY

How long have you been trying unsuccessfully to get pregnant? ______years ________months

Have you previously been pregnant? O Yes O No Have you previously tried to get pregnant? O Yes O No

How many times pregnant? _____ Term births? _____ Premature births? _____ Miscarriages? _____
Still born? _____ Elective abortion? _____ Adopted children? _____

Pregnancy	Date (year)	Mis-carriage	Elective abortion	Ectopic	How long to conceive	Infertility treatment	Wt. & Sex	C-section	Complications?	Is current partner the father?
1	_______	O	O	O	_______	O	_____ F/M	O	O	Y / N
2	_______	O	O	O	_______	O	_____ F/M	O	O	Y / N
3	_______	O	O	O	_______	O	_____ F/M	O	O	Y / N
4	_______	O	O	O	_______	O	_____ F/M	O	O	Y / N
5	_______	O	O	O	_______	O	_____ F/M	O	O	Y / N
6	_______	O	O	O	_______	O	_____ F/M	O	O	Y / N

Complications during or after your pregnancies? Explain. ____

____

Did your mother have any difficulty with conception or pregnancy? Explain. ________________________________

____

Did your mother take diethylstilbestrol (DES) when she was pregnant with you? O Yes O No

C. CONTRACEPTIVE USE

	Type	From when to when	Reason discontinued
1.	________________	________________	________________________________
2.	________________	________________	________________________________

D. MENSTRUAL (HORMONAL) HISTORY

Are your periods regular? O Yes O No How many days from onset to onset? _________

Date your last menstrual period began __________ Your age at your first period _________

How many days does your period last? __________ Do you bleed between periods? _________

Do you have premenstrual symptoms? O almost always O rarely O never

Vigorous exercise? O Yes O No Type ________________________________ Hours/Week ________

Pelvic pain/cramps: O none O during your period O before your period O after your period O at mid-cycle O during intercourse O with urination O with bowel movements

Pelvic pain/cramps are: O mild O moderate O severe O getting worse O improving O not changing O on the right side O on the left side O in the middle

What medications do you take for pain/cramps? ____

If you have a hormonal disorder, please specify type and treatment ________________________________

____

Do you have or have you had:

Hot flashes	O Yes O No	Vision problems	O Yes O No
Breast discharge	O Yes O No	Poor sense of smell	O Yes O No
Chronic headache	O Yes O No	Thyroid disorder	O Yes O No
Head injury	O Yes O No	Excessive stress	O Yes O No
Seizures	O Yes O No	Increased facial or body hair	O Yes O No
Vomiting	O Yes O No	Weight gain (>10 pounds)	O Yes O No
Diabetes	O Yes O No	Weight loss (<10 pounds)	O Yes O No
Increased acne	O Yes O No	Psychiatric treatment	O Yes O No
Autoimmune disease	O Yes O No	Special dietary habits	O Yes O No

If you answered yes to any questions, please explain ____

E. OPERATIONS AND HOSPITALIZATION

Date	Diagnosis	Operation	Where performed	Physician

1. ______________________________

2. ______________________________

3. ______________________________

F. MEDICATIONS: Please list all prescriptions and over-the-counter drugs used during the past year.

Date	Dosage/frequency	From when to when	Reason for taking

1. ______________________________

2. ______________________________

3. ______________________________

4. ______________________________

5. ______________________________

6. ______________________________

G. ALLERGIES

To what? (drug or substance)	When?	What type of reaction?

H. PHYSICAL CONDITIONS/INFECTIONS

Do you have or have you had:

Pelvic infection	O Yes O No	Antichlamydial antibodies	O Yes O No
Chlamydia	O Yes O No	Colitis or enteritis	O Yes O No
Gonorrhea	O Yes O No	Endometriosis	O Yes O No
Syphilis	O Yes O No	Pelvic adhesions	O Yes O No
Mycoplasma	O Yes O No	Uterine fibroids or myomas	O Yes O No
Ureaplasma	O Yes O No	Abnormal uterus (shape, etc.)	O Yes O No
Tuberculosis	O Yes O No	Ovarian cysts	O Yes O No
Appendicitis	O Yes O No	Toxoplasmosis	O Yes O No

Cytomegalovirus (CMV) O Yes O No

I. COMBINED

Do you, or your partner, have or have had:

Cervicitis	O Yes O No	Recurring vaginitis	O Yes O No
Genital herpes	O Yes O No	Abnormal pap smears	O Yes O No
Trichomonas	O Yes O No	Cryo (freezing) or surgery of the cervix	O Yes O No
Genital warts/ Condyloma	O Yes O No		

How many times per week do you have sexual intercourse? ______ Do you use lubricants for intercourse? ______

How many times do you have intercourse around ovulation? ______ Do you douche before or after intercourse? ____

Have you ever had unwanted sexual experiences? O Yes O No ____

Do you have any sexual problems at this time? O Yes O No ____

J. OTHER MEDICAL HISTORY

Female – occupation ____

Partner – occupation____

Years of formal education _____

Cigarettes – packs smoked per day ______

Alcohol – type and number of drinks per week ______

Radiation exposure _____

Hot tub or sauna use ______

Marijuana – amount ______

Caffeine drinks per day ______

Ever used intravenous drugs? ______

Toxic exposure _______

Other drugs – type and amount ____

Are you and your partner related in any way? (other than by marriage)? ________________________________

Are you or your partner of:

	Jewish background?	O Yes O No
	Black/African background?	O Yes O No
	Mediterranean background?	O Yes O No
	Asian background?	O Yes O No
	French-Canadian background?	O Yes O No

J. OTHER MEDICAL HISTORY, continued

Have you, or your partner, or anyone in either family ever had: Myself My partner Either family

A child with Down Syndrome or other chromosome problem?	O Yes O No	O Yes O No	O Yes O No
A child with mental retardation?	O Yes O No	O Yes O No	O Yes O No
Open spine (spina bifida), skull defect or anencephaly?	O Yes O No	O Yes O No	O Yes O No
Heart defect?	O Yes O No	O Yes O No	O Yes O No
Muscle or neuromuscular disease (muscular dystrophy)?	O Yes O No	O Yes O No	O Yes O No
A baby that died shortly after birth or in the first year?	O Yes O No	O Yes O No	O Yes O No
Cystic Fibrosis?	O Yes O No	O Yes O No	O Yes O No
Hemophilia, sickle cell, thalassemia or other blood disorder?	O Yes O No	O Yes O No	O Yes O No
Any birth defect or genetic disease not listed above?	O Yes O No	O Yes O No	O Yes O No

If you answered "Yes" to any of the above questions, it may indicate that a pregnancy is at higher risk for certain hereditary or non-hereditary problems, and genetic counseling may be of value to you. Not all birth defects are preventable or detectable before birth, but this questionnaire may help the physician to determine whether or not referral for genetic counseling or testing is appropriate for you.

K. PREVIOUS EVALUATION

Have you had:	Not Done	Result		Approximate date	Values (if known)
		Normal	Abnormal		
Basal body temperature (BBT)	O	O	O		
Urine LH surge	O	O	O		
Endometrial biopsy	O	O	O		
Blood tests:					
FSH	O	O	O		
LH	O	O	O		
Prolactin	O	O	O		
Thyroid tests (TSH, T4)	O	O	O		
DHEAS	O	O	O		
Testosterone	O	O	O		
Estradiol	O	O	O		
Progesterone	O	O	O		
Postcoital test	O	O	O		
Cervical mucus penetration test	O	O	O		
Mycoplasma culture	O	O	O		
Chlamydia culture	O	O	O		
Antichlamydial antibodies	O	O	O		
Female antisperm antibodies	O	O	O		
Hysterosalpingogram (HSG)	O	O	O		
Ultrasound	O	O	O		
IVP (kidney x-ray)	O	O	O		
Laparoscopy	O	O	O		
Hysteroscopy	O	O	O		
Karyotype	O	O	O		
Anticardiolipin antibodies	O	O	O		
Lupus anticoagulant	O	O	O		
Antinuclear antibodies (ANA)	O	O	O		
Coagulation screen	O	O	O		

Biochemistry/hematology panel	O	O	O	___________	____________
Blood type	O	O	O	___________	____________

Has your partner had:

Semen analysis	O	O	O	___________	____________
Hamster egg penetration assay	O	O	O	___________	____________
Semen antisperm antibodies	O	O	O	___________	____________

List causes of infertility previously diagnosed ____

____

____

L. PREVIOUS TREATMENT

	How many months?	Dose (if known)	Approx. dates taken
Antibiotics	_________	_________	____________
Clomiphene (Clomid, Serophene)	_________	_________	____________
hMG (Pergonal, Gonal-F, Follistim)	_________	_________	____________
hCG (Profasi, Pregnyl)	_________	_________	____________
Progesterone	_________	_________	____________
Dexamethasone	_________	_________	____________
GnRH agonist (Synarel, Lupron)	_________	_________	____________
Danazol	_________	_________	____________
Intrauterine insemination	_________	_________	____________

Insemination with donor sperm	__________	__________	_____________
IVF (in vitro fertilization)	__________	__________	_____________
GIFT	__________	__________	_____________

Other: ____