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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.



NEW PATIENT HISTORY QUESTIONNAIRE - FEMALE

Page 1 of 7

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? Yes No

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

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

Type of relationship: Married or Significant Other _____ Duration of Relationship _____ Duration of Infertility _____

Are you and your partner sexually intimate? Yes No

Biological sex: Female Male (please circle)

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

Self-reported ethnicity: Refused Unknown Not asked
 White Hispanic or Latino Black or African American
 Asian American Indian or Alaska Native
 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: Refused Unknown Not asked
 White Hispanic or Latino Black or African American
 Asian American Indian or Alaska Native
 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 _____

C. CONTRACEPTIVE USE

Type	From when to when	Reason discontinued
1. _____	_____	_____
2. _____	_____	_____

D. MENSTRUAL (HORMONAL) HISTORY

Are your periods regular? Yes 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? almost always rarely never

Vigorous exercise? Yes No Type _____ Hours/Week _____

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

Pelvic pain/cramps are: mild moderate severe getting worse improving not changing
 on the right side on the left side 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	<input type="radio"/> Yes <input type="radio"/> No	Vision problems	<input type="radio"/> Yes <input type="radio"/> No
Breast discharge	<input type="radio"/> Yes <input type="radio"/> No	Poor sense of smell	<input type="radio"/> Yes <input type="radio"/> No
Chronic headache	<input type="radio"/> Yes <input type="radio"/> No	Thyroid disorder	<input type="radio"/> Yes <input type="radio"/> No
Head injury	<input type="radio"/> Yes <input type="radio"/> No	Excessive stress	<input type="radio"/> Yes <input type="radio"/> No
Seizures	<input type="radio"/> Yes <input type="radio"/> No	Increased facial or body hair	<input type="radio"/> Yes <input type="radio"/> No
Vomiting	<input type="radio"/> Yes <input type="radio"/> No	Weight gain (>10 pounds)	<input type="radio"/> Yes <input type="radio"/> No
Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Weight loss (<10 pounds)	<input type="radio"/> Yes <input type="radio"/> No
Increased acne	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric treatment	<input type="radio"/> Yes <input type="radio"/> No
Autoimmune disease	<input type="radio"/> Yes <input type="radio"/> No	Special dietary habits	<input type="radio"/> Yes <input type="radio"/> 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 | <input type="radio"/> Yes <input type="radio"/> No | Antichlamydial antibodies | <input type="radio"/> Yes <input type="radio"/> No |
| Chlamydia | <input type="radio"/> Yes <input type="radio"/> No | Colitis or enteritis | <input type="radio"/> Yes <input type="radio"/> No |
| Gonorrhea | <input type="radio"/> Yes <input type="radio"/> No | Endometriosis | <input type="radio"/> Yes <input type="radio"/> No |
| Syphilis | <input type="radio"/> Yes <input type="radio"/> No | Pelvic adhesions | <input type="radio"/> Yes <input type="radio"/> No |
| Mycoplasma | <input type="radio"/> Yes <input type="radio"/> No | Uterine fibroids or myomas | <input type="radio"/> Yes <input type="radio"/> No |
| Ureaplasma | <input type="radio"/> Yes <input type="radio"/> No | Abnormal uterus (shape, etc.) | <input type="radio"/> Yes <input type="radio"/> No |
| Tuberculosis | <input type="radio"/> Yes <input type="radio"/> No | Ovarian cysts | <input type="radio"/> Yes <input type="radio"/> No |
| Appendicitis | <input type="radio"/> Yes <input type="radio"/> No | Toxoplasmosis | <input type="radio"/> Yes <input type="radio"/> No |
| | | Cytomegalovirus (CMV) | <input type="radio"/> Yes <input type="radio"/> No |

I. COMBINED

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

- | | | | |
|-----------------------------|--|--|--|
| Cervicitis | <input type="radio"/> Yes <input type="radio"/> No | Recurring vaginitis | <input type="radio"/> Yes <input type="radio"/> No |
| Genital herpes | <input type="radio"/> Yes <input type="radio"/> No | Abnormal pap smears | <input type="radio"/> Yes <input type="radio"/> No |
| Trichomonas | <input type="radio"/> Yes <input type="radio"/> No | Cryo (freezing) or surgery of the cervix | <input type="radio"/> Yes <input type="radio"/> No |
| Genital warts/
Condyloma | <input type="radio"/> Yes <input type="radio"/> 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 _____ Marijuana – amount _____
Cigarettes – packs smoked per day _____ Caffeine drinks per day _____
Alcohol – type and number of drinks per week _____ Ever used intravenous drugs? _____
Radiation exposure _____ Toxic exposure _____
Hot tub or sauna use _____
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:	<u>Myself</u>	<u>My partner</u>	<u>Either family</u>
A child with Down Syndrome or other chromosome problem?	O Yes O No	O Yes O No	O Yes O No
A child with Intellectual disability?	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)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Urine LH surge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Endometrial biopsy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Blood tests:					
FSH	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
LH	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Prolactin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Thyroid tests (TSH, T4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
DHEAS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Testosterone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Estradiol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Progesterone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Postcoital test	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Cervical mucus penetration test	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Mycoplasma culture	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Chlamydia culture	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Antichlamydial antibodies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Female antisperm antibodies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Hysterosalpingogram (HSG)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Ultrasound	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
IVP (kidney x-ray)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Laparoscopy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Hysteroscopy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Karyotype	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Anticardiolipin antibodies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Lupus anticoagulant	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Antinuclear antibodies (ANA)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Coagulation screen	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Biochemistry/hematology panel	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Blood type	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Has your partner had:					
Semen analysis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Hamster egg penetration assay	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Semen antisperm antibodies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____

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: _____			