



Gynecology and Fertility Background and Questionnaire

JARRETT FERTILITY GROUP

BUILDING FAMILIES SINCE 1985

ALL patients should complete the following section, regardless of whether you are here for Menopause/HRT or Infertility Treatment.

Name: _____ Date of Birth: _____ Nickname: _____

Husband's Name: _____ Date of Birth: _____ Contact #: _____

Address: _____ City: _____ State: _____ Zip: _____

Hm Phone #: _____ Wk Phone #: _____ Cell Phone: _____

In case of emergency, please notify: _____ Contact #: _____

Please circle any areas with which you currently have problems, or have had problems in the past:

- | | | | |
|----------------------|--------------------|----------------------------|----------------------------|
| Chronic Headaches | Head Trauma | Seizure Disorder | Sense of Smell |
| Visual Disturbances | Loss of Balance | Rapid Weight Changes | Increased Thirst |
| Changes in Appetite | Increased Sweating | Fatigue | Tremors |
| Salt Craving | Loss of Scalp Hair | Hair Growth (face or body) | Change in Size of Clitoris |
| Thyroid Disease | Breast Secretions | Congenital Heart Disease | Scarlet Fever |
| Rheumatic Fever High | Blood Pressure | Tuberculosis | Pneumonia |
| Chronic Bronchitis | Emphysema | Lung Cysts or Tumors | Gall Bladder |
| Hiatal Hernia | Ulcer | Appendicitis | Bowel Problems |
| Pancreatitis | Hepatitis | Liver Problems | Anemia |
| Blood Transfusion | Arthritis | Kidney Problem | Problems w/Urination |
| | | | Auto-Immune Diseases |

Please list any other previous or chronic illnesses not mentioned above: _____

Date of your last PAP smear: _____ Have you ever had an abnormal PAP smear? _____ Date: _____

Do you smoke? _____ Packs per day? _____ For how long? _____ No. of Alcoholic Drinks per wk: _____

Please list all medications to which you are allergic: _____

Please list all medications you are currently taking: _____

Please list all previous hospital admissions: (where, year and reason)

1. _____
2. _____
3. _____

Have you ever had psychiatric treatment? _____ If yes, reason and Doctor: _____

Is your father living? _____ Age: _____ If deceased, cause: _____

Is your mother living? _____ Age: _____ If deceased, cause: _____

How many sisters do you have? _____ What are their ages? _____ Brothers: _____ Ages: _____

Is there any thing else you would like us to know to further assist in your care and treatment?

Date of last period (First Day): _____ Age of first period: _____ Unusual menstrual interval: _____
Do you consider your periods to be irregular? _____ Have they always been that way? _____ If not, how Long? _____
Usual duration of bleeding: _____ Cramping with your periods is: Minimal Moderate Severe
Do cramps start before your period? _____ How much? _____ Are your cramps getting worse? _____
Duration of Marriage: _____ Duration of Infertility: _____ Has either partner been previously married? _____
If yes, did you attempt conception in that marriage? _____ Were there children from that marriage? _____
How long did it take to conceive? _____
Please list, in order, your prior pregnancies and their outcomes: _____

Please describe any complications of those pregnancies: _____

Circle any method of contraception used in the past:

Birth Control Pills	Condoms	Foam	Diaphragm
IUD	Rhythm	Withdrawal	None

Usual frequency of sexual intercourse per week: _____ Does your husband ejaculate during intercourse? _____

Do you use lubricants? _____ If yes, please specify: _____ Do you douche before or after? _____

Is intercourse painful to either partner? _____ Do you achieve orgasm: Never Sometimes Always

Has either partner ever had (Please circle):

Syphilis	Gonorrhea	Pelvic Infection	Chlamydia
Herpes	HIV		

Does your husband smoke? _____ Packs per day: _____ For how long? _____

Has either partner used any illegal drugs? _____ If yes, please explain: _____

If you have had previous evaluation or treatment for infertility, please list the name of any physicians performing those services: _____

For Office Use Only:

Reviewed by: _____

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