Date: __________

Female Fertility Questionnaire

Identifying Information

Name: ______________________ Date of Birth: _______ Age:___
Address: ______________________ Phone (Home): ______________
______________________ Phone (Mobile): ______________
Race: ______________________ Ethnic Background: ______________________
Employer: ______________________
Occupation: ______________________ Hours Worked: ______________
Extensive Travel: Y / N
Referring Physician ______________________ Established OB/GYN ______________________

Chief Medical Problem

Describe the reason for your visit: ______________________
____

Are you interested in using your eggs and your uterus? Y / N
Are you interested in using your eggs and your partner's uterus? Y / N
Are you interesting in using your partner's eggs and your uterus? Y / N
Are you uncertain? Y / N

Medical History

Weight: _________ Height: ______________ Blood Group and RH: ______________________
Do you follow a particular diet or have any special dietary habit: Y/N
If yes, explain: ______________________
Do you exercise on a regular basis? Y/N
If yes, detail frequency and form of exercise: ______________________

Nicotine Usage: Y / N If no, have you smoked previously? ______________
If yes, for how long/Cigarettes per day: ______________
Caffeine Usage: Y / N If yes, Cups per Day: ______________
Alcohol Usage: Y / N Average Weekly Consumption: ______________
Recreational Drug Usage: Y / N If yes, specify: ______________

Allergies (Please List): ______________________
Current Prescription Medication: ______________________
____
Current Over-The-Counter Medication: ______________________
____
Current Herbal Supplements/Medication: ______________________

Do you have or have you ever had: (Check all that apply)

☐ Anemia	☐ Kidney Disease	☐ Psychiatric Disorder	☐ Tubal Infection
☐ Heart Disease	☐ Thyroid Disease	☐ Syphilis	☐ Cystitis
☐ Hypertension	☐ Liver Disease	☐ Gonorrhea	☐ Tumor
☐ Prolonged Fever	☐ Diabetes	☐ Chlamydia	☐ Epilepsy
☐ Congenital disease	☐ Breast Lump	☐ Inguinal Hernia	

If yes to any, or to add something that was not listed, please explain: ____
____
____

Surgical History

What previous surgeries or biopsies have you had performed?

- ☐ Laparoscopy
- ☐ Hysteroscopy
- ☐ Abdominal Surgery
- ☐ Myomectomy
- ☐ Pelvic Surgery

If you checked yes to any of the procedures, or if you have had other procedures or biopsies performed that are not listed, please elaborate: ____
____
____

Menstrual and Pregnancy History

Age at first menstruation: ________________________ Comments: ____________________________________
Age first noted breast development: _______________ Comments: ____________________________________
Age first noted pubic hair: ________________________ Comments: ____________________________________
Age first noted axillary hair: ______________________ Comments: ____________________________________

Present Menstrual Cycles:
Length (in days from start to start): ________ Duration: _______________ Cramps: ____________
Amount of Flow: ________________________________ Spotting/Bleeding between periods:_______________
Pains or Cramps with periods? ___________________ Age at which pains or cramps began: ______________
Are the pains worse now than previously: __________ Pain between menstrual cycles? __________________
Do you experience premenstrual symptoms? If yes, what:_____________________________________
Anything else about your cycles you wish to share? ____

Last Pap smear: _________________________________ Result: ____
Last Mammogram: _______________________________ Result: ____
Last Menstrual Period: ___________________________

Pregnancy History:

Have you ever been pregnant: Y / N (If yes, see below)

	Year	Abortion?	Miscarriage?	Ectopic?	Treatment Required?	How long to Conceive?	Live Birth?	Current Partner Father?
1st Pregnancy								
2nd Pregnancy								
3rd Pregnancy								

Were there any complications during or after your pregnancies? Y / N

If yes, explain: ____

Contraceptive and Marital History

What form of contraception do you use, or have you used in the past?

- ☐ Oral Contraceptive, Name: ______________
- ☐ IUD, Name: ______________
- ☐ Diaphragm
- ☐ Depo-Provera
- ☐ Withdrawal
- ☐ Condoms
- ☐ Tubal Ligation

For each contraceptive method, please specify duration of use:

____

____

If you've ever been on oral contraceptive (pills), were your periods regular after stopping the pill? Y / N

Marital History:

Number of years: ______________

Date of marriage: ______________

Number of children: ______________

Number of adopted children: ______________

Marital Problems: ____

Endocrine History

Have you noticed any of the following symptoms?

- ☐ Increased hair growth
- ☐ Breast secretion
- ☐ Skin stretch marks
- ☐ Weight gain
- ☐ Weight loss
- ☐ Headaches
- ☐ Anxiety
- ☐ Fatigue
- ☐ Hair loss
- ☐ Dry skin
- ☐ Oily skin
- ☐ Acne
- ☐ Increase in size of feet
- ☐ Increase in size of hands

If yes, please explain in more detail: ____

____

____

____

Family History

Have there been any of the following diseases in your family?

- ☐ Diabetes
- ☐ Hypertension
- ☐ Heart disease
- ☐ Kidney disease
- ☐ Tuberculosis
- ☐ Cancer
- ☐ Breast/Ovarian Cancer
- ☐ Cystic Fibrosis
- ☐ Sickle Cell Disease
- ☐ Early deaths
- ☐ Abnormal genitalia
- ☐ Recurrent miscarriage
- ☐ Children born with malformations
- ☐ Other congenital abnormalities
- ☐ Schizophrenia or depressive psychosis
- ☐ Developmental delays
- ☐ Bleeding disorders
- ☐ Deep Vein Thrombosis
- ☐ Pulmonary Embolism
- ☐ Thyroid disorders
- ☐ Spina bifida
- ☐ Muscular dystrophy
- ☐ Cleft lip or palate
- ☐ Limb deformities
- ☐ Blindness
- ☐ Deafness
- ☐ Menstrual problems
- ☐ Infertility
- ☐ Fragile X

If the answer to any of the above is yes, please elaborate: ____

____

____

Fertility Treatment History

Have you had any previous fertility treatment? Y / N

If yes, who was your physician? ________________________________

Was a specific diagnosis identified? ____________________________

What medications, if any, have you taken for treatment? Check all that apply:

- ☐ Clomiphene citrate (Clomid)
- ☐ Letrozole
- ☐ FSH (Follistim, Gonal F)
- ☐ HCG (Pregnyl, Novarel, Ovidrel)
- ☐ Progesterone
- ☐ Antibiotics
- ☐ Ganirelix/Cetrotide
- ☐ hMG (Menopur)
- ☐ Prednisone
- ☐ Estrogen
- ☐ Lupron
- ☐ Metformin
- ☐ Other: specify _________________

Which of the following tests or procedures have you had performed? Check all that apply:

- ☐ Hormone tests When: ______________ Results: __________________
- ☐ Endometrial Biopsy When: ______________ Results: __________________
- ☐ Hysterosalpingogram (HSG) When: ______________ Results: __________________
- ☐ Ultrasound/Sonogram When: ______________ Results: __________________
- ☐ Intrauterine Insemination (IUI) When: ______________ Results: __________________
- ☐ In Vitro Fertilization (IVF) When: ______________ Results: __________________

Have you identified a designated sperm donor: Y / N

Have you researched sperm banks Y / N

Anything else you wish to share that we have not yet asked: ____

____

____

Questions to Ask your Insurance Regarding Fertility/Infertility Coverage

Insurance benefits vary widely dependent upon insurance company, insurance plan, where your company is headquartered, or if your plan is self-insured.

Please complete this insurance verification form prior to your initial consultation with the doctor. Use this form as a questionnaire when calling the member services phone number on your insurance card.

It is *your responsibility* to call your insurance company to review your fertility benefit. Once you have this information, it is your responsibility to inform office staff of benefit information and/or change of insurance.

Patient Name: ____ Patient DOB __________

Provider: ____

ID Number: ____ Group: _____________

Questions to ask:

General:

- Am I in-network with Dr. Wood Molo and the Center for Reproductive Care?
  ____
- What is my deductible/coverage once deductible met:
  ____
- What is my specialist office visit copay?
  ____

Fertility Testing: (Diagnosis Code: Z31.41)

- Are there any restrictions or exclusions to be eligible for fertility benefit?
  ____
- Do I have fertility testing coverage? (CPT: 76856, 76857, 74740, 76830, 76831, 58340)
  ____
- Do I need to register with the insurance as a fertility patient?
  ____

Fertility Treatment: (Diagnosis Code(s): N97.9, Z31.83)

- Do I qualify for infertility benefits?
  ____

- Do I have fertility treatment coverage?
  ____
- Do I have Intrauterine Insemination (IUI) Coverage? (CPT Code: 58322)
  ____
- Do I have In Vitro Fertilization (IVF) Coverage? (CPT: 58970, 58974)
  ____
- Do I have any lifetime or yearly limits for fertility treatments?
  ____
- Does my insurance require a prior authorization before treatment begins?
  - If yes, what is the contact information for the prior-authorization department?

  ____
- Do I have infertility medication coverage?
  - If yes, what is my specialty pharmacy?

  ____
- Do my medications count towards my lifetime or yearly fertility allowance?
  ____

Fertility Preservation (Diagnosis Code(s): Z31.62, Z31.84)

- Does my plan cover fertility preservation counseling?
  ____
- Does my plan have any exclusions for Egg Retrieval CPT 58970?
  ____

Donor Egg: (Diagnosis Code: Z51.810)

- If I am using an egg donor, will her medical services and/or medications be covered?
  ____

Date: ____________________________

Representative: __________________

Reference #: _____________________

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