Appendix B

Sample Patient History Questionnaire

One of the primary and most useful tools in clinical practice is the patient history questionnaire. Information about an individual's medical, familial, occupational, and personal background can be critical to proper diagnosis and appropriate treatment of a medical condition. Moreover, written records may identify patterns of illness among individuals with a common lifestyle element.

A thorough, standardized patient information questionnaire could be particularly useful for recognizing patterns of work-related illness in the population. Epidemiological study of occupational disease is hampered by the fact that there is currently no validated or widely used questionnaire that gathers this information (8).

Consequently, the following section draws together segments of history questionnaires from various types of medical facilities (e.g., occupational medical centers, fertility clinics) in an effort to cover each of the categories that may be important for diagnosis and treatment. These include:

- identification (e.g., name, sex, age);
- occupational history (e.g., present and previous employment, exposures);
- lifestyle characteristics (e.g., use of nicotine and alcohol, exposures in home);
- familial health (e.g., medical conditions/diseases of relatives);
- medical history (e.g., injuries, medical conditions/diseases, surgical procedures); and
- reproductive history (e.g., reproductive difficulties or disorders, past reproductive outcomes)

Since this questionnaire is a composite of questionnaires from a broad range of clinical and research facilities, it is not validated for use. It was developed solely to inform the reader of the number of factors that are pertinent to a thorough understanding of a patient's medical and personal background. Specific investigators would likely select a subset of variables that relate to the reproductive endpoints being studied.

Appendix B References

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3. Katz, David F., Department of Obstetrics and Gynecology, School of Medicine, University of California, Davis (Fertility Questionnaire, 1984).
4. Levine, Richard J., Department of Epidemiology, Chemical Industry Institute of Toxicology, Research Triangle Park, NC (Family History Questionnaire, 1984).
5. National Institute for Occupational Safety and Health, U.S. Department of Health, Education, and Welfare (Occupational History Questionnaire, 1980).
6 New York Committee for Occupational Safety and Health, "Reproductive Hazards in the Workplace: A Course Curriculum Guide" (Sample Reproductive History Questionnaire, 1980).
7 The Occupational and Environmental Health Committee of the American Lung Association of San Diego and Imperial Counties, "Taking the Occupational History," *Annals of Internal Medicine* 99:641-650, 1983.
8 Rosenstock, L., Logerfo, J., Heyer, N.J., and Carter, W.B., "Development and Validation of a Self-Administered Occupational Health History Questionnaire," *Journal of Occupational Medicine* 26:50-54, 1984.
9]. Women Physicians Association, Washington, DC, Obstetrics and Gynecology (Initial Interview Patient (~uestionnaire, 1984).

PATIENT HISTORY QUESTIONNAIRE

I. IDENTIFICATION

Name:_____ **Social Security**:_____

Address:_____ Sex: M F
Birthday:_____

Telephone: home_____ Height:_____
work_____ Weight:_____

11. OCCUPATIONAL HISTORY

A. Present Employment

WHICH OF THE FOLLOWING BEST DESCRIBES YOUR CURRENT JOB STATUS? (PLEASE CHOOSE ONLY ONE)

A. Employed full time _____ if so, since **what year?** _____
B. Employed part **time** — **If so, since what year?** _____
C. Muttiple jobs _____ If so, since **what year?** _____
D. Retired _____ **If so,** since **what year?** _____
E. Disabled _____ **If so,** since what year? _____
F. Unemployed _____ If so, since **what year?** _____
G. Laid off _____ **If so,** since **what year?** _____
H. Student _____ **If so,** since **what year?** _____
1. Homemaker _____ If so, since **what year?** _____

IF YOU ARE PRESENTLY EMPLOYED,WHAT IS YOUR JOB? HOW LONG HAVE YOU BEEN SO EMPLOYED?_____

1. **WHAT HAS BEEN YOUR USUAL OCCUPATION OR JOB — THE** ONE YOU HAVE WORKED AT THE LONGEST?

A. Job/Occupation **(e.g., carpenter,** homemaker) _____

_____

B. Number of years in this occupation _____

C. What kind of business or industry is this? (e.g,yhospital, shipbuilding)

_____

note which of the following types of equipment you use, and about how much of the time that you actually use it of the time that you think you should (for example, you may find **a** mask respirator uncomfortable and wear it only about half the time that you think you should be wearing it)

Mark if used at **all.**

If used, about what part of the time
Is it used that you think it should be used:

		Less than 1/4	About half	About 3/4	All the time
D	Mask respirator				
0	Air supply respirator				
0	Gloves				
0	Coveralls or aprons				
0	Safety glasses				
c1	Hearing protection				
n	**Other** (identify)				

PLEASE CHECK OFF THE FOLLOWING REGARDING ASPECTS OF THIS JOB.

	Yes	No
A. Use separate workclothes		
B. Use separate shoes	❑	
C. Has a lunchroom removed from work exposures		

HOW MUCH HARD PHYSICAL WORK IS REQUIRED ON YOUR JOB — LIKE PUSHING OR CARRYING HEAVY OBJECTS, HANDLING HEAVY TOOLS OR EQUIPMENT, OR DIGGING?

A great deal Some Hardly any None at all

HOW WOULD YOU DESCRIBE THE DEGREE OF EMOTIONAL STRESS ASSOCIATED WITH THIS JOB?

A Great Deal Some Hardly any Don't know

IN TERMS OF THE AMOUNT OF STRESS ON THIS JOB, HOW WOULD YOU COMPARE IT WITH OTHER JOBS YOU HAVE HAD?

Much less About the same A bit more A great deal more

WERE YOU EVER GIVEN JOB SAFETY/HEALTH TRAINING FOR THIS JOB?

Yes N o

if yes, by whom?

Management Union other (specify) _____

IN THIS JOB, HAVE YOU HAD PREEMPLOYMENT OR PERIODIC EXAMS FOR ANY HAZARD-RELATED HEALTH PROBLEMS?

Y e s N O

If yes, have you ever been told that these exams were abnormal and if so describe.

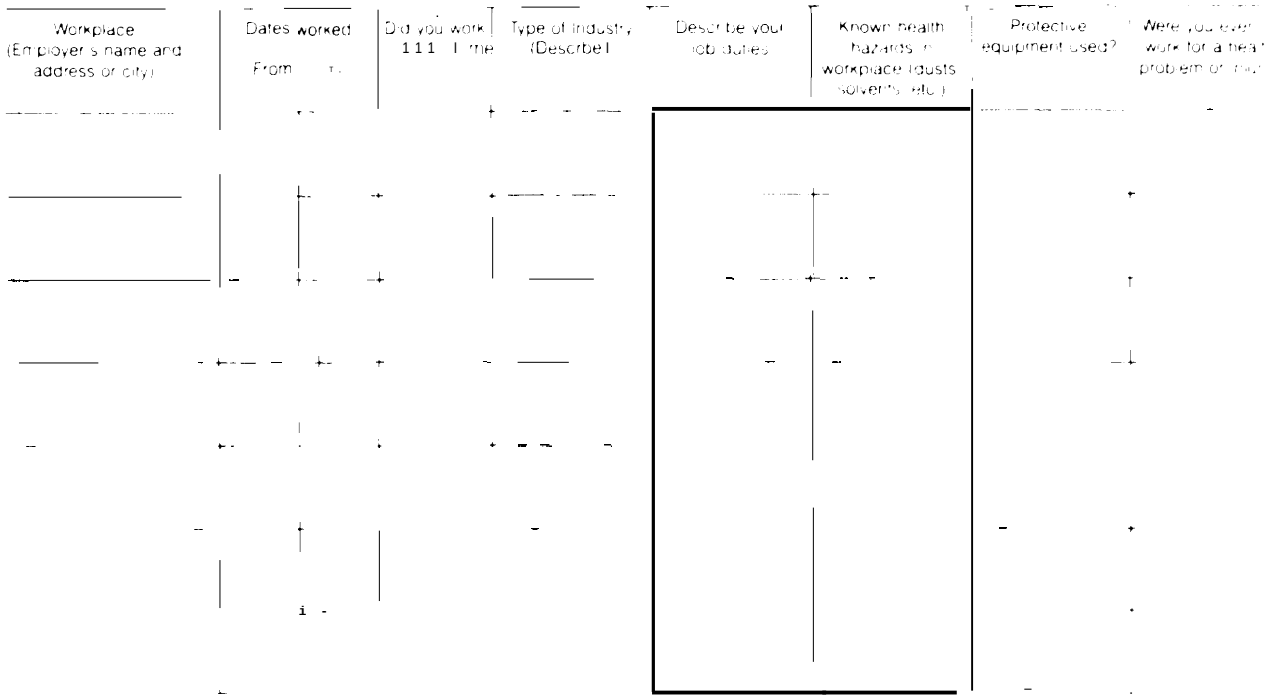
_____

_____

_____

B. Employment History

FILL IN THE TABLE BELOW LISTING ALL JOBS AT WHICH YOU HAVE WORKED, INCLUDING SHORT-TERM, SEASONAL, AND PART-TIME EMPLOYMENT. START WITH YOUR PRESENT 308 AND GO BACK TO THE FIRST. USE ADDITIONAL PAPER IF NECESSARY.



C. Exposure History

HAVE YOU EVER WORKED AT A 306 OR HOBBY IN WHICH YOU CAME INTO DIRECT CONTACT WITH ANY OF THE FOLLOWING SUBSTANCES BY BREATHING, TOUCHING, OR DIRECT EXPOSURE? IF SO, PLEASE CHECK THE BOX BESIDE THE SUBSTANCE.

The questions below **are** an important part of our evaluation of your problem. Below is a list of agents or exposures that you may have encountered in your work or outside work.

The first set of boxes — marked A— refers to your current or most recent job (job #). For any agent or exposure that YOU have worked within this job, mark YES and whether you think the exposure was of low, medium, or high amount.

Do the same for the next set of boxes— marked B — which refer to any previous job (any job aside from job #l). And then do the same for the last set of boxes — marked C — which refer to any activities outside paid work, such as housekeeping, student activities and hobbies.

LIST OF EXPOSURES	YES	IF YES CHECK ONE L - W High	YES	IF YES CHECK ONE Lw Mgd High	YE	IF YES CHECK ONE L~~ Mod ~@h
Example Asbestos	/	‘ /	✔	f Y		
1, FUMES AND DUSTS						
Asbestos						
Plastic Fumes						
Welding Fumes						
Fumes (other)						
Glass (e.g. Fiberglass)						
Silica (e.g. Sand)						
Plaster						
Wood (Specify Type(s) If Known: _____)						
Other (Specify If Known: _____)						

	A. Current or Most Recent Job (Paid Work)				6. Any Previous Job				C. Any Activtty Outside Paid Work			
	Y :	IF YES CHECK ONE low	med	High	YES	IF YES CHECK ONE Low	Med	High	YES	IF YES CHECK ONE LOW	w	Hlah
2. ELEMENTS AND METALS												
Aluminum												
Arsenic												
Cadmium												
Chromium												
Copper												
Lead												
Mercury												
Nickel												
Zinc												
Other (Specify If Known: _____)												
3. SOLVENTS												
ticl~~ls (e.g. Methyl,												
Benzine (Gas), Petroleum Ether												
Benzene, Toluene, Xylene												
Carbon Tetrachloride												
Paint, Varnish, Degreasers												
Tri-, Tetrachloroethylene												
Other (Specify If Known: _____)												
4. OTHER CHEMICALS												
Acids												
Alkali (Caustics)												
Ammonia												
Detergent and Soaps												
Dyes												

	A. Current Most Recent Job (Paid Work)				B. Any Previous Job				C. Any Activity Outside Paid Work			
	YES	IF YES CHECK ONE Low	Med	High	YES	IF YES CHECK ONE Low	Med	High	YES	IF YES CHECK ONE Low	Med	High
Formaldehyde												
Pesticides												
Plastic Resins												
Other (Specify If Known: _____)												
5. MISCELLANEOUS												
Heavy Lifting												
Improper Lighting												
Excess Heat or Cold												
Emotional Stress												
Plant Products												
Ionizing Radiation (e.g., X-ray, Radioisotopes)												
Nonionizing Radiation (e.g., Microwave, UV)												
Noise												
Sitting or Standing in Same Position												
Vibration												
Other (Specify If Known: _____)												

D. Occupational Illness

1. Please describe any health problems or injuries you have experienced connected with your present or past jobs.

HOW MANY PEOPLE WORK WITH YOU IN YOUR IMMEDIATE AREA?

au-s 06-10 011-25 D 25-100 0 Greater than 100

3. Have any of your c-workers also experienced health problems or injuries connected with the same jobs? If yes, please describe.

DID YOU EVER CHANGE JOBS BECAUSE YOU WERE CONCERNED ABOUT OCCUPATIONAL HAZARDS OR DANGERS TO YOUR HEALTH?

DYes DNo

HAVE YOU EVER BEEN DIAGNOSED AS HAVING A WORK-REIATED ILLNESS OR DISEASE?

OYes ONO

If yes, please describe _____

_____

_____

If yes, who made the diagnosis? OSelf OOwn M.D.

Ocompany M.D. or nurse 0 Other (specify) _____

HAVE YOU EVER HAD AN OCCUPATIONAL INJURY OR ILLNESS WHICH RESULTED IN A PERMANENT CHANGE OF JOB OR A TERMINATION OF A JOB?

IJYes DNo

HAVE YOU EVER HAD AN OCCUPATIONAL INJURY/lLLNESS WHICH RESULTED IN A LOST WORKDAY (one in which you could not work or were assigned to a different job)?

OYes CINO

If yes, please describe _____

_____

If yes, about how many workdays have you had in the last five years? —

HAVE YOU EVER HAD AN OCCUPATIONAL INJURY/lLLNESS WHICH DID NOT RESULT IN A LOST WORKDAY BUT REQUIRED MEDICAL TREATMENT?

OYes ONO

111. LIFESTYLE CHARACTERISTICS

1. DO YOU LIVE NEXT DOOR TO OR VERY NEAR AN INDUSTRIAL PLANT? YES NO
If so, please describe:

2. HAVE YOU EVER CHANGED YOUR RESIDENCE OR HOME BECAUSE OF A HEALTH PROBLEM? YES NO
If so, please describe:

3. DOES YOUR SPOUSE OR ANY OTHER HOUSEHOLD MEMBER HAVE: CONTACT WITH DUSTS OR CHEMICALS AT WORK OR DURING LEISURE? YES NO
[f so please describe:

DO YOU HAVE ANY HOBBIES?

Yes No

If yes, list and estimate the number of hours per month you spend on each:

Hobby	Hours

5. DO YOU USE PESTICIDES AROUND YOUR HOME OR GARDEN? YES NO
If so, please describe:

6. WHICH OF THE FOLLOWING DO YOU HAVE IN YOUR HOME?
–Air Conditioner –Air Purifier Humidifier -Electric Stove
–Fireplace –Central Heating

7. DO YOU OR HAVE YOU EVER SMOKED CIGARETTES, CIGARS, OR PIPES? YES NO
If so, how many per day:

8. ALCOHOL–APPROXIMATE NUMBER OF SERVINGS PER WEEK ____
Type of Beverage: _____

9. DO YOU OR HAVE YOU EVER USED MARIJUANA? YES NO
If so, in **what** amounts? _____

10. DO YOU OR HAVE YOU EVER USED

Cocaine	YES NO
Hallucinogens (e.g., LSD)	YES NO
Downers (e.g., sleeping pills)	YES NO
Uppers (e.g., pep pills)	YES NO
Heroin or other hard drugs	YES NO

11. ARE YOU OR HAVE YOU EVER BEEN DRUG AND/OR ALCOHOL DEPENDENT? YES NO
[f so, on which drugs are/were you dependent? For how long?

IV. FAMILY HISTORY

1. HAS ANY BLOOD RELATIVE HAD ANY OF THE FOLLOWING?
Include Father, Mother, Brothers, Sisters, Grandparents, Aunts, Uncles, 1st cousins

YES	NO	
		Anemia or low blood
		Arthritis
		Arteriosclerosis
		Asthma
		Autoimmune Disease (e.g Lupus, Ulcerative Colitis, Scleroderma
		Cancer
		Cystic fibrosis
		Easy bleeding
		Endocrine disorder (e.g. Goiter, Hyperthyroidism
		Glaucoma, Blindness, Cataracts
		High blood pressure (Hypertension)
		Hay fever, pollen allergies, eczema
		Heart disease
		Hodgkins
		Kidney disorders
		Leukemia
		Muscular distrophy
		Necrologic disorders (e.g. Parkinson, Epilepsy, Multiple sclerosis)
		Sickle cell anemia
		Stroke
		Sugar diabetes
		Tay Sachs
		Tuberculosis (TB)

V. MEDICAL HISTORY

1. DO YOU CONSIDER YOUR GENERAL HEALTH:
Poor__ Fair__ Good__ Excellent__

2. DO YOU CONSIDER YOUR GENERAL DISPOSITION:
Calm Nervous Irritable
Depressed__ Happy__ Other__

3. HOW WOULD YOU CHARACTERIZE THE AMOUNT OF STRESS IN YOUR LIFE:
Not Stressful__ Average__ Extraordinary__

4. DO YOU HAVE ANY ALLERGIES OR ALLERGIC CONDITIONS? YES NO
If so, please describe:

5. LIST ALL OF THE MEDICATIONS YOU ARE TAKING INCLUDING THOSE THAT DO NOT REQUIRE A PRESCRIPTION. (e.g. Vitamins, Minerals, Aspirin)
Name of Medicine Amount

_____
_____
_____
_____

6. ARE YOU ALLERGIC OR HAVE YOU HAD A "BAD REACTION" TO ANY MEDICATIONS? Yes No —Don't know
If yes, list the medications and reactions _____
_____

7. HAVE YOU INCURRED ANY INJURIES (e.g. broken **bones, burns,** head injuries)? State any residual deformity or impairment.

8. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING

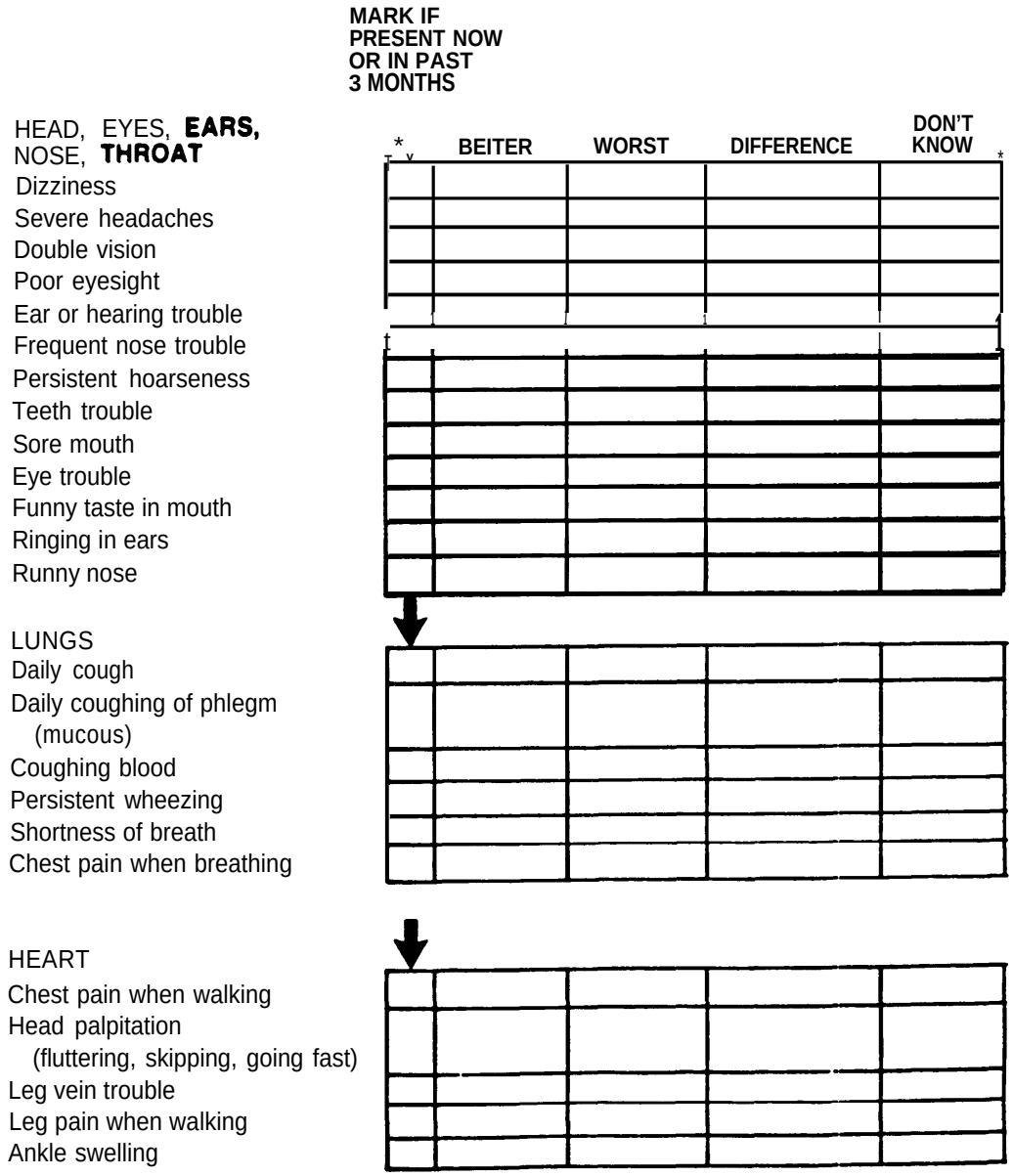
YES	NO	
		Anemia
		Asthma
		Bladder infections
		Bronchitis
		Cancer
		Chicken pox
		Duodenal Ulcer
		Dysentery
		Endocrine disorder (goiter, hyperthyroidism)
		Epilepsy
		Hay fever or grass and tree allergies
		Heart murmer
		Heart disease
		High blood pressure
		Kidney disease
		Liver disease, jaundice, hepatitis
		Long term bowel trouble
		Malaria

Measles
Mental troubles
Mumps
Pneumonia
Rheumatic fever
Serious injury or accident
Sinus trouble
Stomach ulcer
Sugar diabetes
Tuberculosis
Typhoid
Uncontrolled bleeding
Venereal Disease

9. LIST ALL HOSPITALIZATIONS YOU HAVE HAD:

Type of illness/operation	Year

. . . ***SYMPTOMS:*** PLEASE MARK (X) IN THE AVAILABLE BUNKS IF ANY OF THE FOLLOWING APPLY TO YOU NOW OR IN THE PAST 3 MONTHS. FOR ANY SYMPTOM THAT YOU MARK, CHECK WHETHER THIS SYMPTOM IS BETTER, ***WORSE,*** OR NO DIFFERENT WHEN YOU ARE AT WORK.



	MARK IF PRESENT NOW OR IN PAST 3 MONTHS +	BETTER	WORST	DIFFERENCE	DONT KNOW
STOMACH, INTESTINAL					
Trouble swallowing					
Frequent or severe nausea					
Frequent or severe heartburn					
Frequent indigestion					
Frequent or severe stomach pain					
Frequent or severe vomiting					
Vomiting blood					
Yellow jaundice					
Bowel habit change					
Prolonged or frequent diarrhea (bowel movements)					
Constipation					
Blood in bowel movements					
Black bowel movements					
Hemorrhoids (piles)					
URINARY					
Frequent urination					
Painful urination					
Bloody urine					
Trouble starting urine					
Urinate more than 2 times a night					
Trouble holding urine					
BONES, JOINTS, MUSCLES					
Joint pains and swelling					
Severe lack of strength					

	MARK If PRESENT NOW OR tN PAST 3 Moms	BETTER	WORST	DIFFerENCE	DON'T KNOW
GENERAL	+-				
Unexplained weight loss or gain					
Unexplained fever					
Night sweats					
Can't stand hot weather					
Can't stand cold weather					
Persistent skin rash or itching					
Increased sweating					
NERVOUS SYSTEM					
Lack of energy					
Frequent loss of balance					
Fainting spells (black outs)					
Convulsions (seizures, fits, epilepsy)					
Tremor (shaking, trembling)					
Paralysis					
Numbness (body parts "go to sleep")					
Newousness					
Excessive wow					
Trouble sleeping					
Memory trouble					
Trouble concentrating					
Depression (feeling blue)					
Crying spells					
Feelings of worthlessness					
Trouble getting along with people					
Pins and needles, funny sensations					

13. SYMPTOMS (cont.)

	MARK If PRESENT NOW OR IN PAST 3 MONTHS +	BETTER	WORST	DIFF#:ENCE	DON_I KNOW
MALES					
Discharge from penis					
Testicles (balls) trouble					
Sexual trouble					
FEMALES					
Breast lumps or discharge					
Unusual bleeding from vagina (birth canal)					
Unusual discharge from vagina (birth canal)					
Sexual trouble					

14. HAVE YOU OR YOUR SPOUSE (OR PARTNER) HAD ANY DIFFICULTY IN BECOMING PREGNANT? CJYes CINO

15. DO YOU HAVE ANY OTHER HEALTH PROBLEM THESE QUESTIONS HAVE MISSED? OYes UNO

If yes, please list _____

_____

16. IN YOUR OPINION, WHAT ARE YOUR MOST IMPORTANT HEALTH PROBLEMS? LIST AS MANY AS YOU CAN.

1. _____

2. _____

3. _____

VI. REPRODUCTIVE HEALTH*

A. MALE

1. HAVE YOU EVER HAD ANY INJURY OR OPERATION TO THE PENIS OR TESTICLES?

Circumcision	YES NO
Other operations on penis	YES NO
Varicocele operation (varicose veins near testicles)	YES NO
Vasectomy	YES NO
Biopsy of the testicle	YES NO
Other operations or injuries to the testicles	YES NO

2. HAVE YOU EVER HAD AN INFECTION OF THE

Bladder	YES NO
Urethra	YES NO
Epididymis	YES NO
Kidney	YES NO

If so, please give details:

3. HAS THERE BEEN ANY RECENT CHANGE IN THE SIZE OF YOUR TESTICLES? YES NO
If so, please give details:

4. HAVE YOU EVER HAD A HERNIA OPERATION (Even as a baby)? YES NO
If so, please give details:

5. ARE YOU IN THE HABIT OF TAKING VERY HOT BATHS? YES NO

6. ARE YOU IN THE HABIT OF TAKING SAUNAS? YES NO

7. WHAT SORT OF UNDERWEAR DO YOU NORMALLY WEAR?
____Boxer trunks
____Jockey shorts
____Other

8. HAVE YOU EVER BEEN TOLD BY A DOCTOR That YOU HAD A PROSTATE PROBLEM? YES NO

9. HAVE YOU EVER GONE THROUGH A PERIOD OF SEVERAL MONTHS WHEN YOU HAD TROUBLE GETTING OR KEEPING AN ERECTION? YES NO
If so, please give details:

10. DO YOU GET SATISFACTORY EJACULATION OF SPERM DURING INTERCOURSE? YES NO

11. HAVE YOU EVER GONE THROUGH A PERIOD OF SEVERAL MONTHS WHEN YOU HAD LITTLE INTEREST IN SEX? YES NO
If so, please give details:

*This section is designed specifically for the fertility patient. Certain questions are, therefore, unnecessary for a standard patient history form.

12. DO YOUR HAVE ANY PROBLEMS URINATING? YES NO

13. HAVE YOU EVER BEEN EXAMINED BY A UROLOGIST? YES NO
If so, when?_____ For what reason?_____
Were any problems identified?_____

14. HAVE YOU EVER ATTENDED AN INFERTILITY CLINIC OR HAD PREVIOUS TREATMENT FOR INFERTILITY? YES NO
If so, please give name of the doctor and the facility:
_____

15. IS THERE ANY HISTORY OF FERTILITY PROBLEMS IN YOUR FAMILY? (difficulty conceiving, miscarriage, still birth, deformed offspring)
Parents?_____
Brothers?_____
Uncles?_____

16. HAS YOUR SEMEN BEEN EVALUATED BEFORE? YES NO
How many times?_____
When most recently?_____
What were the results?_____
Have other tests (e.g. antibody tests, mucus penetration) been done with your semen? YES NO
If so. when?_____
What were the results?_____

17. HAVE ANY ENDOCRINE (HORMONE) STUDIES BEEN DONE WITH YOUR BLOOD? YES NO
If so, when?_____
What were the results?_____

18. HAVE YOU AND YOUR PRESENT OR ANY PREVIOUS MATE HAD DIFFICULTY CONCEIVING? (unprotected intercourse for a year or more with no pregnancy) YES NO

19. HAVE YOU FATHERED A PREGNANCY THAT ENDED IN ANY OF THE FOLLOWING?
If so, please specify whether it was with your present or a previous mate:
__Miscarriage
__Stillbirth
__Baby born more than 2 weeks early
__Baby with a birth defect:
__Twins/Multiple offspring
__Low birth weight ($5\frac{1}{2}$ pounds or less)
__Cleft palate
__Harelip
__Limb deformity
__Disease or deformity of the heart, lungs, kidney, genitals, urinary tract, gastro-intestinal tract,

nervous system

Malformations of the skull, spine
__ Musculoskeletal disorders (e.g. muscular distrophy

20. HAVE YOU FATHERED ANY CHILDREN WHO HAVE ANY OF THE FOLLOWING CONDITIONS?
Please specify whether these children were born to you and your present or a previous mate:

Allergy
Asthma
Epilepsy
'Downs syndrome
Cystic fibrosis
Hemophilia
Mental retardation or learning problem
'Leukemia
'Tumor or Cancer
'Tay-sachs
'Cerebral palsy
¯ Other (specify)

B. FEMALE

MENSTRUAL HISTORY:

1. HOW OLD WERE YOU WHEN YOU BEGAN TO MENSTRUATE?_____

2. ARE YOUR PERIODS REGULAR? YES NO

3. WHAT IS THE AVERAGE LENGTH OF YOUR CYCLE?_____

4. GIVE THE DATE OF THE 1ST DAY OF YOUR LAST PERIOD:_____

5. GIVE THE DATE OF THE 1ST DAY OF THE PERIOD BEFORE LAST: _____

6. FOR HOW MANY DAYS DO YOU LOSE BLOOD?_____

7 IF YOU EXPERIENCE ANY OF THESE SYMPTOMS, NOTE HOW MANY DAYS BEFORE ONSET OF BLEEDING THE SYMPTOM BEGINS:

Premenstrual:

Abdominal Bloating	Urinary Tract Symptoms_____
Swelling of face. hands or feet_____	
Breast Tenderness_____	Headache _____
Weight Gain_____	[irritability_____
Bowel Changes_____	Other_____

During Period:

Cramps_____	Hot Flashes_____
Nausea _____	Fever _____
Diarrhea _____	Sweats_____
Chills _____	Constipation _____
Headaches_____	Rectal Pain_____
Fainting. Dizziness____	Other _____

8. DO YOU HAVE ANY BLEEDING OR BLOODY DISCHARGE:

Between Periods	YES NO
After Intercourse	YES NO
After Douching	YES NO

CONTRACEPTION:

1. DO YOU USE OR HAVE YOU USED ANY OF THE FOLLOWING TYPES OF CONTRACEPTION?

Oral contraceptive pill	**Permanent sterilization**
Diaphragm_____	Tubal ligation_____
Condom _____	Coitus interruMus_____
Spermacidal foam or gel	[UD _____

2. WHAT FORM OF CONTRACEPTION, IF ANY, ARE YOU CURRENTLY USING?

GYNECOLOGIC HISTORY:

1. DO YOU HAVE ANY PAIN OR DISCOMFORT Associated WITH INTERCOURSE? YES NO

2. DO YOU HAVE ANY PROBLEMS OR DIFFICULTY RELATED TO SEXUAL ACTIVITY? YES NO

3. HAVE YOU HAD GENITAL HERPES? YES NO

4. HAVE YOU HAD VENEREAL DISEASE? YES NO

5. HAVE YOU EVER HAD AN ABNORMAL PAP SMEAR? YES NO

6. HAVE YOU HAD OR DO YOU HAVE RECURRENT VAGINAL INFECTION? YES NO

7. HAVE YOU HAD OR DO YOU HAVE PROBLEMS WITH VAGINAL DISCHARGE? YES NO

8. DID YOUR MOTHER TAKE DES WHILE PREGNANT WITH YOU? YES NO

9. HAVE YOU HAD ANY TYPE OF PELVIC INFECTION, DISEASE, ABNORMALITY OR SURGERY OF THE
Vulva Vagina Cervix
Uterus Tubes____ Ovaries
Urinarytract _Anus____ Rectum___

10. HAVE YOUR EVER HAD ENDOMETRIOSIS?
If so, when?_____ How was is treated? _____

11. ARE YOUR FALLOPIAN TUBES OPEN? YES NO

12. HAS EITHER TUBE BEEN REMOVED? YES NO

13. HAVE YOU EVER HAD A HYSTEROSALPINGOGRAM (tubal dye studyyES NO
If so, when?_____ What were the results?_____

14. HAVE YOU EVER HAD A LAPAROSCOPY? YES NO
If so, when?_____ What were the results?_____

13. HAVE YOU EVER HAD A FERTILITY INVESTIGATION? YES NO
If so, what was the diagnosis?
____Anatomical defect
____Hormonal/Glandular disorder
____Other
____No abnormality found

14. HAVE YOU EVER HAD SURGERY FOR INFERTILITY? YES NO
[f so, **give details:**

REPRODUCTIVE HISTORY:

1. ARE YOU MARRIED? YES NO

2. HAVE YOU BEEN MARRIED PREVIOUSLY? YES NO
If so, how many times?_____

3. HOW LONG HAVE YOU BEEN TRYING FOR A PREGNANCY WITH YOUR PRESENT MATE? YES NO

4. HOW MANY TIMES PER WEEK DO YOU HAVE SEXUAL INTERCOURSE WITH YOUR PRESENT MATE? _____

5. DO YOU TRY TO HAVE INTERCOURSE DURING THE FERTILE TIME OF THE MONTH? YES NO
[f so, how do you decide that the best time is?

6. DO YOU HAVE ANY PHYSICAL DIFFICULTIES WITH SEX THAT WOULD PREVENT A CONCEPTION (e.g. pain during intercourse sufficient to prevent penetration)? YES NO

7. DO YOU USE LUBRICANTS DURING SEXUAL INTERCOURSE? YES NO

8. HAVE YOU EVER GONE THROUGH A PERIOD OF SEVERAL MONTHS WHEN YOU HAD LITTLE INTEREST IN SEX? YES NO
If so, give details:

9. HAVE YOU AND YOUR PRESENT MATE EVER HAD A POST COITAL TEST (examination of the cervix for sperm after intercourse)? YES NO
If so, was any incompatibility noted? _____

10. HAVE THERE BEEN ANY PREGNANCIES DURING THIS MARRIAGE? YES NO
If so, when did they occcur?

11. HAVE THERE **BEEN** ANY MISCARRIAGES, ECTOPIC PREGNANCIES OR STILLBIRTHS DURING THIS MARRIAGE? YES NO
If so, when did they occur?

12. HAVE YOU EVER HAD A PREGNANCY THAT RESULTED IN ANY OF THE FOLLOWING?
If so, please specify whether it was with your present or a previous mate:
LOW birth weight baby (less than 5 1/2 Pounds)
'Baby born more than 2 week early?
'Twins, triplets, etc.
'Baby with a birth defect:
Cleft palate
'Harelip
'Limb deformity
'Disease or deformity of the heart, lungs, kidney, genitals, urinary tract, gastro-intestinal 1 tract, nervous system
Malformations of the skull, spine
'Musculoskeletal disorders (e.g. muscular distrophy

distrophy

13. HAVE YOU GIVEN BIRTH TO CHILDREN WHO HAVE ANY OF THE FOLLOWING CONDITIONS?
Please specify whether these children were born to you with your present or a previous mate.

Allergy
‘Asthma
‘Epilepsy
‘Downs syndrome
‘Cystic fibrosis
‘Hemophilia
Mental retardation or learning problem
‘Leukemia
‘Tumor or Cancer
‘Tay-sachs
‘Cerebral palsy
‘Other (specify)

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