BRI Reproductive Immunology Endometriosis Surgery

Dr. Andrea Vidali, MD • **Melvin H. Thornton II, MD**
Director of Reproductive Surgery *Reproductive Endocrinologist & Immunologist*
155 East 76th Street, Suite 1H, New York, NY 10021
135 Pinelawn Road, Suite 115 South, Melville, NY 11747
516.584.8710 T • 516.584.8711 F

NEW PATIENT CONSULTATION QUESTIONNAIRE

PATIENT DEMOGRAPHICS

Name: _____
Patient ID: _____
DOB: _____
Age: _____
Height: _____
Weight: _____
BMI: _____

PARTNER DEMOGRAPHICS

Name: _____
Partner's ID: _____
DOB: _____
Age: _____
Height: _____
Weight: _____
BMI: _____

Address: _____
Phone: _____ Email Address: _____

PATIENT FERTILITY AND MEDICAL HISTORY: SUMMARY

How long have you been trying to conceive (months):
Have you ever been pregnant: ☐ Y ☐ N
Have you ever experienced a miscarriage (Please note that a chemical pregnancy CP is a loss): ☐ Y ☐ N
Age at first miscarriage:_____
Please indicate below the number and mention if the embryo was PGS tested or if the loss was tested (normal/abnormal)
Live births: # miscarriages (including CP): # stillbirth:
ectopic pregnancy: # fresh failed transfers: # frozen failed transfers:
Sequence of event (ex: loss in 2019, live birth in 2017):

Infertility: ☐ Primary ☐ Secondary ☐ Tertiary
Unexplained infertility: ☐ Y ☐ N
Recurrent Pregnancy Loss: ☐ Y ☐ N
AUTO-IMMUNE DISORDER: ☐ Y ☐ N, LIST HERE: _____
Medical condition: ☐ Y ☐ N, LIST HERE: _____
Chief Complaint: Pelvic Pain: ☐ Y ☐ N Abdominal Pain: ☐ Y ☐ N Bladder Pain: ☐ Y ☐ N
Painful Period: ☐ Y ☐ N Pain During Intercourse: ☐ Y ☐ N
Symptoms Present for (months): _____
Please List Any Medical Conditions and Autoimmune Disease in your Family (Precise relationship: endometriosis-mother):

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CURRENT PATIENT MEDICAL HISTORY:

ALLERGIES TO MEDICATION: ☐Y ☐N IF YES LIST: _____

ALLERGIES TO LATEX: ☐Y ☐N CURRENT MEDICATION: _____

PRENATAL VITAMINS: ☐Y ☐N

HABITS: SMOKING: ☐Y ☐N RECREATIONAL DRUGS: ☐Y ☐N

OB/GYN INFORMATION:

Name of OB/GYN: _____

MENSTRUAL HISTORY: REGULAR 28 DAYS: ☐Y ☐N CYCLE DAYS: _____

NUMBER OF DAYS BLEEDING: _____ BLEEDING: ☐ LIGHT ☐ MEDIUM ☐ HEAVY

ANY PRE-MENSTRUAL SPOTTING? ☐Y ☐N IF YES, HOW MANY DAYS: _____

PAP SMEAR W/NORMAL LIMITS: ☐Y ☐N DATE OF LAST PAP SMEAR: _____

MAMMOGRAM NORMAL: ☐Y ☐N DATE OF LAST MAMMOGRAM: _____

ANY HISTORY OF STD'S? ☐Y ☐N PID (pelvic inflammatory disease): ☐Y ☐N IF YES, PLEASE LIST:

_____

HAVE YOU BEEN DIAGNOSED WITH?

ENDOMETRIOSES: ☐Y ☐N PCOS: ☐Y ☐N DYSMENORRHEA: ☐Y ☐N DYSPAREUNIA: ☐Y ☐N

LAPAROSCOPIC SURGERY: ☐Y ☐N IF YES, DATE: _____

FINDINGS: _____

FERTILITY HISTORY

CURRENT RE / FERTILITY CLINIC PHYSICIAN: _____

ADDRESS / TOWN / STATE / ZIP: _____

OFFICE PHONE / FAX: _____

CONTACT NURSE: NAME / EMAIL ADDRESS: _____

FERTILITY TREATMENT HISTORY

HAVE YOU UNDERGONE ANY IUI TREATMENT? ☐Y ☐N

IF YES, HOW MANY CYCLES: _____ NUMBER OF FAILED CYCLES: _____

HAVE YOU HAD ANY MONITORING CYCLES? ☐Y ☐N

IF YES, HOW MANY CYCLES: _____ NUMBER OF FAILED CYCLES: _____

HAVE YOU HAD ANY IVF CYCLES? ☐Y ☐N

IF YES, HOW MANY CYCLES: _____ NUMBER OF FAILED CYCLES: _____

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HAVE YOU HAD ANY FROZEN transfer (FET)? ☐ Y ☐ N
IF YES, HOW MANY TRANSFERS: _____ NUMBER OF FAILED TRANSFERS: _____

DO YOU HAVE ANY FROZEN EMBRYOS AT YOUR CURRENT CLINIC: ☐ Y ☐ N IF YES, HOW MANY _____

ARE THEY PGS TESTED: ☐ Y ☐ N IF YES, HOW MANY _____

FERTILITY CYCLE HISTORY

FSH Cycle (day 3): ☐ Y ☐ N, Value and Date: _____

AMH Levels: ☐ Y ☐ N, Value and Date: _____

Progesterone (day 7 after ovulation): ☐ Y ☐ N, Value and Date: _____

TSH Levels: ☐ Y ☐ N, Value and Date: _____

Prolactin Levels: ☐ Y ☐ N, Value and Date: _____

DHEAS Levels: ☐ Y ☐ N, Value and Date: _____

Testosterone Levels: ☐ Y ☐ N, Value and Date: _____

17-OH Progesterone Levels: ☐ Y ☐ N, Value and Date: _____

PARTNER FERTILITY/MEDICAL INFORMATION

HAVE YOU EVER HAD A SPERMOGRAM TEST: ☐ Y ☐ N

IF YES, WAS IT IN NORMAL RANGE: ☐ Y ☐ N

IF NO, PLEASE CHECK: ☐ LOW SPERM COUNT ☐ LOW MOTILITY ☐ HIGH LEVEL OF OXIDATIVE STRESS

OTHER: _____

HABITS: SMOKING: ☐ Y ☐ N RECREATIONAL DRUGS: ☐ Y ☐ N ALCOHOL: ☐ Y ☐ N

LIST ANY MEDICAL CONDITIONS THAT YOU MAY HAVE:

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PREGNANCY HISTORY *LIVE BIRTH (LB)*

	LB1	LB2	LB3	LB4	LB5
Own Egg / Donor Egg (O/D)					
Sperm Donor / Partner (D/P)					
DOB					
Sex Female (F), Male (M)					
Type of conception Spontaneous (S), IUI, Fresh Transfer (FT), Frozen Transfer (F)					
If IVF, # of Embryos Transferred					
If IVF, Embryo Quality, Grade					
If Frozen Transfer, PGS Test (Y/N)					
Have you been told that your endometrial lining was suboptimal (Y/N)					
If Yes, (Details Required Below)					
Weeks of Gestation					
Delivery Vaginal (V), C-section (C)					
Complication During Pregnancy (Y/N), if yes details required below					
Baby Development Normal (N), Abnormal (A)					
If Abnormal, (Details Required Below)					

Any medications during pregnancy (List of immune therapy etc..)

Endometrial lining was suboptimal details:

Complication During Pregnancy, please detail:

Baby development abnormal *please precise* (ASD, speech delay) details:

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PREGNANCY HISTORY: MISCARIAGE OR STILL BIRTH

Please Check if Miscarriage (SAB) or Stillbirth (SB)	☐ SAB1 ☐ SB1	☐ SAB1 ☐ SB1	☐ SAB1 ☐ SB1	☐ SAB1 ☐ SB1	☐ SAB1 ☐ SB1
Own Egg / Donor Egg (O/D)					
Sperm Donor / Partner (D/P)					
Date					
Type of conception Spontaneous (S), IUI, Fresh Transfer (FT), Frozen Transfer (F)					
If IVF, # of Embryos Transferred					
If IVF, Embryo Quality, Grade					
If Frozen Transfer, PGS Test (Y/N)					
Have you been told that your endometrial lining was suboptimal (Y/N)					
If Yes, (Details Required Below)					
Stage of Loss					
Fetal heart beat detected (Y/N)					
Product of Conception Tested Normal (N), Abnormal (A)					
If Abnormal, (Details Required Below)					
Any report of maternal contamination (Y/N)					

Any medications during pregnancy (List of immune therapy etc.):

If stillbirth, please explain (chorioamnionitis, umbilical cord accident etc.):

Endometrial lining was suboptimal details:

Product of Conception Tested Abnormal please be precise (Trisomy, etc.) details:

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SURGICAL HISTORY

Have You Ever Had Surgery Under Anesthesia? _____

Please List Any Prior Abdominal Surgery:

Surgery Type: _____

YEAR: _____ DOCTORS NAME: _____

FINDINGS: _____

_____

Surgery Type: _____

YEAR: _____ DOCTORS NAME: _____

FINDINGS: _____

_____

Please List Any Prior Uterine Surgery:

HYSTEROSCOPY:

YEAR: _____ DOCTORS NAME: _____

FINDINGS: _____

_____

MYOMECTOMY:

YEAR: _____ DOCTORS NAME: _____

FINDINGS: _____

ENDOMETRIOSIS: ☐ Y ☐ N WAS THE ENDOMETRIOSIS ☐ REMOVED OR ☐ COAGULATED

Please add a timeline of your symptoms and their severity to Dr. Vidali in the section below. Include PDF medical reports associated with this condition. i.e. MRI's, Operative Reports.
Return to: patientrecords@reproductiveimmunology.com.

Add Additional Comments: