**DR. H. ANTHONY PATTINSON**

**Infertility, Gynecology and Obstetrics,**

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Dear Future Parents:

 Your doctor has referred you to my practice to assist you in achieving a healthy pregnancy. In order for your first appointment with me to be as informative as possible, please read this letter over carefully. My staff will be calling you a few weeks prior to your appointment to confirm the date and time and remind you that **you must** **attend together.**

 We have attached lab papers for future Mom to take to the lab on day 2 or 3 of the menstrual cycle. If you do not have a regular period, you may attend the lab on any day. You do not need to fast for this blood test. Please have this test at least 2 weeks before your appointment. It is also recommended that you take a prenatal vitamin and vitamin D 4000iu daily prior to conception.

 Instructions and a lab paper for blood tests and a sperm count are included with the male infertility package for future Dad. You may obtain a sample container from any lab or doctors office. This test must be completed at least 2 weeks prior to our first appointment.

 At your first appointment, we will ask both of you for your completed questionnaires. section. It would also help us to arrive at an earlier diagnosis and treatment plan if you would gather any previous medical records related to your reproductive health for this appointment.

 We look forward to our first visit with you. If you do not feel that you can complete your lab tests in time for your appointment, please contact my office and we will reschedule your appointment for a time that is more convenient for you. If you have any further questions, please do not hesitate to contact my office.

Yours truly,

Dr. Tony Pattinson and Team

Facebook page: “Pattinson Clinic”, Website: www.PattinsonClinic.com

**FEMALE INFERTILITY HISTORY**

This is a confidential document which will be used only for your treatment. Please obtain previous infertility or gynecology records to bring to your first appointment with Dr. Pattinson. **Couples referred for infertility must attend their first appointment together and must both have valid current OHIP cards with photo id in order to be seen.**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_OHIP#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Date of Birth \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_

Marital Status: Married / Common-law / Single,

Husband / Partner’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you been together? ­­­­­­\_\_\_\_\_\_ yrs, and trying to have a baby? \_\_\_\_\_\_\_\_ yrs

If you have ever been pregnant, please give dates and details for the outcome of each pregnancy (eg normal delivery, Cesarean section, miscarriage, abortion etc). Include pregnancies with previous partners.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Pregnancy # | Date M/Y | Duration? full term | Outcome | C-section or vaginal | Complications (if any) | Present health of child if applicable |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

What birth control measures have you ever used?

A. The “pill” yes / no If yes, From \_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you take the pill for cycle control or menstrual pain? Yes/No

B. An IUD yes / no If yes, From \_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_

## C. Have you had a tubal ligation (sterilization) yes / no If yes, when \_\_\_\_\_\_\_\_\_\_

Did you have any problems with any contraceptive method? Yes/No

If yes please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe any exposure to fumes, chemicals or other environmental agents which you feel may be affecting your fertility?

### Menstrual History

How old were you when you had your first period? \_\_\_\_\_\_\_\_\_\_\_ yrs

## As a teenager, were your periods regular? Yes / No Were they painful? Yes / No

How many days to you usually flow with your period? \_\_\_\_\_\_\_\_\_\_ days

What is your cycle length ie how often do you start a period? every \_\_\_\_\_\_\_\_\_\_ days

In the past 12 months, how long was your longest cycle? \_\_\_\_\_\_\_\_\_\_ days

Shortest cycle? \_\_\_\_\_\_\_\_\_\_ days

Are your periods painful? Yes / No

If yes, what do you take for the pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Does it help? Yes / No

Do you experience cramping around the expected time of ovulation? Yes / No

Do you ever notice any discharge from your breasts? Yes / No

Approximately how often do you have intercourse per week \_\_\_\_ or per month \_\_\_\_\_

Do you have pain with intercourse? Yes / No

Do you use any creams or lubricants with intercourse? Yes / No

Are there any other sexual problems you would like to discuss Yes / No

Has there been any abuse in your current relationship? Yes/No Have you had any of the following tests to investigate your fertility problem?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Test** | **Yes/No/Not sure** | **When** | **Doctor** | **Result (normal / abnormal) – describe if possible** |
| Hormone Blood tests to check fertility |  |  |  |  |
| Any other blood test (Describe) |  |  |  |  |
| X-Ray to see if tubes open |  |  |  |  |
| Laparoscopy |  |  |  |  |
| Ultrasounds |  |  |  |  |
| Other (Describe) |  |  |  |  |

Have you ever been given a diagnosis by a specialist about your fertility problem?

Yes/No If yes please explain.

Do you have, or have you had, any long term illness, or any other medical condition that you have required treatment for? Yes / No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last Pap? \_\_\_\_\_\_\_\_\_\_ Was it normal? Yes/No

Have you ever had an abnormal pap? Yes/No. If yes what treatment did you have?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had Surgery? If yes, give details:

|  |  |  |  |
| --- | --- | --- | --- |
| Date | Hospital | Surgeon | Procedure |
|  |  |  |  |

Do you smoke? Yes/No If yes how much?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? Yes/No If yes how much?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many caffeine containing drinks do you consume daily (coffee, cola etc) \_\_\_\_\_

Are you taking any medications, including “natural remedies” and vitamins? Yes / No

If yes, please describe which drugs and how often you use them \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any allergies? Yes / No

If yes, please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use any street drugs? Yes / No If yes, What \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had an infection of the tubes or ovaries (eg “PID”) Yes / No

Have you ever had a sexually transmitted (venereal) disease or hepatitis? Yes / No

Are you immune to Rubella (German Measles) Yes / No

What is your Height? \_\_\_\_\_\_\_\_\_\_Weight? \_\_\_\_\_\_\_\_\_\_\_BMI?\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your weight been stable over the past two years? Yes / No

If no, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe your physical fitness strategies:

Have you had any of the following treatments for your infertility?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Treatment** | **When** | **How often** | **Success?** | **Comments** |
| Clomiphene (Clomid, Serophene) or Letrozole |  |  |  |  |
| Artificial Insemination (IUI, TDI, sperm wash) |  |  |  |  |
| Ovarian Stimulation with Puregon, or Gonal-F |  |  |  |  |
| IVF |  |  |  |  |
| ICSI |  |  |  |  |
| Other |  |  |  |  |

Have either of you, or anyone in either of your families, ever had any of the following disorders?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Who? |  | Who? |
| Down’s Syndrome (mongolism) | Yes/No |  | Cystic Fibrosis | Yes/No |  |
| Other chromosomal abnormalities (Trisomy, Turner’s, Kleinfelter’s) | Yes/No |  | Neural tube defect, eg spina bifida, hydrocephalus etc | Yes/No |  |
| Cleft lip and/or palate | Yes/No |  | Mental retardation | Yes/No |  |
| Limb abnormalities | Yes/No |  | Diabetes Mellitus (sugar) | Yes/No |  |
| Hemophilia | Yes/No |  | Epilepsy | Yes/No |  |
| Muscular dystrophy | Yes/No |  | Tay Sachs | Yes/No |  |
| Thyroid disease | Yes/No |  | Deafness/Blindness | Yes/No |  |
| Tuberculosis | Yes/No |  | High Cholesterol | Yes/No |  |

If yes, details\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Think of your brothers and sisters and their children. Are there any among them with:

|  |  |  |  |
| --- | --- | --- | --- |
| Birth defects / genetic disease | Yes / No | Stillbirth | Yes / No |
| Mental retardation (or “slow”) | Yes / No | Childhood death | Yes / No |
| Childhood handicap | Yes / No |  |

Think of your parents, uncles, aunts and cousins. Are there any among them with:

|  |  |  |  |
| --- | --- | --- | --- |
| Birth defects / genetic disease | Yes / No | Childhood handicap | Yes / No |
| Mental retardation or mental illness | Yes / No | Cancers | Yes / No |

Do either you or your partner have a birth defect? Yes / No

 If yes, please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did either of your mothers have any miscarriages or infant/childhood deaths? Yes/No

Have either you or your partner had any genetic or chromosome testing? Yes/No

Are you and your partner related by blood? Yes / No

Do either of you belong to any of the following ethnic groups Yes / No

|  |  |
| --- | --- |
| African (sickle cell) | Jewish (Tay Sachs) |
| Chinese (α or β Thalassemia) | Portugese (β Thalassemia) |
| Greek, Italian or Maltese (β Thalassemia) | South East Asian (α or β Thalassemia)  |
| East Indian (α or β Thalassemia) | Other orthodox religious groups |