Guidelines for scheduling preconception appointments for Dr. Bathgate:

1. Please urge new patients to come early to fill out paper work and verify insurance.
2. The patient's partner is invited and encouraged to come to the appointment.
3. The woman and her partner should both fill out the preconception questionnaires and bring these completed questionnaires with them to their appointment.
4. If they have any specific medical questions about past conditions, if possible please have them bring copies of any medical records or tests that they might have.
5. A physical exam is not part of the preconception visit. If they are in need of an annual exam or have a specific physical problem requiring an examination, they should schedule a separate visit for this.
6. Please mail or fax a set of one female and one male preconception questionnares to the patient at the time she makes the appointment.
7. Encourage the couple to notify our office in advance of her appointment if she has not received the questionnaires.

Thank you.

Dear Patient,

Thank you for scheduling an appointment with me for preconception counseling. My interest in helping couples prepare for pregnancy comes from my work with complicated and high risk pregnancies. My goal is to identify and help modify risk factors for poor prenancy outcome before pregnancy whenever possible. To make the most out of your appointment, I would like you and your partner to complete the enclosed questionnaires before your appointment, and bring them with you to your visit. If you have particular medical questions about past or current medical conditions, please bring any copies of medical records and results of tests that you may have. I look forward to seeing you at your upcoming appointment.

Sincerely,

Susanne L. Bathgate, MD
Assistant Professor
Division of Maternal-Fetal Medicine

INTRODUCTION

The Pre-Conception Program of the Department of Obstetrics & Gynecology and the Center for Integrative Medicine at George Washington University Medical Center is a clinical program designed to optimize your obstetrical potential. We believe that by putting you in an optimal health **– *physical, emotional and social* –** environment, you will achieve the best possible obstetrical outcome. This may mean the reduction or prevention of miscarriages and other pregnancy related complications. If you have difficulty in conceiving, the program may enhance the results of your fertility treatments.

This program is based on the sound principle of prevention and supported by the result of the *Foresight Program* of the University of Surrey, England (web address), which was established in 1990. This is a six month program starting with two months of testing, diagnosis and planning followed by four months of implementation of the treatment plan, prior to any effort to conceive. It is rigorous and demands your and your partner's commitment and active participation in every phase of the program. We will provide tools, guidance and encouragement and you have to do the work.

The first step is to fill out the enclosed questionnaire. This is your complete health inventory and forms the basis of our management plan. It is therefore important that you fill this out to the best of your ability. We will address any questions and concerns at the initial interview. This is part of your confidential medical record and **will not** be shared with anyone other than direct caregivers without your expressed permission.

We are privileged to be your healthcare partners and we are committed to do our best to help you reach your healthcare goals.

Susanne Bathgate MD
Assistant Professor
Medical Director – Pre-Conception Program
Department of Obstetrics & Gynecology

John Pan MD
Clinical Professor
Director
Center for Integrative Medicine

MALE QUESTIONNAIRE

PATIENT INFORMATION

Name ____

Spouse/Partner's Name______________________________

Address ____

_______________________________ zip______________

Tel: Home ________________Work___________________

Fax______________________E-Mail__________________

Date of Birth ____________________________Age_______

Education ____

Occupation ____

****

Were you referred by another healthcare professional? If so, by whom were you referred?

What do you hope to achieve by participating in this preconception program?

What are your goals?

FEMALE QUESTIONNAIRE

PATIENT INFORMATION

Name ____

Spouse/Partner's Name______________________________

Address ____

_______________________________ zip______________

Tel: Home ________________Work___________________

Fax______________________E-Mail__________________

Date of Birth ____________________________Age_______

Education ____

Occupation ____

****

Were you referred by another healthcare professional? If so, by whom were you referred?

What do you hope to achieve by participating in this preconception program?

What are your goals?

MEDICAL HISTORY

Past Medical Illnesses: (Check diseases/conditions that apply to you. Indicate date if in the past.)

Please use the bottom or reverse side of the page to elaborate if necessary.

Disease/Condition	Now	Past/Date	Disease/Condition	Now	Past/Date	Disease/Condition	Now	Past/Date
Chicken Pox			Tuberculosis			Cystic Acne		
German Measles			Stomach Ulcers			Psoriasis		
Measles			Colitis			Anemia		
Mumps			Hiatal Hernia			Diabetes		
Polio			Irritable Bowel			Hayfever		
Rheumatic Fever			Gallbladder Disease			Heart Disease		
Scarlet Fever			Hepatitis			Hypertension		
CMV virus			Jaundice			Reynaud's Syndrome		
HIV virus (AIDS)			Bladder infection			SLE (Lupus)		
Lyme Disease			Kidney infection			Thyroid Disease		
Menigitis			Kidney Disease			Depression/Anxiety		
Tension headaches			Bursitis/Tendonitis			Anorexia		
Migraine headaches			Gout			Bulimia		
Seizures			Osteoarthritis			Alcohol problem		
Asthma			Rheumatoid Arthritis			Drug problem		
Pleurisy			Eczema			Food/Drug/Chemical Poisoning		
Pneumonia								

Review of Symptoms: (Check symptoms that apply to you)

Symptoms	now	past	Symptoms	now	past	Symptoms	now	past
Back/Leg pain			Strange odor/taste			Blood in urine		
Neck/Shoulder/Arm Pain			Persistent hoarseness			Burning on urination		
Joint stiffness			Difficulty Swallowing			Swollen legs		
Joint pain			Mouth dryness			Fatigue		
Joint swelling			Mouth tightness			General weakness		
Joint redness/heat			Mouth sores			Fever		
Numbness			Chronic cough			Chills		
Fainting spells			Chest Pain			Night sweats		
Dizziness			Shortness of breath			Easy bruising		
Unconscious spells			Heart palpitation			Sun sensitivity		
Blurred/Double vision			Belching/Heartburn			Heat sensitivity		
Eyes red/gritty/pain/dry			Stomach ulcer			Cold sensitivity		
Hearing problems			Nausea/Vomiting			Hair loss		
Ringing in ears			Diarrhea			Bleeding gums or gum disease		
Nose bleeds			Constipation					
Sinus problems			Blood in stool					

Last dental examination _______________

Have you ever been vaccinated against:

	Yes	No		Yes	No		Yes	No
Tetanus			Hepatitis A			Pneumococcus		
Rubella (German measles)			Hepatitis B			Lyme Disease		
Influenza			Varicella (chicken pox)					

Have you been diagnosed and/or treated for cancer?

What kind ____When:________________

What type of treatment & dates: ____

____

Have you been diagnosed and/or treated for a psychiatric disorder or sought counseling?

What type:____

Describe treatment & dates:____

Have you been hospitalized for any illness? Please describe:

____

____

Have you ever had injuries (broken bones, concussion, etc.) or accidents? Please describe & date

____

____

Have you had any surgery? Please describe & date

____

____

Have you had a blood or plasma transfusion?_____________

Allergies (drugs, food, etc.)

____

FAMILY & GENETIC HISTORY

MEDICAL

Any of your blood relatives have:

Stroke ___ who ________ Heart Disease ___ who ________

High Blood Pressure ___ who ________ Diabetes___ who ________

Blood Clots/Phlebitis ___ who ________ Arthritis ___ who ________

Tuberculosis ___ who ________ Alcoholism ___ who ________

Cancer ___ Type ______________________________ who______________________________

Psychiatric Disorder ___ Type ____________________ who ____________________________

Other medical problems ____

GENETIC

Do you have any children with birth defects, handicaps, or a genetic disease? ___

Explain ____

Are you and your partner blood relatives? _____ Explain __________________________________

Any of your blood relatives have the following: (check)

Anencephaly (open skull)	Hemophilia (bleeding disorder)	Neurofibromatosis
Blindness or Eye problem	Huntington's disease	Neuologic disorders
Bone disorder	Infertility – Miscarriages	Phenylketonuria
Cerebral Palsy	Kidney disease	Short stature (under 5 ft.)
Chromosomal abnormality	Limb defects	Sickle cell anemia
Cleft lip/palate	Malformation at birth	Skin condition
Deafness	Mental illness	Slow growth in child
Down Syndrome (Mongolism)	Mental retardation	Spina Bifida (open spine)
Epilepsy or Seizures	Muscular Dystrophy	Tay Sachs disease
Heart defects	Myotonic Dystrophy	

Ethnicity:

What is your ethnic background?
What countries or parts of the world are your ancestors from?
Do you have any of the following in your ancestry:

African American		Celtic – English Isle		French Canadian	
Cajun		Hispanic		Mid-Eastern	
Caribbean		Indian		Greek	
Caucasian		Italian		Others specify	
Eastern European		Oriental			

Have you been tested for any of the following? If so, indicate carrier (c) or non-carrier (n)

Sickle cell trait		Tay Sachs disease		Cystic fibrosis	
Alpha or Beta thalassemia		Canavan's disease		Gaucher's disease	

SOCIAL & ENVIRONMENTAL HISTORY

Residence & Travel

Country of birth _______________ Have you lived outside the US ___________

Where & When ____

Do you or your partner regularly travel outside US ______

Where & How Often ____

Domestic

Who lives in your household:____

Are you a caretaker outside your home? Who __________________________________

Do you have smoke detectors ____ Do you have cats in your household _____

Occupation

What is it? ______________________________

Describe your typical work day:____

Do you commute: _______ How long: ________ Use seat belt? ______

Toxic Exposures – Are you regularly exposed to, in contact with or consume:

Aluminum utensils		Herbicides		Plastic wrap	
Anesthetic gasses		Lead (old paint/pipes)		Radiation	
Anti acids		Microwave		Video monitor	
Copper/brass jewelry		Mothballs		Blood borne diseases	
Electric blanket		Organic chemicals		Viral diseases	
Foil wrap		Paint stripper		Cats	
Food additives		Pesticides		Rare/Raw meat	

Domestic Violence

*You may choose to answer the following questions personally if you prefer

In the past 12 months:

Has anyone threatened you with or actually used a knife or gun to scare or hurt you? ___

Has anyone choked, kicked, bit or punched you? ___

Has anyone slapped, pushed, grabbed or shoved you? ___

Has anyone forced or coerced you to have sex? ___

Have you been afraid that a current or former intimate partner would hurt you physically?

If any of the above answer is yes:

What is the relationship with the person who hurt you? ___________________________

Have the police been notified? ______ When: ___________________________________

NUTRITION, WELLNESS & LIFESTYLE

Height____ Weight: Now_____ One year ago_____ Maximum _____ When?_________________

Describe weight fluctuation ____

I consider my weight to be: (Please check which statement applies to you)
____not a factor in my present health issues
____somewhat a factor
____a significant factor

Do you smoke?____ If so, how many packs per day?____
Are you exposed to second hand smoke?__________
Do you drink alcohol?____ How many drinks per week?____
Do you drink caffeinated coffee?____ How much?____
Have you ever used intravenous drugs?____

Please describe your present eating style (Please check any that apply)

Omnivore (Include meat/poultry/fish/eggs/dairy)____
Semi-vegetarian____ (I exclude some animal products, specifically______________________________).
Ovo-lactovegetarian (I exclude all animal flesh but include dairy and eggs)____
Vegan (I do not include any animal products)____
Macrobiotic____
Other (Please describe)____
How many times per week do you eat red meat?____
How many times per week do you eat chicken or fish?____
How many times per week do you eat desserts?____
Indicate how many servings of fruits and vegetables you eat per day____
How many whole eggs do you eat a week?____
How often do you eat out?____
Do you eat unpasteurized cheese or unpackaged deli meat or cheeses _______
Do you regularly add salt at the table?____
I have food allergies and/or intolerances (please describe)_____________________________________
I tend to eat pretty much the same things on a regular basis, i.e., not a lot of variety____
I tend to skip meals, specifically____
I tend to snack a lot, specifically throughout the day____; mainly at night____
I tend to overeat if I am not careful_____
I often succumb to food cravings, specifically____
I am concerned about getting optimum nutrition because of______________________________________
Briefly, how would you describe your diet (what ever you want to say)____________________________
____
____

Recent improvements that I have made in my diet include_______________________________________
____

The factors in my life that interfere with eating better are___________________________________
____

My interest and motivation to make and sustain improvements in my diet at this time are:

____none ____slight ____moderate ____strong ____very strong

Do you participate in aerobic exercise?____ How often?____
How many minutes do you exercise at one time?____
Do you perform strength training or floor exercises, resistance training or lift weights?____
Do you stretch regularly?____
Describe any physical problems that prevent you from exercising ________________________________

Have you felt tired, worn out, or exhausted during the past month?____

How often do you get at least 7 to 8 hours of sleep each day?_____

Do you often have insomnia?____

Do you consider yourself generally happy these days? _______

Do you feel as though you have a strong social support system/people to talk to, share things with (family, friends)?____

How many sick days have you taken in the past 12 months due to sickness or injury?____

Do you feel as though you are often under stress or pressure?____

On a scale from 0 to 10, where 0 is a thoroughly easy-going person and 10 is a very high-strung person, please rate how you generally consider yourself. ____ How do you think others would rate you?____

Please identify the three biggest stresses in your life right now
1.
2
3.

If there were three things you could change about yourself right now, what would they be?
1.
2.
3.

Please describe two or three of your greatest strengths and/or achievements

____

____

____

Are you generally satisfied with your job?____

Please describe any physical factors or environmental problems at work that impact your health, safety or job satisfaction (for example: temperature, workspace, relations with coworkers, etc.)

____

____

How important is spirituality in your daily life? (Not important) 1 2 3 4 5 (Very Important)
Do you participate in a faith community?____
What is your religious affiliation?______________________________
How important is your religious affiliation in your daily life? (Not important) 1 2 3 4 5 (Very important)

MALE FERTILITY HISTORY

Have you ever fathered a pregnancy before?________

If so, was the pregnancy miscarried or aborted?__________

Do you have any children?________

What is the health of the child or children?________________________________

Have you ever had sores or rashes of the penis?

Have you previously been treated for a sexually transmitted disease?________________

Have you ever had any genital injuries or surgeries?_______________________

Have you ever sought evaluation or treatment for difficulty conceiving?___________

If so, what tests or treatments have you had, and what were the result?__________

____

____

OBSTETRIC, GYNECOLOGIC & FERTLITY HISTORY

Date of last gynecologic exam __________Pap smear result ______ Previous abnormal____
Date of last mammogram______________

Current method of birth control: Pills ___ Injections ___ Condom/Diaph ___ IUD ___Rhythm ___ None ___
Past method of birth control: Pills ___ Injections ___ Condom/Diaph ___ IUD ___Rhythm ___ None ___

Previous Gynecologic Surgery (list date, type, indication):

Do you have history of:
Painful intercourse ____ Sexual dysfunction _____________________________

Genital Herpes ____Genital Warts ____STD ______Recurrent vaginal infections ____
Partner with penile discharge or sores ____
Uterine Fibroids_____ Endometriosis ______ Infertility______
Ovarian cysts_____ Fibrocystic Breasts______
Have you ever been tested for chlamydia or gonorrhea ________
Have you been tested for chlamydia or gonorrhea during this relationship__________

Menstrual History
Date of last menstrual period: _____________ Age of onset: ______
Length of menstruation _________days Frequency, every __________days
Amount: ___ Heavy ___Medium ____Light
Cramps: ___Severe ___Moderate ____Mild
Abnormal Period ____ Describe:
Medications (including herbs):
____

Pregnancy History

	Year	Type of Delivery	Miscarriage/Termination	Length of Pregnancy	Complication	Health of Child
1						
2						
3						
4						
5						
6						

Infertility History
Primary infertility ___ How long ____ Secondary infertility ___ How long ____
Male factor ___ What kind ____
Work-up: Hormonal/BBT ___ HSG ___ Laparoscopy ___

Result: ____
Treatment: Ovulation induction ___Corrective surgery ___ IVF ___

Describe:____

Medications (including herbs):

____

COMPLEMENTARY ALTERNATIVE MEDICAL CARE HISTORY

Please check each type of complementary care that you have tried or that interests you:

	TRIED	INTERESTED		TRIED	INTERESTED
Acupuncture			Massage Therapy		
Alexander Technique			Meditation		
Chinese Herbs			Mind-Body Medicine		
Western Herbs			Nutrition Counseling		
Chiropractic			Reiki		
Guided Imagery			Spiritual Direction		
Homeopathy			Yoga		

Others: ____

If you have already tried a complementary therapy, please explain the reason you selected the therapy and your goals. How effective has the therapy been? _______________________________________

____

____

____

Please list the practitioners: ____

____

____Do you use herbs or vitamin supplements? What are you using? For what purpose?_______________

____

____

____

____

MEDICATION HISTORY

What prescription medications are you now taking or have you taken in the past?

Medication and Dose	Indication	Start Date	Stop Date

What nonprescription (over-the-counter) medications are you now taking or have you taken in the past?

Medication and Dose	Indication	Start Date	Stop Date