NEW PATIENT HISTORY

REFERRED BY: _____

1. IDENTIFYING INFORMATION

Name _____ DOB ____/____/____ Age _____

Significant Other Name _____ DOB ____/____/____ Age _____

Date this form completed ____/____/____ Primary Care MD _____

Primary GYN _____ Number of years together _____

How long have you been attempting conception? _____ Marital Status _____

Reasons you are coming to see us: _____

_____

_____

2. RACE (You)

❑ Caucasian ❑ Hispanic
❑ Asian ❑ African American
❑ Other (_____)

ETHNICITY
❑ Ashkenazi Jew ❑ Southeastern Asian
❑ Greek/Italian

Significant Other

❑ Caucasian ❑ Hispanic
❑ Asian ❑ African American
❑ Other (_____)

❑ Ashkenazi Jew ❑ Southeastern Asian
❑ Greek/Italian

3. PREGNANCY HISTORY

Times pregnant _____ Term births _____ Premature births _____ Miscarriages _____ Elective abortion _____ Adopted children ____

Date	Miscarriage	Elective Abortion	Ectopic	Months to conceive?	Infertility Treatment	Weight and Sex?	C-section?	Complications?	Is current Partner the father?
1.									
2.									
3.									
4.									

4. CONTRACEPTIVE USE

Type	From when to when	Reason discontinued
1.		
2.		
3.		

5. OPERATIONS AND HOSPITALIZATIONS

Date	Diagnosis	Operation	Where	Physician
1.				
2.				
3.				

6. MEDICATIONS

List all prescriptions and over-the-counter drugs used during the past year

Date	Dose and Frequency	From when to when	Reason
1.			
2.			
3.			

7. ALLERGIES

Drug or substance	When	Reaction
1.		
2.		

8. MENSTRUAL/HORMONAL

Height _____ Weight _____ Blood Type (if known) _____

Age at first period ..... Date of last two menstrual periods ____/____/____ and ____/____/____

Are your periods regular? ❑ yes ❑ no Do you bleed between periods? ❑ yes ❑ no

How many days from onset to onset? ..... What is the usual duration of your periods? .....days

Premenstrual symptoms occur: ❑ almost always ❑ rarely ❑ never

Vigorous exercise: type ..... hrs/week ..... type ..... hrs/week.....

If you have a hormonal disorder, please specify type and treatment: .....

Last pap smear ____/____/____ Last mammogram ____/____/____

Pelvic pain/cramps: ❑ none ❑ during menses ❑ before menses ❑ after menses ❑ at midcycle

❑ during intercourse ❑ with bowel movements ❑ with urination ❑ cause you to miss work ❑ cause you to miss usual activities

Pelvic pain/cramps are: ❑ mild ❑ moderate ❑ severe

❑ worsening ❑ improving ❑ no change ❑ in midline ❑ on right side ❑ on left side

Frequency of intercourse _____

Do you have or have you had? (Check all that apply).

- ❑ Hot flushes
- ❑ Breast discharge
- ❑ Visual disturbance
- ❑ Poor sense of smell
- ❑ Chronic headache
- ❑ Head trauma
- ❑ Increased facial or body hair
- ❑ Increased acne
- ❑ Weight increase > 10 pounds
- ❑ Weight loss > 10 pounds
- ❑ Special dietary habits
- ❑ Vomiting
- ❑ Seizures
- ❑ Diabetes
- ❑ Thyroid disorder
- ❑ Autoimmune disease
- ❑ Extraordinary stress
- ❑ Psychiatric treatment

Please explain a "Yes" answer: _____

_____

_____

9. GYNECOLOGIC / INFECTION

Do you have or have you had?

- ❑ Pelvic infection
- ❑ Chlamydia
- ❑ Endometriosis
- ❑ Pelvic adhesions
- ❑ Cervicitis
- ❑ Genital herpes
- ❑ Appendicitis
- ❑ Colitis or enteritis
- ❑ Uterine fibroids or myomas
- ❑ Abnormal uterus shape
- ❑ Recurrent vaginitis
- ❑ Abnormal Pap smears
- ❑ Gonorrhea
- ❑ Syphilis
- ❑ Mycoplasma
- ❑ Ureaplasma
- ❑ Genital warts / condyloma
- ❑ Cryo (freezing) or surgery of the cervix
- ❑ Ovarian cysts
- ❑ Toxoplasmosis
- ❑ Cytomegalovirus (CMV)
- ❑ Tuberculosis
- ❑ Trichomonas

10. OTHER HISTORY

Your occupation: ..... Spouse's occupation: .....

Cigarettes - packs smoked per day: .....

Alcohol - type and number per week: .....

Marijuana - amount: .....

Other drugs - type and amount: .....

Caffeine drinks per day: .....

Video display terminal hours / day: .....

Electric blanket use: ❑ yes ❑ no Toxic exposure: ❑ yes ❑ no

Ever used intravenous drugs? ❑ yes ❑ no Hot tub or sauna use: ❑ yes ❑ no

Radiation exposure: ❑ yes ❑ no

11. MEDICAL ILLNESSES

Do you have or have you had?

- ❑ Cancer
- ❑ Diabetes
- ❑ Hypertension
- ❑ High cholesterol
- ❑ Heart disease
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ Mitral valve prolapse
- ❑ Heart murmur
- ❑ Asthma
- ❑ Pneumonia
- ❑ Bronchitis
- ❑ Tuberculosis
- ❑ Hepatitis / liver disorder
- ❑ Gall bladder problems
- ❑ Ulcers
- ❑ Colitis / enteritis
- ❑ Kidney disorder
- ❑ Rubella
- ❑ Anesthetic complication
- ❑ Mumps
- ❑ Chicken pox
- ❑ Mononucleosis
- ❑ Serious injury / accident
- ❑ Blood transfusion
- ❑ Psychiatric disorder
- ❑ Seizures
- ❑ Stroke
- ❑ Blood clots
- ❑ Anemia
- ❑ Bleeding disorder
- ❑ Thyroid disorder
- ❑ Recent immunization

Please explain a "Yes" answer to any of the above: .....

.....

.....

12. FAMILY HISTORY

	Living?	Age or age at death	Health Problems
Mother	:	:	:
Father	:	:	:
Sister(s)	:	:	:
	:	:	:
	:	:	:
Brother(s):	:	:	:
	:	:	:
	:	:	:
Daughter(s)	:	:	:
	:	:	:
Son(s)	:	:	:
	:	:	:

Which of your blood relatives have?

- Cancer .....
- Venous Thrombosis (blood clotting) .....
- Diabetes .....
- Hypertension .....
- High Cholesterol .....
- Heart disease .....
- Stroke .....
- Premature menopause .....
- Endometriosis .....
- Uterine fibroids (myomas) .....

13. GENETIC HISTORY

Do you, your partner, or anyone in either family have? ❑ Any inherited disorders?

- ❑ Neural tube defects/spina bifida/anencephaly
- ❑ Thalassemia
- ❑ Down syndrome
- ❑ Cystic fibrosis
- ❑ Muscular dystrophy
- ❑ Huntington chorea
- ❑ Mental retardation / fragileX
- ❑ Tay-Sachs disease
- ❑ Sickle cell disease or trait
- ❑ Hemophilia
- ❑ Hormonal disorder
- ❑ Chromosomal disorder
- ❑ Genetic / inherited disorder
- ❑ Baby with birth defects
- ❑ Infertility

Please explain a "Yes" answer to any of the above: .....

.....

14. SYSTEMIC REVIEW

Headaches: Number per week _____ Medication used _____

- ❑ mild
- ❑ improving
- ❑ with visual symptoms
- ❑ stress related
- ❑ moderate
- ❑ worsening
- ❑ with vomiting
- ❑ migraines
- ❑ severe
- ❑ no change

- ❑ Wear glasses
- ❑ Wear contact lenses
- ❑ Sinus problems
- ❑ Hayfever
- ❑ Ringing in ears
- ❑ Hearing loss
- ❑ Denture / bridges

- ❑ Anemia
- ❑ Chest pain
- ❑ Irregular heart beat
- ❑ Fainting spells
- ❑ Leg swelling
- ❑ Calf pain
- ❑ Blood clots (venous thromboembolism)
- ❑ Cough
- ❑ Shortness of breath
- ❑ Wheezing
- ❑ Cough up blood
- ❑ Chest x-ray
- ❑ TB skin test

- ❑ Bladder/kidney infections
- ❑ Urgent / frequent / painful urination
- ❑ Blood / abnormal color of urine
- ❑ Unable to control urination
- ❑ Abnormal urinary tract
- ❑ Kidney x-ray
- ❑ Bladder cystoscopy

- ❑ Varicose veins
- ❑ Easy bruising
- ❑ Prolonged bleeding
- ❑ Bleeding from gums
- ❑ Nosebleeds
- ❑ Take aspirin/ibuprofen frequently

- ❑ Breast mass
- ❑ Fibrocystic changes
- ❑ Breast implants
- ❑ Mammogram
- ❑ Do monthly breast self-exam

- ❑ Abdominal pain
- ❑ Nausea and vomiting
- ❑ Vomiting blood
- ❑ Ulcer
- ❑ Food intolerance
- ❑ Gallstones
- ❑ Jaundice / hepatitis
- ❑ Chronic constipation
- ❑ Diarrhea
- ❑ Blood in bowel movement
- ❑ Irritable bowel
- ❑ Hemorrhoids
- ❑ Hernia
- ❑ Abnormal liver test
- ❑ Arthritis
- ❑ Back pain

- ❑ Acne
- ❑ Skin disorder
- ❑ Rash
- ❑ Hives
- ❑ Skin cancer

- ❑ Counseling
- ❑ Recent stress increase
- ❑ Recent anxiety increase

- ❑ Sensation loss / numbness
- ❑ Muscle control / weakness
- ❑ Heat or cold intolerance
- ❑ Damp skin
- ❑ Unusual hair loss
- ❑ Extraordinary fatigue

OTHER: _____

_____

_____

15. MALE HISTORY:

- ❑ Medications:
- ❑ Illnesses:
- ❑ Mumps:
- ❑ Smoker:
- ❑ Alcohol:
- ❑ Ejaculatory Disorder:
- ❑ Reproductive surgery:
- ❑ STDs:
- ❑ Testicular trauma:
- ❑ Impotence:
- ❑ Allergies: _____

_____

Have you seen a urologist for infertility? ❑ Yes ❑ No
If yes: Physician name and location .....

Have you ever fathered a child/pregnancy with another woman? ❑ Yes ❑ No
If yes, when? ..... years ago

Have you ever been diagnosed with an infertility diagnosis except for currently? ❑ Yes ❑ No
If yes, when? ..... years ago

Comments: _____

_____

16. HISTORY OF FERTILITY THERAPY (Fill out, if applicable).

Have you been treated for infertility previously? ❑ yes ❑ no
If yes, who was your physician? .....

What cause of infertility was diagnosed? .....

What drugs have you taken for infertility? Please check all that apply:

❑ Clomid (Serophene)	❑ hCG Profasi	❑ Antibiotics
❑ Gonal F	❑ Progesterone	❑ Baby aspirin
❑ Follistim	❑ Lupron	❑ Heparin
❑ Repronex	❑ Microdose Lupron	❑ Steroids
❑ Pergonal	❑ Antagon	❑ Oral Contraceptives
❑ Fertinex	❑ Parlodel	❑ Other .....

Which of the following tests have you or your partner had performed? Please check all that apply and results, if known:

❑ BBT	When ____/____/____	Results .....
❑ Postcoital Test	When ____/____/____	Results .....
❑ Hormonal Assays (FSH, LH, Prolactin, Estradiol, DHEA-S, Testosterone, Progesterone)	When ____/____/____	Results .....
❑ Endometrial biopsy	When ____/____/____	Results .....
❑ Hysterosalpingogram	When ____/____/____	Results .....
❑ Sonohystogram	When ____/____/____	Results .....
❑ Ultrasound	When ____/____/____	Results .....
❑ Laparoscopy, Hysteroscopy	When ____/____/____	Results .....
❑ Mycoplasma culture	When ____/____/____	Results .....
❑ Chlamydia culture	When ____/____/____	Results .....
❑ GC Culture	When ____/____/____	Results .....
❑ Thyroid tests	When ____/____/____	Results .....
❑ Rubella (German measles)	When ____/____/____	Results .....
❑ Varicella (Chicken pox)	When ____/____/____	Results .....
❑ Cytomegalovirus (CMV)	When ____/____/____	Results .....
❑ Antibody screen	When ____/____/____	Results .....
❑ Blood type	When ____/____/____	Results .....
❑ Chromosomes	When ____/____/____	Results .....
❑ Genetic screening	When ____/____/____	Results .....
❑ Hepatitis B	When ____/____/____	Results .....
❑ Hepatitis C	When ____/____/____	Results .....
❑ HIV	When ____/____/____	Results .....
❑ HTLV	When ____/____/____	Results .....
❑ RPR (Serology)	When ____/____/____	Results .....
❑ Semen analysis	When ____/____/____	Results .....
❑ Antisperm antibodies	When ____/____/____	Results .....
❑ Varicocele repair	When ____/____/____	Results .....
❑ Testicular biopsy	When ____/____/____	Results .....

❑ OTHER: .....

Have you ever undergone Artificial Insemination (IUI) or In Vitro Fertilization (IVF)? ❑ yes ❑ no
If yes, ❑ partner ❑ donor sperm

Clomid ❑ yes ❑ no Fertility Shots ❑ yes ❑ no name of medications_____

#IUI's _____ Dates_____

#IVF cycles _____ Dates_____