

Patient Label

Date of Visit: ____/____/____

Age: ____ Height: ____ BMI: ____

New Patient History

Please Note: All information is confidential and will only be used for the purpose of ensuring you the best treatment possible. Please answer all areas:

Why have you come to the office today?
Are you having any problems? How long have you had the problem(s)?

Who referred you to our practice: Self Friend Physician (List Name) _____

Who is your current Ob/Gyn? _____ Location: _____

Past Medical History (√ If you have or have ever had)

	√		√		√
Anemia/blood disease		Gall bladder disease		Prior blood clots (DVTs)	
Arthritis		Headaches/migraine		Reflux/Hiatal Hernia	
Asthma		Heart disease/valve problems		Skin disease	
Bladder problem/infections		High blood pressure		Stomach ulcer	
Blood transfusion		Kidney disease		Thyroid disease	
Bowel/intestinal disorder		Leukemia		Tuberculosis	
Cancer		Liver disease/hepatitis		Varicose veins/phlebitis	
Diabetes		Lung disease		Weight loss/gain ≥ 10 lbs	
Endometriosis		PCOS (Polycystic Ovarian Syndrome)			
Epilepsy/neurologic disease		Prior Pulmonary Embolus (PE)			

Other medical problems (list):

Surgeries/Operations (Any procedure, including D&C's)

Type/Reason	Date	Location	Physician

**Other Illnesses/
Hospitalizations**

Type/Reason	Year

Current Medications

(Include any hormones, vitamins, herbs, over the counter & nonprescription meds) **Dose**

Allergies/Reactions

(List any drug or food allergy & reaction type)

History

First day of last menstrual period: / /	Have you ever had an abnormal Pap test? Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have regular monthly periods? Yes <input type="checkbox"/> No <input type="checkbox"/>	Have you ever had a procedure on your cervix due to an abnormal pap test? (LEEP, Cryo, Cone) Yes <input type="checkbox"/> No <input type="checkbox"/> Year: _____
Usual number of days from <u>start</u> of one period to <u>start</u> of the next:	
Any recent changes? Yes <input type="checkbox"/> No <input type="checkbox"/> Describe: _____	When was your last Pap test? What was the Pap result? <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Number of days of bleeding:	Have you ever had a mammogram? Yes <input type="checkbox"/> No <input type="checkbox"/> Year of last: _____ Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Age periods began:	
Do you have problems with pelvic pain? Yes <input type="checkbox"/> No <input type="checkbox"/> When?	Present method of birth control: <input type="checkbox"/> Pills-Patch-Ring <input type="checkbox"/> Depo Provera <input type="checkbox"/> IUD <input type="checkbox"/> Diaphragm <input type="checkbox"/> Rhythm Method <input type="checkbox"/> Male Condom <input type="checkbox"/> Withdrawal <input type="checkbox"/> Implanon <input type="checkbox"/> NONE <input type="checkbox"/> Female Sterilization (Tubal Ligation) <input type="checkbox"/> Male Sterilization (Vasectomy)
Are you sexually active? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Age of first sexual intercourse:	
Do you have pain with intercourse? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Sexual partner(s) is/are: Men <input type="checkbox"/> Women <input type="checkbox"/> Both <input type="checkbox"/>	
Have you ever had any of the following infections? <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Chlamydia <input type="checkbox"/> Herpes <input type="checkbox"/> HPV <input type="checkbox"/> HIV <input type="checkbox"/> PID <input type="checkbox"/> NONE Number of times: _____ Year(s): _____	Weight at age 20: _____ Current Weight: _____
	Have you ever used Birth Control Pills? Yes <input type="checkbox"/> No <input type="checkbox"/> Age when started birth control: _____ Age when last stopped: _____

Hirsutism (excessive hair growth) & Acne

Do you feel that you have problems with excessive hair growth? Yes <input type="checkbox"/> No <input type="checkbox"/>
<u>If yes, circle all areas of concern:</u>
Face Chest/Breasts Back Stomach Arms Legs Thighs
Age that hair growth became noticeably worse? _____ Does this continue to worsen? Yes <input type="checkbox"/> No <input type="checkbox"/>
Prior Treatments: <input type="checkbox"/> Waxing <input type="checkbox"/> Shaving <input type="checkbox"/> Plucking <input type="checkbox"/> Creams <input type="checkbox"/> Laser <input type="checkbox"/> Spironolactone(Aldactone) Treated how often? _____
Do you have problems with excessive acne? Yes <input type="checkbox"/> No <input type="checkbox"/> At what age did acne problems begin? _____
Does this continue to worsen? Yes <input type="checkbox"/> No <input type="checkbox"/>
Current acne treatment: _____

Obstetrical History

	Number
Total number of pregnancies	
Term births (>37 wks)	
Premature (20-37 wks)	
Miscarriages (<20 wks)	
Ectopic (tubal) pregnancies	
Elective abortions	
Living children	

Immunizations

Type	Date		Date
Have you ever had Chicken Pox?	Yes/No	TB test	
Chicken pox vaccine		Flu vaccine	
Hepatitis A vaccine		Pneumonia vaccine	
Hepatitis B vaccine		Other:	
Rubella/MMR vaccine			
HPV vaccine (Gardasil)			
Tetanus-Diphtheria-Pertussis			

Obstetrical History: Please list all pregnancies in order

	Month /Year	Outcome (Yes/No)				Delivery: Vag/C-Section	Complications	Length of Time to Conceive	Required Fertility Treatment	Current Partner?
		Live born	Miscarriage	Abortion	Ectopic					
1 st										
2 nd										
3 rd										
4 th										
5 th										
6 th										
7 th										

Social History:

Occupation:	Diet Restrictions?
Status: Married / Single Partner / No Partner	
Length of time with current partner (years):	
Routine exercise: Yes <input type="checkbox"/> No <input type="checkbox"/> Hours per time: _____ Times/week: _____ Type: _____	
Routine exposures to chemicals? Yes <input type="checkbox"/> No <input type="checkbox"/>	No. of Meals/day: Skip meals?

Currently Use:

Tobacco: Yes <input type="checkbox"/> No <input type="checkbox"/>	Packs/day: Years:
Have you ever smoked >100 cigarettes? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Alcohol: Yes <input type="checkbox"/> No <input type="checkbox"/>	Drinks/week:
Caffeine: Yes <input type="checkbox"/> No <input type="checkbox"/> (coffee, soda, tea)	Drinks/day:
Other drugs: Yes <input type="checkbox"/> No <input type="checkbox"/> (Including marijuana)	Type(s):

Genetic Diseases:

Cystic Fibrosis

Cystic Fibrosis (CF) is a hereditary disease that affects mainly the lungs and digestive system, causing progressive disability, recurrent infections and, usually, early death. CF does not affect intelligence or appearance. Average life expectancy is around 37 years. Approximately 1 in 29 Caucasians carry this gene defect, as well as 1 in 46 Hispanics, and 1 in 65 African Americans. If you are a carrier, you have a 50% chance of your child being a carrier, but not affected. If your partner is also a carrier, you have a 25% chance of having a child with the disease. The American College of Obstetricians and Gynecologists recommends offering all patients testing for CF. Current testing can detect the genes that are responsible for >90% of cases of CF. Testing may not be covered by your insurance. The test costs approximately \$395 to perform if not covered by insurance. If you do not have insurance coverage for this, you may be able to coordinate a reduced fee with our laboratory if you arrange this before having the test done.

Have you been tested for Cystic Fibrosis (CF)? Yes No

Would you like to be tested: Yes No

Family History (Parents, Grandparents, Siblings, Aunts/Uncles)

Illness	√	List affected relative(s) and age at onset
Alcohol or drug addiction		
Birth defects/Mental retardation		
Bleeding disorders		
Blood clots in lungs or legs		
Breast cancer		
Cancer-Colon		
Cancer-Ovary		
Cancer-Uterus		
Diabetes		
Endometriosis		
Heart disease		
Hepatitis		
High blood pressure		
High cholesterol		
HIV		
Infertility		
Mental illness/depression		
Osteoporosis (weak bones)		
Sickle Cell/Thalassemia		
Stroke		
Tuberculosis		
Any other genetic diseases		
Recurrent miscarriages?		List miscarriages for <u>both</u> your family's side <u>and</u> your partner's
Early menopause <40 years old. (Premature Ovarian Failure)		Age of mother at menopause if known:
Other:		
What is your ancestry?	<input type="checkbox"/> African-American <input type="checkbox"/> American Indian <input type="checkbox"/> Ashkenazi Jewish <input type="checkbox"/> Northern European	<input type="checkbox"/> East Asian/Pacific Islands <input type="checkbox"/> Caucasian <input type="checkbox"/> Eastern European <input type="checkbox"/> Hispanic/Latin American
		<input type="checkbox"/> South Asian <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Other

Fertility History (May STOP here if not being seen for fertility reasons)

Note: In order to help us more efficiently treat you, please obtain copies of your past fertility treatments, operative reports, IVF cycle, ultrasound reports, labs and hard copies (Films or disk) of any **Hysterosalpingogram (HSG)** (X-ray test of your tubes) that you have had done. It is important that we review the HSG films that were previously done. **Please bring these records to your appointment with you.**

How long have you been actively trying to conceive? _____ yrs _____ mo.	Do you use lubricants? Yes <input type="checkbox"/> No <input type="checkbox"/> Type: _____
Number of times of intercourse per week? _____	Do you douche? Yes <input type="checkbox"/> No <input type="checkbox"/>
How long have you been off any birth control? _____ yrs _____ mo.	Frequency of intercourse near ovulation: _____

Do you have insurance coverage for fertility? Yes No

Type of insurance benefit:

- Testing/diagnosis only Testing & treatment
 IVF Artificial insemination

Prior Fertility Evaluation/Labs/Treatment

Treating physician / location:	Was a cause of infertility found?
Have you had an HSG (x-ray study of tubes)? Yes <input type="checkbox"/> No <input type="checkbox"/>	When? Result? Where was this performed?
Laparoscopy? Yes <input type="checkbox"/> No <input type="checkbox"/> Dates: _____ Number of times:	When? Findings? Were they able to detect whether your tubes were open? Yes <input type="checkbox"/> No <input type="checkbox"/>
Ovulation Testing? Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you consistently ovulate? Checked by: Temperature/Urine Ovulation Testing Ultrasound/ Blood
Pelvic Ultrasound? Yes <input type="checkbox"/> No <input type="checkbox"/> Date: _____	Where done? Any abnormal findings?

Prior fertility treatments:	√	Please list dates, dosage, number of cycles:
Clomiphene (Clomid)		
Letrozole (Femara)		
Intrauterine Insemination (IUI)		
Ovulation Induction with injectable fertility medications (Menopur, Bravelle, Repronex, Gonadotropin)		
In Vitro Fertilization (IVF)		
Frozen Embryo Transfer (FET)		

Male Partner History

Partner's Name:	Age:	Height:	Weight:
Medical problems:			
Take routine medications or supplements?	Medications or supplements:		
Past surgeries:	Family History of diseases:		
Has he had a semen analysis? Yes <input type="checkbox"/> No <input type="checkbox"/> When? Results?	History of hernia or testicular surgery	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	History of injury to testicles	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Has he seen a Urologist? Yes <input type="checkbox"/> No <input type="checkbox"/> Urologist's Name/Location?	Exposure to chemicals/radiation/toxins?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Routine hot tub use:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Occupation?	Wears: Boxers/ Briefs		
Previously fathered a child? Yes <input type="checkbox"/> No <input type="checkbox"/>	Trouble with erections?		Yes <input type="checkbox"/> No <input type="checkbox"/>
Age of children:	Trouble with ejaculation?		
Does he currently smoke? Yes <input type="checkbox"/> No <input type="checkbox"/> Amount: Packs/day: Years:	Currently or has ever used any type of steroids? Yes <input type="checkbox"/> No <input type="checkbox"/> Length of time since last usage:		
Use marijuana or other drugs? Yes <input type="checkbox"/> No <input type="checkbox"/> Last use:	Any illnesses/fevers in the past 3 months?		Yes <input type="checkbox"/> No <input type="checkbox"/>
Alcohol use: Yes <input type="checkbox"/> No <input type="checkbox"/>	History of sexually transmitted diseases?		Yes <input type="checkbox"/> No <input type="checkbox"/>
What is your ancestry?	<input type="checkbox"/> African-American <input type="checkbox"/> American Indian <input type="checkbox"/> Ashkenazi Jewish <input type="checkbox"/> Northern European	<input type="checkbox"/> East Asian/Pacific Islands <input type="checkbox"/> Caucasian <input type="checkbox"/> Eastern European <input type="checkbox"/> Hispanic/Latin American	<input type="checkbox"/> Caucasian <input type="checkbox"/> South Asian <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Other