New Patient History Form

Date of Visit: ____________________

Physician: ____________________

DEMOGRAPHIC INFORMATION

Name: ______________________________ Age: ________ Date of Birth: ____________________

Your Occupation & Employer: ____

Spouse/Partner's Name: ____________________ Age: ________ Date of Birth: ____________________

Spouse/Partner's Occupation & Employer: ____

If referred by another physician please list name and address: ______________________________

____

HISTORY OF PRESENT CONDITION

Reason for your visit: ____

____

Describe as thoroughly as possible the background of your present problem: ____________________

____

____

____

____

FOR PHYSICIAN USE ONLY:

NOTES: ____

____

____

____

____

All records from outside source reviewed with patient? [ ] No [ ] Yes

New Patient History Form

ALLERGIES AND MEDICATIONS:

Do you have any allergies or sensitivity to any of the following?

Medications: [ ] No [ ] Yes List: ____________________

Iodine/Dyes/Shellfish: [ ] No [ ] Yes List: ____________________

Latex: [ ] No [ ] Yes List: ____________________

List current medications. State the name of the drug, reason you are taking it, and for how long:

Medication	Reason	Dates/Duration/Last time taken
1. ______	______	
2. ______	______	
3. ______	______	
4. ______	______	

MEDICAL HISTORY:

Present Weight:________ Present Height:________

Have you ever been hospitalized for reasons other than pregnancy or surgery? [ ] No [ ] Yes If so, please list date, reason, duration of stay, name of hospital: ____________________

Have you ever been exposed to chemicals, toxic substances, or radiation? [ ] No [ ] Yes

Have you ever been in a serious accident? [ ] No [ ] Yes If so, details:____________________

Have you ever been in a serious accident? [ ] No [ ] Yes If so, details: ____________________

Have you ever received a blood transfusion? [ ] No [ ] Yes If so, details:____________________

Have you had any of the following? Check all that apply.

[ ] Measles, German Measles (Rubella), Mumps
[ ] Burning on urination or recurrent urinary infections
[ ] Chicken Pox
[ ] Discharge from nipples
[ ] Other Childhood diseases
[ ] Sexually transmitted disease or PID (pelvic infection)
[ ] Heart/Vascular disease, Mitral valve prolapse
[ ] Stomach or Intestinal problems, Ulcers
[ ] Lung Disease, Chronic Bronchitis or Asthma
[ ] Kidney Disease or Kidney Stones
[ ] Chronic/Migraine Headaches
[ ] Anemia or Blood clotting disorders
[ ] Head Trauma
[ ] Chronic or serious disease
[ ] Seizures
[ ] Cancer
[ ] Diabetes mellitus (high blood sugar)
[ ] Psychiatric disorder (depression, anxiety…)
[ ] Hypoglycemia (low blood sugar)
[ ] Multiple Miscarriages
[ ] High or low blood pressure (circle)
[ ] Baby with defects, retardation or genetic abnormality
[ ] Thyroid disorder
[ ] Poor sense of smell
[ ] Obesity
[ ] Hepatitis/Liver Disease

New Patient History Form

SURGICAL HISTORY:

List surgical history. Please include D+C's and surgery on cervix.

	Date(s)	Type of Surgery	Name of surgeon & hospital
1.	____________	____________	____________
2.	____________	____________	____________
3.	____________	____________	____________
4.	____________	____________	____________

REVIEW OF SYSTEMS:

Check any of the following disorders YOU currently have or have a history of:

Constitutional

[ ] Increase or decrease in appetite (circle)
[ ] Weight gain or loss (circle)
[ ] Difficulty concentrating
[ ] Hot flashes / Night sweats
[ ] Fatigue

Genitourinary

[ ] Bladder infections (cystitis)
[ ] Kidney infections
[ ] Other kidney or bladder problems: ______________________

Musculo-Skeletal

[ ] Lupus erythematous
[ ] Tremors
[ ] Rheumatoid arthritis/joint pain
[ ] Auto-immune disorder
[ ] Problems w/ smell
[ ] Other:____

Central Nervous System

[ ] Dizziness
[ ] Other:____

Eyes/Ears/Nose/Throat

[ ] Problems with head, eyes, ears, nose or throat
[ ] Visual problems
[ ] Other:____

Hematological

[ ] Anemia
[ ] Blood clotting disorder / Bleeding tendency
[ ] Sickle cell anemia or trait
[ ] Other:____

Endocrine

[ ] Excessive hair growth
[ ] Heat or Cold intolerance (circle)
[ ] Unexplained rash
[ ] Excessive thirst or hunger
[ ] Other:____
[ ] ROS all Negative

Cardiovascular

[ ] High/low blood pressure
[ ] Mitral Valve Prolapse
[ ] Rheumatic Fever
[ ] Other:____

[ ] Any other pertinent information not already asked? ____

New Patient History Form

FAMILY HISTORY:

Check all of the following disorders which have affected a blood member of your family.

[ ] Diabetes
[ ] Cystic Fibrosis
[ ] Cancer (breast, ovary, colon, other)
[ ] Muscular Dystrophy
[ ] Thyroid disorder
[ ] Spinal Disorders (anencephaly, neural tube defect, hydrocephalus)
[ ] Blood clotting disorders / Hemophilia
[ ] Mental Retardation
[ ] High blood pressure / Stroke
[ ] Down's Syndrome (Trisomy 21)
[ ] Heart/Vascular disease
[ ] Tay Sach's Dz. (Jewish descent)
[ ] Seizures
[ ] Sickle Cell Dz. or Trait (African American descent)
[ ] Birth Defects
[ ] Thalassemia (Italian, Greek, Med, Oriental descent, Fr. Canadian)
[ ] Osteopenia/Osteoporosis
[ ] Huntington chorea
[ ] Tuberculosis
[ ] Other inherited or chromosomal disorders
[ ] Psychiatric Disorder (specify)

SOCIAL HISTORY:

Are you (check all that apply): [ ] married [ ] widowed [ ] separated [ ] divorced [ ] remarried [ ] single [ ] single in a committed relationship

Have you ever had an eating disorder such as anorexia or bulimia? [ ] No [ ] Yes If so, details: ______________________
____

Do you exercise regularly? [ ] No [ ] Yes If so, describe: ______________________________________
____

How much **caffeine** do you drink per day? _____ cups_______________________________________
How much **alcohol** do you drink per week? _____ glasses
How many **cigarettes** do you smoke per day? _____ cigarettes/packs (circle one), for ____ years.

Have you used any street drugs in the past 5 years? [ ] No [ ] Yes
If so, what and how much? ____
____

New Patient History Form

GYNECOLOGICAL HISTORY:

Age of onset of periods: ________ Date of last menstrual period (LMP): ______ Are your cycles regular? [ ] No [ ] Yes

Menstrual flow lasts ___ days and is (check those that apply): [ ] Light [ ] Moderate [ ] Heavy

Length of menstrual cycle _____ days (interval from 1st day of bleeding until day before bleeding of next cycle).

Do you have pain around time of your period? [ ] No [ ] Yes

Do you have pain around the time of ovulation? [ ] No [ ] Yes

Do you bleed between periods? [ ] No [ ] Yes

Do you have symptoms of bloating, breast tenderness, cramping, or mood changes prior to period? [ ] No [ ] Yes

Do you have any history of abnormal Pap? [ ] No [ ] Yes, date: ________________________________

Date of last gynecologic exam: ________________________ Date and result of last Pap's Smear: ___________________

Date and result of last mammogram (if applicable): ____

Any history of the following? Provide dates for all positives.

Chlamydia [ ] No [ ] Yes, date: __________ Pelvic or tubal infection [ ] No [ ] Yes, date: __________

Gonorrhea [ ] No [ ] Yes, date: __________ DES [ ] No [ ] Yes, date: __________

Have you previously been told by another physician that you have:

Endometriosis [ ] No [ ] Yes, date: __________ Fibroids [ ] No [ ] Yes, date: __________

OBSTETRICAL HISTORY:

[ ] Not applicable (never pregnant)

Please fill out the following information for each pregnancy:

First Pregnancy Year: _______ Time to conceive (mths/years): _________

Delivery: [ ] Liveborn Infant (vag or C/S) [ ] Premie [ ] Fullterm _____ weeks

[ ] Ectopic Pregnancy [ ] Miscarriage or Induced Abortion _____ weeks

Was infertility therapy used to conceive? [ ] No [ ] Yes Is your current partner the father? [ ] No [ ] Yes

Second Pregnancy Year: _______ Time to conceive (mths/years): _________

Delivery: [ ] Liveborn Infant (vag or C/S) [ ] Premie [ ] Fullterm _____ weeks

[ ] Ectopic Pregnancy [ ] Miscarriage or Induced Abortion _____ weeks

Was infertility therapy used to conceive? [ ] No [ ] Yes Is your current partner the father? [ ] No [ ] Yes

OBSTETRICAL HISTORY (con't):

Third Pregnancy Year: _______ Time to conceive (mths/years): _________

Delivery: [ ] Liveborn Infant (vag or C/S) [ ] Premie [ ] Fullterm _____ weeks

[ ] Ectopic Pregnancy [ ] Miscarriage or Induced Abortion _____ weeks

Was infertility therapy used to conceive? [ ] No [ ] Yes Is your current partner the father? [ ] No [ ] Yes

Fourth Pregnancy Year: _______ Time to conceive (mths/years): _________

Delivery: [ ] Liveborn Infant (vag or C/S) [ ] Premie [ ] Fullterm _____ weeks

[ ] Ectopic Pregnancy [ ] Miscarriage or Induced Abortion _____ weeks

Was infertility therapy used to conceive? [ ] No [ ] Yes Is your current partner the father? [ ] No [ ] Yes

Fifth Pregnancy Year: _______ Time to conceive (mths/years): _________

Delivery: [ ] Liveborn Infant (vag or C/S) [ ] Premie [ ] Fullterm _____ weeks

[ ] Ectopic Pregnancy [ ] Miscarriage or Induced Abortion _____ weeks

Was infertility therapy used to conceive? [ ] No [ ] Yes Is your current partner the father? [ ] No [ ] Yes

Sixth Pregnancy Year: _______ Time to conceive (mths/years): _________

Delivery: [ ] Liveborn Infant (vag or C/S) [ ] Premie [ ] Fullterm _____ weeks

[ ] Ectopic Pregnancy [ ] Miscarriage or Induced Abortion _____ weeks

Was infertility therapy used to conceive? [ ] No [ ] Yes Is your current partner the father? [ ] No [ ] Yes

INFERTILITY HISTORY:

How long have you been trying to get pregnant? _____ years _____ months

Length of time not employing contraception? _____ years _____ months

Length of time with current partner? _____ years _____ months

Number of children with current partner: _____

Any children from a previous partner? [ ] No [ ] Yes

Number of times married: _____

Number of children with previous partner: _____

SEXUAL HISTORY:

Frequency of intercourse _____ per week

Do you use lubricant? [ ] No [ ] Yes

Sex drive: [ ] Decreased [ ] Normal [ ] Increased

Orgasm: [ ] Always [ ] Usually [ ] Rarely [ ] Never

Pain with intercourse? [ ] No [ ] Yes If yes, is it superficial/deep? (circle one) Occasional/frequent? (circle one)

Do you bleed during or after intercourse? [ ] No [ ] Yes [ ] Not Applicable

New Patient History Form

CONTRACEPTIVE HISTORY:

[ ] Not applicable

Contraceptives, check all that apply: [ ] Birth control pill [ ] IUD [ ] Diaphragm [ ] Condom [ ] Rhythm

Surgical Sterilization: [ ] Male [ ] Female [ ] Other: ____________________

Have you experienced any of the following? (check all that apply)

[ ] Menstrual irregularity

[ ] Hirsutism *(excessive hair growth)*

[ ] Primary amenorrhea *(never had a period)*

[ ] Galactorrhea *(milky breast discharge)*

[ ] Oligomenorrhea *(very few periods)*

[ ] Visual disturbances/headaches

SPOUSE/PARTNER HISTORY:

Birth date of spouse/partner: ________ Present Age: ______ Duration of present marriage/relationship: ______________

Has husband/partner initiated a pregnancy in a previous relationship? [ ] No [ ] Yes If yes, please give dates and outcome of pregnancy: ____________________

Has husband/partner had a previous relationship where pregnancy did not occur, even though no contraception used? [ ] No [ ] Yes If yes, how long a period was involved? ____________________

Any history of possible reproductive tract problem? Provide dates for all positives.

[ ] No [ ] Yes Prostatitis __________

[ ] No [ ] Yes Epididymitis __________

[ ] No [ ] Yes Orchitis __________

[ ] No [ ] Yes Previous vasectomy __________

[ ] No [ ] Yes Testicular tumor __________

[ ] No [ ] Yes Injury to testes __________

[ ] No [ ] Yes Undescended testicles __________

[ ] No [ ] Yes Radiation or Chemotherapy __________

Any history of sexually transmissible disease?

[ ] No [ ] Yes Gonorrhea

[ ] No [ ] Yes Syphillis

[ ] No [ ] Yes Chlamydia

[ ] No [ ] Yes Nonspecific urethritis

[ ] No [ ] Yes Any history of reproductive tract surgery? If yes, procedure & date: ____________________

[ ] No [ ] Yes Any difficulty achieving or maintaining erection?

[ ] No [ ] Yes Any difficulty with ejaculation (e.g. retrograde, premature)

[ ] No [ ] Yes Any history of discharge from penis?

[ ] No [ ] Yes Any history of cancer? If yes, procedure & date: ____________________

New Patient History Form

SPOUSE/PARTNER MEDICAL HISTORY:

Present Weight:_______________ Present Height:_______________

General health: ____

Any recent illnesses or change in health? [ ] No [ ] Yes Describe: ____

ALLERGIES AND MEDICATIONS:

Do you have any allergies or sensitivity to any of the following?

Medications: [ ] No [ ] Yes List:____

Iodine/Dyes/Shellfish: [ ] No [ ] Yes List:____

Latex: [ ] No [ ] Yes List:____

List all significant medical illness which husband/partner has experienced requiring treatment, including dates and name of physician/hospital: ____

____

List all surgical procedures which your husband/partner has undergone: ____

____

List current medications. State the name of the drug, reason you are taking it, and for how long:

Medication Reason Dates/Duration/Last time taken

1. ____ ____
2. ____ ____
3. ____ ____
4. ____ ____

How much **alcohol** does your husband/partner drink per week? _____ glasses

How many **cigarettes** does your husband/partner smoke per day? _____ cigarettes/packs (circle one), for ____ years

Has your husband/partner used any street drugs in the past 5 years? [ ] No [ ] Yes, what and how much? ______________

____

Has your husband/partner been exposed to the following?

[ ] High temperatures (work, hot tubs, etc.) [ ] Radiation [ ] Chemicals [ ] Toxic Substances

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PAST INFERTILITY EVALUATION FOR COUPLE:

Previous Testing:

Give dates and results for all positives (check all that apply).

[ ] Semen Analysis

[ ] Post Coital Test

[ ] HSG (X-ray of tubes)

[ ] Ovulation Predictor

[ ] Hysteroscopy

[ ] Thyroid (TSH, T4) ____________________

[ ] Endometrial Biopsy ____________________

[ ] Sonohysterogram ____________________

[ ] Laparoscopy ____________________

[ ] Testicular Biopsy ____________________

Hormonal Tests:

Give dates and results for all positives (check all that apply).

[ ] Prolactin ____________________

[ ] BBT Charts ____________________

[ ] Day 3 FSH, Estradiol, LH ____________________

[ ] Serum Progesterone ____________________

[ ] DHEAS ____________________

[ ] Testosterone ____________________

Previous Treatments:

Treatment (check all that apply)	Dose/Type	Dates
[ ] Clomiphene (Clomid)	____________________	____________________
[ ] Injectable Gonadotropins	____________________	____________________
[ ] Intrauterine Insemination (IUI)	____________________	____________________
[ ] In Vitro Fertilization (IVF)	____________________	____________________
[ ] Intracytoplasmic Sperm Injection (ICSI)	____________________	____________________
[ ] Tubal Reconstructive Surgery	____________________	____________________
[ ] Estrogens	____________________	____________________
[ ] Progestins (oral or vaginal)	____________________	____________________
[ ] Surgical removal of adhesions	____________________	____________________
[ ] Endometriosis	____________________	____________________

[ ] Other ____________________