

**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
- Asian
- Other ( \_\_\_\_\_ )

- Hispanic
- African American

**ETHNICITY**

- Ashkenazi Jew
- Greek/Italian
- Southeastern Asian

**Significant Other**

- Caucasian
- Asian
- Other ( \_\_\_\_\_ )

- Ashkenazi Jew
- Greek/Italian
- Southeastern Asian

**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).

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

Please explain a "Yes" answer: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**9. GYNECOLOGIC / INFECTION**

Do you have or have you had?

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

**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?

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

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?

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

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

**14. SYSTEMIC REVIEW**

Headaches: Number per week \_\_\_\_\_ Medication used \_\_\_\_\_

- |   |  |                                    |
|---|--|------------------------------------|
| <input type="checkbox"/> mild                 | <input type="checkbox"/> moderate      | <input type="checkbox"/> severe    |
| <input type="checkbox"/> improving            | <input type="checkbox"/> worsening     | <input type="checkbox"/> no change |
| <input type="checkbox"/> with visual symptoms | <input type="checkbox"/> with vomiting |                                    |
| <input type="checkbox"/> stress related       | <input type="checkbox"/> migraines     |                                    |

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Wear glasses                         | <input type="checkbox"/> Bladder/kidney infections             | <input type="checkbox"/> Abdominal pain          | <input type="checkbox"/> Acne                      |
| <input type="checkbox"/> Wear contact lenses                  | <input type="checkbox"/> Urgent / frequent / painful urination | <input type="checkbox"/> Nausea and vomiting     | <input type="checkbox"/> Skin disorder             |
| <input type="checkbox"/> Sinus problems                       | <input type="checkbox"/> Blood / abnormal color of urine       | <input type="checkbox"/> Vomiting blood          | <input type="checkbox"/> Rash                      |
| <input type="checkbox"/> Hayfever                             | <input type="checkbox"/> Unable to control urination           | <input type="checkbox"/> Ulcer                   | <input type="checkbox"/> Hives                     |
| <input type="checkbox"/> Ringing in ears                      | <input type="checkbox"/> Abnormal urinary tract                | <input type="checkbox"/> Food intolerance        | <input type="checkbox"/> Skin cancer               |
| <input type="checkbox"/> Hearing loss                         | <input type="checkbox"/> Kidney x-ray                          | <input type="checkbox"/> Gallstones              |  |
| <input type="checkbox"/> Denture / bridges                    | <input type="checkbox"/> Bladder cystoscopy                    | <input type="checkbox"/> Jaundice / hepatitis    | <input type="checkbox"/> Counseling                |
|   |  | <input type="checkbox"/> Chronic constipation    | <input type="checkbox"/> Recent stress increase    |
| <input type="checkbox"/> Anemia                               | <input type="checkbox"/> Varicose veins                        | <input type="checkbox"/> Diarrhea                | <input type="checkbox"/> Recent anxiety increase   |
| <input type="checkbox"/> Chest pain                           | <input type="checkbox"/> Easy bruising                         | <input type="checkbox"/> Blood in bowel movement |  |
| <input type="checkbox"/> Irregular heart beat                 | <input type="checkbox"/> Prolonged bleeding                    | <input type="checkbox"/> Irritable bowel         | <input type="checkbox"/> Sensation loss / numbness |
| <input type="checkbox"/> Fainting spells                      | <input type="checkbox"/> Bleeding from gums                    | <input type="checkbox"/> Hemorrhoids             | <input type="checkbox"/> Muscle control / weakness |
| <input type="checkbox"/> Leg swelling                         | <input type="checkbox"/> Nosebleeds                            | <input type="checkbox"/> Hernia                  | <input type="checkbox"/> Heat or cold intolerance  |
| <input type="checkbox"/> Calf pain                            | <input type="checkbox"/> Take aspirin/ibuprofen frequently     | <input type="checkbox"/> Abnormal liver test     | <input type="checkbox"/> Damp skin                 |
| <input type="checkbox"/> Blood clots (venous thromboembolism) |  | <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Unusual hair loss         |
| <input type="checkbox"/> Cough                                | <input type="checkbox"/> Breast mass                           | <input type="checkbox"/> Back pain               | <input type="checkbox"/> Extraordinary fatigue     |
| <input type="checkbox"/> Shortness of breath                  | <input type="checkbox"/> Fibrocystic changes                   |  |  |
| <input type="checkbox"/> Wheezing                             | <input type="checkbox"/> Breast implants                       |  |  |
| <input type="checkbox"/> Cough up blood                       | <input type="checkbox"/> Mammogram                             |  |  |
| <input type="checkbox"/> Chest x-ray                          | <input type="checkbox"/> Do monthly breast self-exam           |  |  |
| <input type="checkbox"/> TB skin test                         |  |  |  |

OTHER: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**15. MALE HISTORY:**

- |  |  |
|--|--|
| <input type="checkbox"/> Medications:          | <input type="checkbox"/> Reproductive surgery: |
| <input type="checkbox"/> Illnesses:            | <input type="checkbox"/> STDs:                 |
| <input type="checkbox"/> Mumps:                | <input type="checkbox"/> Testicular trauma:    |
| <input type="checkbox"/> Smoker:               | <input type="checkbox"/> Impotence:            |
| <input type="checkbox"/> Alcohol:              | <input type="checkbox"/> Allergies: _____      |
| <input type="checkbox"/> Ejaculatory Disorder: | _____  |

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:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Clomid (Serophene) | <input type="checkbox"/> hCG Profasi      | <input type="checkbox"/> Antibiotics         |
| <input type="checkbox"/> Gonal F            | <input type="checkbox"/> Progesterone     | <input type="checkbox"/> Baby aspirin        |
| <input type="checkbox"/> Follistim          | <input type="checkbox"/> Lupron           | <input type="checkbox"/> Heparin             |
| <input type="checkbox"/> Repronex           | <input type="checkbox"/> Microdose Lupron | <input type="checkbox"/> Steroids            |
| <input type="checkbox"/> Pergonal           | <input type="checkbox"/> Antagon          | <input type="checkbox"/> Oral Contraceptives |
| <input type="checkbox"/> Fertinex           | <input type="checkbox"/> Parlodel         | <input type="checkbox"/> Other .....         |

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

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