



NEW PATIENT INFORMATION PACKET

Physician whom you will be seeing: _____ Date of visit: _____

Physician/Person who referred you to our practice: _____

Health care providers you see on a regular basis: _____

Your Name: _____			
	Last Name	First	Middle
Age: _____	Date of Birth: _____		
Home Address: _____			
City: _____		State: _____	Zip Code: _____
Telephone: (H) _____		(W) _____	(C) _____
Occupation: _____		Employer: _____	
Emergency Contact: _____			
Allergies: _____		Last menstrual period: _____	

Partner/Spouse's Name (if applicable): _____
Last Name First Middle

Age: _____ Date of Birth: _____ Occupation: _____

Date of Marriage (if applicable): _____

Reason for your office visit: _____

Please describe the background of your present problem. Include all symptoms, duration, and whether they have changed in severity over time:



SEXUAL HISTORY

Are you currently sexually active? Yes No (if no, continue to the next section)

How many times per week do you have sexual intercourse? _____

How many times do you have intercourse around ovulation? _____

Do you bleed during or after intercourse? Yes No

Do you have any pain during or after intercourse? Yes No

Do you have difficulty achieving orgasm? Yes No

Do you have any specific sexual issues to discuss: _____

CONTRACEPTIVE HISTORY

Please check (√) any of the following methods of contraception you are currently using and/or have used in the past. Fill in the dates of usage.

Never used contraception (continue on to next section): _____

Methods	Dates of Usage
<input type="radio"/> Birth Control Pills Type:_____	_____
<input type="radio"/> IUD Type:_____	_____
<input type="radio"/> Depo-Provera	_____
<input type="radio"/> Diaphragm	_____
<input type="radio"/> Condom	_____
<input type="radio"/> Jellies/Foam	_____
<input type="radio"/> Withdrawal	_____
<input type="radio"/> Sterilization ____ male ____ female	_____
<input type="radio"/> Other:_____	_____



OBSTETRICAL HISTORY

Have you ever been Pregnant? _____ (If No, continue to next section)

Times Pregnant _____ Term Births _____ Premature Births _____
 Miscarriages _____ Elective Abortions _____ Ectopic _____

PREGNANCY	1	2	3	4	5
Date of pregnancy					
Miscarriage?					
Elective Abortion?					
Ectopic (tubal)?					
How many months did it take to conceive?					
Was infertility treatment required?					
Gestation (weeks) at delivery					
Mode of delivery (vaginal vs cesarean)					
Weight and Sex?					
Is your current partner the father? (Y/N)					
Is the child healthy? (Y/N)					
Complications					



SURGICAL HISTORY

Have you had *surgery* for any of the following?

DIAGNOSIS	DATE	SURGEON	PROCEDURE
Pelvic Pain			
Pelvic Adhesions (scar tissue)			
Endometriosis			
Tubal Blockage			
Ectopic Pregnancy			
Fibroids (Leiomyoma)			
Irregular or Abnormal Uterine Bleeding			
Tubal Sterilization			
Abnormally Shaped Uterus			
Ovarian Cyst(s)			
Other Surgery (Please List)			

PAST MEDICAL HISTORY

List all serious medical illnesses (include hospitalization dates, duration, location):



Do you have any **allergies** to food or medications? Yes No

(Specify): _____

List current medications

Medication	Start Date	Medication	Start Date
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

List any current nutritional supplements, herbal preparations, or over the counter medications

Name	Start Date	Name	Start Date
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

Are you on a special diet (vegetarian, lactose-free, low salt, low fat, Kosher, etc)? Yes No

Do you exercise regularly? Yes No Describe? _____

Have you had any difficulty or recent change in you habits of sleep, diet or exercise? Yes No

If so, describe? _____

Do you drink alcohol? Yes No Approximate drinks per week: _____

Do you currently smoke cigarettes? Yes No

Number packs per day? _____ Number of years? _____

If you are a former smoker, when did you quit? _____

Do you use any illicit or recreational drugs (i.e., marijuana, cocaine)? Yes No

Describe: _____ (you may also discuss this with your doctor privately)

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

If so, state the substance and extent of exposure: _____

What is your **blood type**? _____ Don't know

Have you ever had a blood transfusion? Yes No Date: _____



REVIEW OF SYSTEMS

Check (✓) any of the following that you currently have or have experienced in the past

Central Nervous System

- Seizures
- Migraine headaches
- Depression
- Other: _____

Eyes, Ears, Nose and Throat

- Wear contact lenses
- Eye disorders
- Problem with sense of smell
- Other: _____

Cardiovascular

- Chest Pain
- Palpitations
- Rheumatic Fever
- Heart valve disease
- High blood pressure
- Mitral valve prolapse
- Take antibiotics before dental work or surgery
- Other: _____

Respiratory

- Shortness of breath
- Asthma (date of last attack: _____)
- Bronchitis
- Pneumonia
- Blood in sputum
- Other: _____

Gastrointestinal

- Nausea/vomiting
- Blood in stool
- Ulcers
- Hepatitis
- Constipation/diarrhea
- Irritable bowel syndrome
- Inflammatory bowel disease (Crohn's, ulcerative colitis)
- Decreased appetite/anorexia
- Other: _____

Genitourinary

- Bladder infections (cystitis)
- Kidney infections
- Incontinence (leakage of urine)
- Vaginal Infections
- Pelvic Pain
- Other: _____

Musculoskeletal

- Unusual muscle weakness
- Decreased energy/stamina
- Rheumatoid Arthritis
- Lupus erythematosus (SLE)
- Other: _____

Hematologic

- Blood clotting disorder
- Sickle Cell Anemia or trait
- Other: _____

Endocrine

- Diabetes
- Hypoglycemia
- Thyroid disorder
- Increased facial or body hair
- Baldness
- Breast discharge (milk, blood, other)
- Rapid weight gain
- Rapid weight loss
- Other: _____

Skin

- Rash
- Eczema
- Vitiligo
- Problems with skin pigmentation
- Acne
- Other: _____



FAMILY HISTORY

Check (√) all of the following disorders for which you have a family history. Include which blood relative (mother/father/sister(s)/brother(s), maternal/paternal grandmother or grandfather, maternal/paternal aunt(s) or uncle(s), cousins) had the disorder. Do not include yourself.

- o Cancer (specify) _____
- o Kidney Disease
- o Diabetes
- o Excessive hair growth
- o Heart Disease
- o Neurological (nerve) disorders
- o Hypertension (high blood pressure)
- o Alcoholism or Substance Abuse
- o Thyroid problems (including goiter)
- o Depression
- o Blood Clotting disorders
- o Schizophrenia
- o Early Menopause
- o Other: _____
- o Osteoporosis

Do any genetic disorders run in your family or your husband/partner's family? o Yes o No

Please Describe: _____

Please check (√) if any member of your family or husband/partner's family has a history of:

- o cystic fibrosis
- o birth defects
- o infertility
- o color blindness
- o low sperm count
- o irregular menstrual cycles
- o blood clotting disorders
- o miscarriages
- o mental retardation
- o sickle cell disease
- o muscular dystrophy
- o psychiatric problems
- o thalassemia
- o fragile X syndrome
- o other inherited diseases

INFERTILITY HISTORY (if applicable)

How long have you been attempting pregnancy? _____

Have you monitored to determine the timing of ovulation? o Yes o No
If so, what are the results? _____

How are you timing intercourse? _____

Do you use lubricants? oYes o No If so, what kind? _____

Do you douche before or after intercourse? o Yes o No

Have you received pre-pregnancy counseling? o Yes o No

Are you currently taking folic acid supplements? o Yes o No



Which of the following apply? *(Check all that apply)*

	DATES	RESULTS
Had or vaccinated for Rubella (German Measles)		
Had or vaccinated for Varicella (Chicken Pox)		
Tested for Cystic Fibrosis		
Tested for Tay Sach's		
Tested for Gaucher's Disease		
Tested for Canavan's Disease		
Tested for Sickle Cell Trait		
Tested for Thalassemia		
Tested for Toxoplasmosis		

Which of the following **infertility tests** have been performed? *(Check all that apply)*

	DATES	RESULTS
Semen Analysis		
Post Coital Test		
Female Hormone Studies		
Endometrial Biopsy		
Hysterosalpingogram (HSG) (x-ray of the uterus and tubes)		
Saline sonogram		
Laparoscopy / Hysteroscopy		
Other (please specify)		

Have you had any of the following **infertility treatments**?

TREATMENT	DATES	# OF CYCLES
Intrauterine insemination (IUI)		
Clomiphene Citrate (Clomid or Serophene)		
Gonadotropin injections (e.g. Follistim, Gonal-F, Bravelle, Repronex, Menopur)		
Progesterone Suppositories		
In Vitro Fertilization (IVF)		
Donor Egg		
Other (Please Specify)		



MALE PARTNER HISTORY (if applicable)

Has any female ever become pregnant by you in the past? Yes No

Dates of pregnancies: _____

Age/health of children from other relationships: _____

Have you ever had a semen analysis (sperm test)? Yes No

If yes, include date and results: _____

Do you come in contact with chemicals or toxins at home or work? Yes No

If so, please list: _____

Do you have difficulty achieving or maintaining erections? Yes No

Do you have difficulty with ejaculation? Yes No

Please list any medical problems: _____

Please list any prior surgeries: _____

What is your **blood type** (if known): _____

Please list any medication **allergies**: _____

Please list all medications or herbal supplements you are currently taking:

Do you drink alcohol? Yes No Approximate drinks per week: _____

Do you smoke cigarettes? Yes No Packs per day? _____ Duration? _____

Do you use any illicit/recreational drugs? Yes No _____

Have you ever had any of the following?

Chlamydia	<input type="radio"/> Yes <input type="radio"/> No	Vasectomy	<input type="radio"/> Yes <input type="radio"/> No
Gonorrhea	<input type="radio"/> Yes <input type="radio"/> No	Vasectomy Reversal	<input type="radio"/> Yes <input type="radio"/> No
Syphilis	<input type="radio"/> Yes <input type="radio"/> No	Varicocele	<input type="radio"/> Yes <input type="radio"/> No
Genital Herpes	<input type="radio"/> Yes <input type="radio"/> No	Varicocele Surgery	<input type="radio"/> Yes <input type="radio"/> No
Genital Warts	<input type="radio"/> Yes <input type="radio"/> No	Biopsy of the testicles	<input type="radio"/> Yes <input type="radio"/> No
Urethritis/epididymitis	<input type="radio"/> Yes <input type="radio"/> No	Hernia Surgery	<input type="radio"/> Yes <input type="radio"/> No
Prostatitis	<input type="radio"/> Yes <input type="radio"/> No	Abdominal Surgery	<input type="radio"/> Yes <input type="radio"/> No
Penile discharge or pain	<input type="radio"/> Yes <input type="radio"/> No	Cancer	<input type="radio"/> Yes <input type="radio"/> No
Undescended testicle	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No
Injury to the testicle (s)	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No
Difficulty smelling/tasting	<input type="radio"/> Yes <input type="radio"/> No	Colitis	<input type="radio"/> Yes <input type="radio"/> No
Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Seizures	<input type="radio"/> Yes <input type="radio"/> No
Mumps	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Treatment	<input type="radio"/> Yes <input type="radio"/> No
DES exposure in the womb	<input type="radio"/> Yes <input type="radio"/> No	Strenuous Exercise	<input type="radio"/> Yes <input type="radio"/> No