



Name: _____

Please list the health care providers you see on a regular basis:

MENSTRUAL/GYNECOLOGIC HISTORY

At what age did you begin to menstruate? _____

What were the dates of your two most recent menstrual periods? _____

Are your periods regular or irregular? (circle one)

If irregular, please describe _____

What is the usual number of days between the first day of one period and the first day of the next? _____

Have you ever gone more than 2 months without a period? Yes No When? _____

How long does your menstrual flow last? _____ days

Do you consider your flow to be excessive? Yes No

Do you experience cramps with your period? Yes No

Do you take medication to alleviate the cramps? Yes No What kind? _____

Do you bleed between your periods? Yes No Describe: _____

Do you have any noticeable vaginal discharge? Yes No

If so, describe (color, consistency, presence of odor, itching, etc): _____

Have you been diagnosed or treated for any of the following?

Chlamydial infection Yes No

Gonorrhea Yes No

Herpes Yes No

HIV/ AIDS Yes No

HPV (genital warts) Yes No

Syphilis Yes No

Tubal infection (PID) Yes No

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Name: _____

Date of last PAP smear _____ Result _____

Have you ever had an abnormal PAP smear? Yes No

If yes, what treatment did you receive? (freezing, laser, surgery) _____

Did your mother take any hormones (like DES) when she was pregnant with you? Yes No

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: _____

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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)

<u>Methods</u>	<u>Dates of Usage</u>
<input type="checkbox"/> Birth Control Pills Type: _____	_____
<input type="checkbox"/> IUD Type: _____	_____
<input type="checkbox"/> Diaphragm	_____
<input type="checkbox"/> Condom	_____
<input type="checkbox"/> Jellies/Foam	_____
<input type="checkbox"/> Withdrawal	_____
<input type="checkbox"/> Sterilization _____ male _____ female	_____
<input type="checkbox"/> Other: _____	_____

OBSTETRICAL HISTORY

_____ Never been pregnant (continue on to next section)

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

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

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GYNECOLOGIC SURGERY

Have you had *surgery* for any of the following? (Give dates and Surgeon):

<i>DIAGNOSIS</i>	<i>DATE</i>	<i>SURGEON</i>	<i>PROCEDURE</i>
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 Gynecologic Surgery (Please List)			

PAST MEDICAL HISTORY

List all serious medical illnesses requiring hospitalization, the date(s), duration of your hospitalization(s) and name of the hospital(s):

List all non-gynecologic surgical problems you have had, the approximate date(s), duration of your hospitalization(s) and name of the hospital(s): _____

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Name: _____

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

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

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

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

ROUTINE HEALTH SCREENING

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

	TEST	DATES	RESULTS
	Mammogram		
	Hepatitis B virus antibody test (or vaccination)		
	Hepatitis C virus antibody test		
	HIV antibody test		
	Cervical culture for Gonorrhea		
	Cervical culture for Chlamydia		
	Serum cholesterol measurement		
	Colonoscopy		
	Other (please specify)		

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: _____

- Problem with sense of smell
- Other: _____

Cardiovascular

- Chest Pain
- Palpitations
- Rheumatic Fever
- Heart valve disease

Eyes, Ears, Nose and Throat

- Wear contact lenses
- Eye disorders

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- 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
- Spastic colon
- Poor 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

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FAMILY HISTORY

Check (✓) all of the following disorders for which you have a family history. Next to each item, state 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 Diabetes	o Blood Clotting disorders
o Kidney Disease	o Excessive hair growth
o Thyroid problems (including goiter)	o Neurological (nerve) disorders
o Early Menopause	o Alcoholism or Substance Abuse
o Osteoporosis	o Depression
o Heart Disease	o Schizophrenia
o Hypertension (high blood pressure)	o Other: _____

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

Please Describe: _____

Please check (3) if any member of your family or your husband/partner's family has a history of the following:

- | | | |
|----------------------------|----------------------|------------------------------|
| 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 |

Additional Comments: _____

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INFERTILITY HISTORY

(if not trying to become pregnant, please skip)

How long have you been attempting pregnancy? _____ Years

Have you received pre-pregnancy counseling? Yes No

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

	<i>DATES</i>	<i>RESULTS</i>
Had or been vaccinated for Rubella (German Measles)		
Had or been vaccinated for Varicella (Chicken Pox)		
Tested for Cystic Fibrosis		
Tested for HIV		
Tested for Hepatitis B virus		
Tested for Toxoplasmosis (if you have cats or consume raw meats in your diet)		

If you or your husband/partner are Jewish or of French Canadian extraction, have you been screened for Tay-Sach’s Disease? Yes No N/A Results? _____

If you or your husband/partner are Jewish, have you been screened for Gaucher’s Disease? Yes No N/A Results? _____

Canavan’s Disease? Yes No N/A Results? _____

If you or your husband/partner are of African ancestry, have you been screened for Sickle-Cell trait? Yes No N/A Results? _____

If you or your husband/partner are of Spanish, Indian, Italian, Greek, Southeast Asian, African, or Chinese ancestry, have you been screened for Thalassemia? Yes No N/A Results? _____

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Are you currently taking folic acid supplements? Yes No

Have you monitored to determine the timing of ovulation? Yes No

If so, what are the results? _____

How are you timing intercourse? _____

Do you use lubricants? Yes No What kind? _____

Do you douche before or after intercourse? Yes No

What causes of infertility have been diagnosed? _____

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

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

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Have you had any of the following *infertility treatment*? (Give Dates and Number of Cycles):

<i>TREATMENT</i>	<i>DATES</i>	<i># OF CYCLES</i>
Intrauterine insemination (IUI)		
Donor sperm inseminations (AID)		
Clomid or Serophene (Clomiphene Citrate)		
Progesterone Suppositories		
Pergonal/Humegon/Repronex		
Follistim/Gonal-F/Bravelle/Fertinex		
Parlodel/Dostinex		
In Vitro Fertilization (IVF)		
In Vitro Fertilization Associated with Intracytoplasmic Sperm Injection (IVF/ICSI)		
GIFT/ZIFT		
Donor Egg		
Other (please specify)		

MALE PARTNER HISTORY

(if there is no male partner, please skip this section)

Has any female ever become pregnant by you in the past? Yes No
 If yes, when was the last pregnancy? _____

Do you have any children from a previous relationship? Yes No
 If yes, give ages and health:

Have you ever had a semen analysis (sperm test)? Yes No
 If so, what were the results? _____

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Name: _____

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

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

List current medications

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

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

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

Do you have any special concerns you would like to discuss? (please explain) _____

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