



Date: _____

General Information:

Name: _____ Age: _____ Who referred you to us? _____

Who is your OB/GYN ? _____

What is the primary reason for your visit? _____

Past Medical History:

Please check any problems below that you have had, or are currently experiencing:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Absent/Irregular Menses | <input type="checkbox"/> HIV | <input type="checkbox"/> Abnormal Hair Growth | |
| <input type="checkbox"/> Abnormal Hair Growth | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Pain with Intercourse | |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Interstitial Cystitis | <input type="checkbox"/> Painful Periods | |
| <input type="checkbox"/> Depression | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pneumonia | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pulmonary Embolus | |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Fibroids | <input type="checkbox"/> Blocked Fallopian Tube(s) |
| <input type="checkbox"/> Deep Vein Thrombosis | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> PID | <input type="checkbox"/> Low Sperm Count (Husband) |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Previous Tubal Pregnancy |
| <input type="checkbox"/> Acid Reflux / Heartburn | <input type="checkbox"/> Abnormal PAP Smear | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Lupus Erythematosus | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Migraines | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Ulcers |

Other:

Past Surgical History:

Please check all previous surgeries you have had:

- | | | |
|--|--|--|
| <input type="checkbox"/> I Take Antibiotics Before Dental Procedures | <input type="checkbox"/> D&C | <input type="checkbox"/> Myomectomy |
| <input type="checkbox"/> I Had a Blood Transfusion | <input type="checkbox"/> Gall Bladder Surgery | <input type="checkbox"/> Surgery for Tubal Pregnancy |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Hernia Surgery | <input type="checkbox"/> Thyroid Surgery |
| <input type="checkbox"/> Back Surgery | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Removal of Ovary(s) |
| <input type="checkbox"/> Breast Augmentation | <input type="checkbox"/> Hysterosalpingogram (HSG) | <input type="checkbox"/> Removal of Tube(s) |
| <input type="checkbox"/> C Section | <input type="checkbox"/> Hysteroscopy | <input type="checkbox"/> Tonsilectomy |
| <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Laparoscopy (Scope) | <input type="checkbox"/> Tubal Surgery |
| | <input type="checkbox"/> Laparotomy (Open Surgery) | <input type="checkbox"/> Tubal Ligation |

Other:

Current Medications:

Please list all medications you are currently taking:

Allergies:

Please list any allergies you have:

Medication Allergies:

Food Allergies:

Environmental Allergies:

Family Medical History:

Please check any conditions that are prevalent in your immediate family:

 Asthma Diabetes Mental Illness Breast Cancer Gynecologic Cancer Stroke Colon Cancer Heart Attack

Other: _____

Reproductive History:

Approximate date of last Menstrual Period: _____

Are Your Periods Regular?

 YES NO

Do you have pain with menstrual periods?

 YES NO

Problems with Heavy Bleeding?

 YES NO

Do you take birth control pills?

 YES NO

Total Number of Pregnancies: _____ Number of Vaginal Deliveries: _____ Number of C-Sections _____

Full Term Pregnancies: _____ Premature Deliveries: _____ Miscarriages: _____ Tubal Pregnancies: _____

Last Pap Smear was: Normal Abnormal (Date / Details) _____**Social History:**

Please check all that apply to you:

Alcohol Currently Use Never Use Previously UsedCigarettes Currently Use Never Use Previously UsedIllicit Drugs Currently Use Never Use Previously UsedMarital Status: Married Single Widowed Divorced

Occupation: _____

REVIEW OF SYSTEMS

Please review each of the following boxes and check all that apply to you.

Periods: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Absent <input type="checkbox"/> Painful	Tests: <input type="checkbox"/> Thyroid <input type="checkbox"/> FSH <input type="checkbox"/> Prolactin	Treatment: <input type="checkbox"/> Clomid <input type="checkbox"/> Provera <input type="checkbox"/> Other:
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Pelvic Factor: <input type="checkbox"/> Endometriosis <input type="checkbox"/> Scar Tissue (Adhesions) <input type="checkbox"/> Fibroids <input type="checkbox"/> Other : _____	Tests: <input type="checkbox"/> HSG <input type="checkbox"/> Ultrasound	Treatment: <input type="checkbox"/> Laparoscopy <input type="checkbox"/> Hysteroscopy <input type="checkbox"/> In Vitro Fertilization (IVF)
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Male Factor: Husband's Name: _____ <input type="checkbox"/> Father of a previous pregnancy? <input type="checkbox"/> Varicocele <input type="checkbox"/> Undescended Testicle	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Anxiety/Depression	<input type="checkbox"/> Chemotherapy <input type="checkbox"/> Radiation Therapy <input type="checkbox"/> Vasectomy <input type="checkbox"/> Other:
List Medications : _____		
Semen Analysis? <input type="checkbox"/> No <input type="checkbox"/> Yes, Date _____ Results _____		