

PATIENT INTAKE HISTORY

PATIENT INFORMATION	PARTNER'S INFORMATION
NAME: _____	NAME: _____
ADDRESS: _____ _____	ADDRESS: _____ _____
DATE OF BIRTH: ____/____/____	DATE OF BIRTH: ____/____/____
HOME #: () _____ IS IT OKAY TO LEAVE A MESSAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	HOME #: () _____ IS IT OKAY TO LEAVE A MESSAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO
WORK #: () _____ MAY WE CONTACT YOU AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO IS IT OKAY TO LEAVE A MESSAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	WORK #: () _____ MAY WE CONTACT YOU AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO IS IT OKAY TO LEAVE A MESSAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO
MOBILE # () _____ IS IT OKAY TO LEAVE A MESSAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	MOBILE # () _____ IS IT OKAY TO LEAVE A MESSAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO
EMPLOYER: _____	EMPLOYER: _____
<i>PLEASE ANSWER & SIGN:</i> MAY WE DISCUSS YOUR TEST RESULTS WITH YOUR PARTNER/SPOUSE? <input type="checkbox"/> YES <input type="checkbox"/> NO SIGNATURE: _____	<i>PLEASE ANSWER & SIGN:</i> MAY WE DISCUSS YOUR TEST RESULTS WITH YOUR PARTNER/SPOUSE? <input type="checkbox"/> YES <input type="checkbox"/> NO SIGNATURE: _____
REFERRING PHYSICIAN:	
WHO WILL BE MANAGING YOUR PREGNANCY?	
PREFERRED PHARMACY:	
E-MAIL ADDRESS:	

IF YOU OR YOUR PARTNER IDENTIFY AS A GENDER OTHER THAN THE GENDER ASSIGNED AT BIRTH, PLEASE EXPLAIN AND LIST YOUR PREFERRED NAME AND PRONOUNS:

WHAT ARE YOUR GOALS FOR OUR FIRST VISIT?

PATIENT INTAKE HISTORY (Continued)

PATIENT NAME:

DATE: / /

If you are uncomfortable answering any questions, please leave them blank; you can discuss them with your provider

SECTION 1. PERSONAL PAST HISTORY OF ILLNESSES

MAJOR ILLNESSES	YES (DATE)	NO	NOTES
ASTHMA			
PNEUMONIA/LUNG DISEASE			
HEART ATTACK/ HEART PROBLEMS			
HIGH BLOOD PRESSURE			
STROKE			
BLOOD CLOTS IN LUNGS OR LEGS			
HIV/AIDS			
THYROID DISEASE			
DIABETES			
EATING DISORDERS			
DEPRESSION/ANXIETY			
ARTHRITIS/JOINT PAIN/BACK PROBLEMS			
COLLAGEN VASCULAR DISEASE (LUPUS)			
CANCER			
HEPATITIS/JAUNDICE/LIVER DISEASE			
COLITIS/CROHN'S DISEASE			
ANEMIA			
BLOOD TRANSFUSIONS			
BLEEDING DISORDERS			
MIGRAINE HEADACHES			
SEIZURES/CONVULSIONS/EPILEPSY			
CHICKENPOX/SHINGLES/VARICELLA VACINATION			
OTHER			

SECTION 2. OPERATIONS/HOSPITALIZATIONS – IF NONE CHECK HERE -

SURGERY/REASON	DATE OR YEAR	HOSPITAL

PATIENT INTAKE HISTORY (Continued)

PATIENT NAME:

DATE: / /

SECTION 3. FAMILY HISTORY

If a family member has an illness, please check the box and list their age at diagnosis

ILLNESS	Mother	Father	Brother	Sister	Child	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
BREAST CANCER									
COLON CANCER									
DIABETES									
HYPERTENSION									
OVARAIN CANCER									
HIGH CHOLESTEROL									
RECURRENT MISCARRIAGE									
STROKE									
GENETIC DISORDER									
BIRTH DEFECTS									
BLOOD CLOTS IN LUNGS OR LEGS									
DECEASED									
OTHER									

SECTION 4. SOCIAL HISTORY

	NOTES
EVER SMOKE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
IF YOU ARE CURRENTLY SMOKING: PACKS PER DAY: HOW MANY YEARS:	
IF YOU ARE CURRENTLY SMOKING, ARE YOU READY TO QUIT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
ALCOHOL: DRINKS PER DAY: DRINKS PER WEEK:	
RECREATIONAL DRUG USE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
HAVE YOU BEEN SEXUALLY ABUSED, THREATENED, OR HURT BY ANYONE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
OCCUPATION/JOB:	

SECTION 5. OBSTETRIC HISTORY – If no pregnancies please check here -

#	DATE (Month/Year)	WEEKS PREGNANT	OUTCOME (MISCARRIAGE, ECTOPIC PREGNANCY, TERMINATION, STILLBIRTH, VAGINAL DELIVERY, CESAREAN SECTION)	IF THE PREGNANCY RESULTED IN A BIRTH, PLEASE LIST THE CHILD'S SEX AND BIRTH WEIGHT	COMPLICATIONS
1					
2					
3					
4					
5					
6					

PATIENT INTAKE HISTORY (Continued)

PATIENT NAME:

DATE: / /

SECTION 6. GYNECOLOGIC HISTORY IF YOU ARE BEING SEEN FOR FIBROIDS PLEASE SKIP TO SECTION 16.

	NOTES		
AGE AT FIRST PERIOD:			
HOW OFTEN DO YOU GET PERIODS?			
LENGTH OF YOUR PERIOD (NUMBER OF DAYS OF BLEEDING):			
	YES	NO	NOTES
ANY RECENT CHANGES IN YOUR PERIODS?			
ARE YOUR PERIODS HEAVY?			
DO YOU BLEED BETWEEN PERIODS?			
DO YOU BLEED AFTER INTERCOURSE?			
DO YOU HAVE PAINFUL PERIODS?			
DATE OF YOUR LAST PAP TEST (YEAR ALONE IS OK):			
WAS IT NORMAL?			
HAVE YOU EVER HAD AN ABNORMAL PAP TEST?			
HAVE YOU HAD A SEXUALLY TRANSMITTED DISEASE?			
HAVE YOU HAD PELVIC INFLAMMATORY DISEASE (PID)?			
DO YOU HAVE ENDOMETRIOSIS?			
DO YOU HAVE FIBROIDS?			
DO YOU HAVE PAIN WITH INTERCOURSE?			
ESTIMATE OF SEXUAL FREQUENCY?			
HAS YOUR WEIGHT CHANGED?			
DO YOU HAVE EXCESS HAIR GROWTH?			
DO YOU HAVE ACNE?			
DO YOU HAVE NIPPLE DISCHARGE?			
DO YOU HAVE HOT FLASHES?			

SECTION 7. CURRENT MEDICATIONS – If none please check here - (Including hormones, vitamins, herbs, nonprescription medications)

CURRENT MEDICATIONS	DOSAGE	WHO PRESCRIBES

PATIENT INTAKE HISTORY (Continued)

PATIENT NAME:

DATE: / /

SECTION 8. MEDICATION ALLERGIES or OTHER ALLERGIES – If none please check here -

ALLERGY	TYPE OF REACTION

SECTION 9. PERSONAL PROFILE

ETHNICITY: CAUCASIAN ASHKENAZI JEWISH AFRICIAN AMERICAN ASIAN HISPANIC MEDITERRANEAN
 FRENCH CANADIA/CAJUN OTHER:

MARITAL STATUS: MARRIED LIVING WITH PARTNER SINGLE WIDOWED DIVORCED SEPARATED

SECTION 10. INFERTILITY HISTORY

IF YOU ARE EXPERIENCING INFERTILITY, HOW LONG HAVE YOU BEEN TRYING TO BECOME PREGNANT?

	DATE	LOCATION	NOTES
HYSTEOSALPINGOGRAM?			
SALINE SONOHYSTEROGRAM?			
LAPAROSCOPY?			
SEMEN ANALYSIS?			
HORMONAL STUDIES?			
CLOMID?			
LETROZOLE?			
GONADOTROPINS? (“injectables”)			
INTRAUTERINE INSEMINATION			
IN VITRO FERTILIZATION			
OTHER			

SECTION 11: MALE PARTNER HISTORY (if applicable):

NAME:

DATE OF BIRTH:

OCCUPATION/JOB:

ETHNICITY: CAUCASIAN ASHKENAZI JEWISH AFRICIAN AMERICAN ASIAN HISPANIC MEDITERRANEAN
 FRENCH CANADIA/CAJUN OTHER:

	YES	NO	NOTES
DO YOU HAVE CHILDREN?			
EVER SEEN A UROLOGIST?			
WERE YOU BORN WITH UNDESCENDED TESTICLES?			
DID PUBERTY OCCUR AT A NORMAL AGE AS A TEENAGER?			
EVER DIAGNOSED WITH CHLAMYDIA OR GONORRHEA?			

PATIENT INTAKE HISTORY (Continued)

PATIENT NAME:

DATE: / /

EVER EXPOSED TO SIGNIFICANT RADIATION?			
EVER EXPOSED TO SIGNIFICANT PESTICIDE OR TOXIC SOLVENTS?			
EVER TAKE BODY BUILDING MEDICATIONS OR SUPPLEMENTS?			
EVER SMOKE?			
IF YOU ARE CURRENTLY SMOKING: PACKS PER DAY: HOW MANY YEARS?			
IF YOU ARE CURRENTLY SMOKING, ARE YOU READY TO QUIT?			
ALCOHOL: DRINKS PER DAY: DRINKS PER WEEK:			
EVER USE RECREATIONAL DRUGS?			

SECTION 12. MALE PARTNER MEDICATIONS – If none please check -
(Including vitamins, herbs, nonprescription medications)

CURRENT MEDICATIONS	DOSAGE	WHO PRESCRIBES

SECTION 13. MALE PARTNER MEDICATION ALLERGIES or OTHER ALLERGIES – If none please check here -

ALLERGY	TYPE OF REACTION

SECTION 14. MALE PARTNER OPERATIONS/HOSPITALIZATIONS – IF NONE CHECK HERE -

SURGERY/REASON	DATE OR YEAR	HOSPITAL

SECTION 15. PARTNER FAMILY HISTORY

ILLNESS	Mother	Father	Brother	Sister	Child	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
INFERTILITY									
BIRTH DEFECTS									
GENETIC DISORDER									

**IF YOU ARE BEING SEEN FOR INFERTILITY, YOUR FORM IS COMPLETE.
 THANK YOU.**

PATIENT INTAKE HISTORY (Continued)

PATIENT NAME:

DATE: / /

IF YOU ARE BEING SEEN FOR FIBROIDS PLEASE COMPLETE THIS SECTION.

SECTION 16. FIBROID HISTORY

16A. CHIEF COMPLAINT(S)

	YES	NO	HOW LONG? (MONTHS)
MENSTRUAL DISTURBANCE			
PELVIC PAIN/PRESSURE			
URINARY SYMPTOMS			
BOWEL SYMPTOMS			
INFERTILITY			
SOCIAL DISTURBANCE (BLEEDING THROUGH CLOTHING, AVOIDING SOCIAL GATHERING, ETC.)			
PAIN WITH INTERCOURSE?			
OTHER			

16B. MENSTRUAL HISTORY

	NOTES
DATE OF LAST MENSTRUAL PERIOD (1 ST DAY):	
AGE PERIODS BEGAN:	

HISTORICALLY:	YES	NO	NOTES
MENSTRUAL INTERVAL FROM (21-35 DAYS):			
DURATION OF FLOW (0-10 DAYS):			
DID YOU HAVE HEAVY PERIODS?			
DID YOU BLEED BETWEEN PERIODS?			
DID YOU BLEED AFTER INTERCOURSE?			
DID YOU HAVE PAINFUL PERIODS?			

CURRENTLY:	YES	NO	NOTES
MENSTRUAL INTERVAL FROM (21-35 DAYS):			
DURATION OF FLOW (0-10 DAYS):			
DO YOU HAVE HEAVY PERIODS?			
DO YOU BLEED BETWEEN PERIODS?			
DO YOU BLEED AFTER INTERCOURSE?			
DO YOU HAVE PAINFUL PERIODS?			

DATE OF YOUR LAST PAP TEST (YEAR ALONE IS OK):			
WAS IT NORMAL?			
HAVE YOU EVER HAD AN ABNORMAL PAP TEST?			
HAVE YOU HAD A SEXUALLY TRANSMITTED DISEASE?			
HAVE YOU HAD PELVIC INFLAMMATORY DISEASE (PID)?			
DO YOU HAVE ENDOMETRIOSIS?			