



NEW PATIENT GYNECOLOGIC HISTORY

a. IDENTIFYING DATA

Your Name: _____ Partner's Name: _____
 Age: _____ Duration of Relationship: _____
 Birth Date: _____ Duration of no contraception: _____
 Are you married? _____ Previously married? _____
 Date this form completed: _____ Attempted pregnancy previously? _____
 How did you first hear about our practice? _____
 Who referred you? (name & mailing address): _____

 Reason(s) you are coming to see us: _____

b. PATIENT ETHNICITY * PATIENT RELIGION * PARTNER ETHNICITY * PARTNER RELIGION *

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> American Indian or Alaska Native
<input type="checkbox"/> Black Hispanic
<input type="checkbox"/> Black or African American
<input type="checkbox"/> Hispanic or Latino
<input type="checkbox"/> Native Hawaiian or other Pacific Islander
<input type="checkbox"/> Japanese
<input type="checkbox"/> Chinese
<input type="checkbox"/> Korean
<input type="checkbox"/> Vietnamese
<input type="checkbox"/> Filipino
<input type="checkbox"/> Middle Eastern
<input type="checkbox"/> Thai
<input type="checkbox"/> Persian
<input type="checkbox"/> East Indian
<input type="checkbox"/> White
<input type="checkbox"/> Other _____ | <input type="checkbox"/> Jewish
<input type="checkbox"/> Protestant
<input type="checkbox"/> Catholic
<input type="checkbox"/> Muslim
<input type="checkbox"/> Buddhist
<input type="checkbox"/> Hindu
<input type="checkbox"/> No religion
<input type="checkbox"/> Other _____ | <input type="checkbox"/> American Indian or Alaska Native
<input type="checkbox"/> Black Hispanic
<input type="checkbox"/> Black or African American
<input type="checkbox"/> Hispanic or Latino
<input type="checkbox"/> Native Hawaiian or other Pacific Islander
<input type="checkbox"/> Japanese
<input type="checkbox"/> Chinese
<input type="checkbox"/> Korean
<input type="checkbox"/> Vietnamese
<input type="checkbox"/> Filipino
<input type="checkbox"/> Middle Eastern
<input type="checkbox"/> Thai
<input type="checkbox"/> Persian
<input type="checkbox"/> East Indian
<input type="checkbox"/> White
<input type="checkbox"/> Other _____ | <input type="checkbox"/> Jewish
<input type="checkbox"/> Protestant
<input type="checkbox"/> Catholic
<input type="checkbox"/> Muslim
<input type="checkbox"/> Buddhist
<input type="checkbox"/> Hindu
<input type="checkbox"/> No religion
<input type="checkbox"/> Other _____ |
|---|---|---|---|

** Optional. Data will be used for statistical purposes only. This information will assist in fertility research.*

c. PREGNANCY HISTORY

Times Pregnant ___ Term births ___ Premature births ___ Miscarriages ___ Elective abortions ___ Adopted Children ___

	Date	Mis-carriage?	Elective Abortion?	Ectopic?	Months to conceive?	Infertility treatment?	Weight and sex?	C-section?	Complications?	Was current partner the father?
1										
2										
3										
4										
5										

d. CONTRACEPTIVE USE

	Type	From when to when	Reason discontinued
1			
2			
3			
4			

e. OPERATIONS AND HOSPITALIZATIONS

	Date	Diagnosis	Operation	Where	Physician
1					
2					
3					
4					

f. 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				
4				

g. ALLERGIES

	Drug or substance	When	Reaction
1			
2			
3			
4			

h. MENSTRUAL/HORMONAL

Weight _____ Height _____

Date your last menses began: _____

Age at first period: _____

Are your periods regular? _____

How many days from onset to onset? _____

How many days does your period last? _____

Do you bleed between periods? _____

Premenstrual symptoms occur: almost always rarely never

Vigorous exercise: type _____ hours per week _____

type _____ hours per week _____

h. MENSTRUAL/HORMONAL (continued)

If you have a hormonal disorder please specify type and treatment: _____

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

What medication do you take for pain/cramps? _____

Do you have or have you had:

	Yes	No		Yes	No
Hot flushes	<input type="checkbox"/>	<input type="checkbox"/>	Increased facial or body hair	<input type="checkbox"/>	<input type="checkbox"/>
Breast discharge	<input type="checkbox"/>	<input type="checkbox"/>	Increased acne	<input type="checkbox"/>	<input type="checkbox"/>
Visual disturbance	<input type="checkbox"/>	<input type="checkbox"/>	Weight increase > 10 pounds	<input type="checkbox"/>	<input type="checkbox"/>
Poor sense of smell	<input type="checkbox"/>	<input type="checkbox"/>	Weight loss > 10 pounds	<input type="checkbox"/>	<input type="checkbox"/>
Chronic headache	<input type="checkbox"/>	<input type="checkbox"/>	Special dietary habits	<input type="checkbox"/>	<input type="checkbox"/>
Head trauma	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disorder	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disease	<input type="checkbox"/>	<input type="checkbox"/>
Extraordinary stress	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric treatment	<input type="checkbox"/>	<input type="checkbox"/>

If yes, please explain: _____

i. ANATOMIC/INFECTION

Do you have or have you had:

	Yes	No		Yes	No
Pelvic infection	<input type="checkbox"/>	<input type="checkbox"/>	Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>
Chlamydia	<input type="checkbox"/>	<input type="checkbox"/>	Colitis or enteritis	<input type="checkbox"/>	<input type="checkbox"/>
Antichlamydial antibodies	<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>
Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>	Pelvic adhesions	<input type="checkbox"/>	<input type="checkbox"/>
Syphilis	<input type="checkbox"/>	<input type="checkbox"/>	Uterine fibroids or myomas	<input type="checkbox"/>	<input type="checkbox"/>
Mycoplasma	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal uterus shape/anomaly	<input type="checkbox"/>	<input type="checkbox"/>
Ureaplasma	<input type="checkbox"/>	<input type="checkbox"/>	Ovarian cysts	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Toxoplasmosis	<input type="checkbox"/>	<input type="checkbox"/>
In utero DES exposure	<input type="checkbox"/>	<input type="checkbox"/>	Cytomegalovirus (CMV)	<input type="checkbox"/>	<input type="checkbox"/>

j. COMBINED

Do you have or have you had:

	Yes	No		Yes	No
Cervicitis	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent vaginitis	<input type="checkbox"/>	<input type="checkbox"/>
Genital herpes	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Pap smears	<input type="checkbox"/>	<input type="checkbox"/>
Genital warts/condyloma	<input type="checkbox"/>	<input type="checkbox"/>	Cryo (freezing) or surgery of the cervix	<input type="checkbox"/>	<input type="checkbox"/>
Trichomonas	<input type="checkbox"/>	<input type="checkbox"/>			

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

How many times do you have intercourse around ovulation? _____

Do you use lubricants for intercourse? _____

Do you douche before or after intercourse? _____

Have you ever had unwanted sexual experiences? _____

Do you have any sexual problems at this time? _____

k. OTHER MEDICAL HISTORY

Your occupation: _____

Years formal education: _____

Cigarettes – packs smoked per day: _____

Alcohol – Type and number per week: _____

Marijuana – amount: _____

Other drugs – type and amount: _____

Ever used intravenous drugs? _____

Caffeine drinks per day: _____

Radiation exposure: _____

Toxic exposure: _____

Paint exposure: _____

Video display terminal hours / day: _____

Electric blanket use: _____

Hot tub or sauna use: _____

List all serious or chronic illnesses or injuries not already described: _____

Do any family members have: Infertility Hormonal disorder Other inherited disorders

If yes, please explain: _____

I. PARTNER HISTORY

Your partner's age & occupation: _____

List all serious or chronic illnesses or injuries: _____

What medications does your partner take? _____

Medication allergies? _____

Cigarettes - packs smoked per day: _____

Alcohol - type and number per week: _____

Marijuana – amount: _____

Other drugs - type and amount: _____

Ever use intravenous drugs? _____

Caffeine drinks per day: _____

Radiation exposure: _____

Toxic exposure: _____

Video display terminal hours/day: _____

Electric blanket use: _____

Hot tub or sauna use: _____

Any problems with erection or ejaculation? _____

Has semen analysis ever been abnormal? _____

Has your partner seen a doctor for infertility evaluation? _____

Doctor: _____ Diagnosis: _____

Treatment: _____

Has your partner ever fathered a pregnancy with another woman? _____

Any inherited disorders in your partner's family? _____

Does **your partner** have or has had:

	Yes	No		Yes	No
Chlamydia	<input type="checkbox"/>	<input type="checkbox"/>	Vasectomy	<input type="checkbox"/>	<input type="checkbox"/>
Antichlamydial antibodies	<input type="checkbox"/>	<input type="checkbox"/>	Vasectomy reversal	<input type="checkbox"/>	<input type="checkbox"/>
Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>	Varicocele	<input type="checkbox"/>	<input type="checkbox"/>
Syphilis	<input type="checkbox"/>	<input type="checkbox"/>	Varicocele surgery	<input type="checkbox"/>	<input type="checkbox"/>
Genital herpes	<input type="checkbox"/>	<input type="checkbox"/>	Testicular biopsy	<input type="checkbox"/>	<input type="checkbox"/>
Genital warts/condyloma	<input type="checkbox"/>	<input type="checkbox"/>	Hernia surgery	<input type="checkbox"/>	<input type="checkbox"/>
Mycoplasma	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal surgery	<input type="checkbox"/>	<input type="checkbox"/>
Ureaplasma	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Urethritis/epididymitis	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Prostatitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Penile discharge or pain	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>
Undescended testicle	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Testicular injury	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric treatment	<input type="checkbox"/>	<input type="checkbox"/>
Mumps with testes injury	<input type="checkbox"/>	<input type="checkbox"/>	Extraordinary stress	<input type="checkbox"/>	<input type="checkbox"/>
Congenital anomaly	<input type="checkbox"/>	<input type="checkbox"/>	Extraordinary exercise	<input type="checkbox"/>	<input type="checkbox"/>
DES exposure in utero	<input type="checkbox"/>	<input type="checkbox"/>	Tight underwear	<input type="checkbox"/>	<input type="checkbox"/>

m. PREVIOUS EVALUATION

	<u>Not Done</u>	<u>Normal result</u>	<u>Abnormal result</u>	<u>Approx. date</u>	<u>Values (if known)</u>
Semen Analysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hamster egg penetration assay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Semen antisperm antibodies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Basal body temperature (BBT)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Urine LH surge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Endometrial biopsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Female Blood:					
FSH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
LH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Prolactin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Thyroid tests (TSH, T4)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
DHAS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Testosterone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Estradiol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Progesterone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Postcoital test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Cervical mucus penetration test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mycoplasma culture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Chlamydia culture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Antichlamydial antibodies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Female antisperm antibodies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hysterosalpingogram (HSG)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Ultrasound	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
IVP (Kidney x-ray)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Laparoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hysteroscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Karyotype	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Anticardiolipin antibodies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Lupus anticoagulant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Antinuclear antibodies (ANA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Coagulation screen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Biochemistry / hematology panel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Blood type	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Other: _____

List causes of infertility previously diagnosed: _____

n. PREVIOUS TREATMENT

	<u>How many Months</u>	<u>Dose (if known)</u>	<u>Approx. dates</u>
Antibiotics	_____	_____	_____
Clomiphene (Clomid, Serophene)	_____	_____	_____
hMG (Pergonal)	_____	_____	_____
FSH (Metrodin)	_____	_____	_____
hCG (Profasi)	_____	_____	_____
Progesterone	_____	_____	_____
Dexamethasone	_____	_____	_____
GnRH Agonist (Lupron, Synarel)	_____	_____	_____
Danazol	_____	_____	_____
Intrauterine insemination	_____	_____	_____
Insemination with donor sperm	_____	_____	_____
IVF (In vitro fertilization)	_____	_____	_____
GIFT	_____	_____	_____
Other: _____	_____	_____	_____

o. GENETIC HISTORY

Do you, your partner, or anyone in either family have:

	Yes	No		Yes	No
Neural tube defects/spina bifida/anencephaly	<input type="checkbox"/>	<input type="checkbox"/>	Cystic fibrosis	<input type="checkbox"/>	<input type="checkbox"/>
Thalassemia	<input type="checkbox"/>	<input type="checkbox"/>	Muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
Down syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Huntington chorea	<input type="checkbox"/>	<input type="checkbox"/>
Tay-Sachs	<input type="checkbox"/>	<input type="checkbox"/>	Mental retardation/ Fragile X	<input type="checkbox"/>	<input type="checkbox"/>
Sickle cell disease or trait	<input type="checkbox"/>	<input type="checkbox"/>	Chromosomal disorder	<input type="checkbox"/>	<input type="checkbox"/>
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Baby with birth defects	<input type="checkbox"/>	<input type="checkbox"/>