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? □YES □ NO**	HOME #: ( ) _____ **IS IT OKAY TO LEAVE A MESSAGE? □YES □ NO**
WORK #: ( ) _____ **MAY WE CONTACT YOU AT WORK? □ YES □ NO** **IS IT OKAY TO LEAVE A MESSAGE? □ YES □ NO**	WORK #: ( ) _____ **MAY WE CONTACT YOU AT WORK? □ YES □ NO** **IS IT OKAY TO LEAVE A MESSAGE? □ YES □ NO**
MOBILE # ( ) _____ **IS IT OKAY TO LEAVE A MESSAGE? □YES □ NO**	MOBILE # ( ) _____ **IS IT OKAY TO LEAVE A MESSAGE? □YES □ NO**
EMPLOYER: _____	EMPLOYER: _____
PLEASE ANSWER & SIGN: **MAY WE DISCUSS YOUR TEST RESULTS WITH YOUR PARTNER/SPOUSE?** **□YES □ NO** **SIGNATURE:_____**	***PLEASE ANSWER & SIGN:*** **MAY WE DISCUSS YOUR TEST RESULTS WITH YOUR PARTNER/SPOUSE?** **□ YES □ NO** **SIGNATURE:_____**
REFERRING PHYSICIAN/OB/GYN:	
PRIMARY CARE PROVIDER:	
PREFERRED PHARMACY:	
E-MAIL ADDRESS:	

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	PHYSICIAN/NURSE 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			
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

	PHYSICIAN/NURSE NOTES
EVER SMOKE? □ YES □ NO	
IF YOU ARE CURRENTLY SMOKING: PACKS PER DAY: HOW MANY YEARS:	
IF YOU ARE CURRENTLY SMOKING, ARE YOU READY TO QUIT? □ YES □ NO	
ALCOHOL: DRINKS PER DAY: DRINKS PER WEEK:	
RECREATIONAL DRUG USE? □ YES □ NO	
HAVE YOU BEEN SEXUALLY ABUSED, THREATENED, OR HURT BY ANYONE? □ YES □ NO	
OCCUPATION/JOB:	
EDUCATION COMPLETED: □ HIGH SCHOOL □ SOME COLLEGE □ COLLEGE /BA DEGREE □ GRADUATE DEGREE □ OTHER	

PATIENT INTAKE HISTORY (Continued)

PATIENT NAME:	DATE: / /

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 IF MALE OR FEMALE AND BIRTH WEIGHT	COMPLICATIONS
1					
2					
3					
4					
5					
6					

SECTION 6. CURRENT MEDICATIONS – If none please check here - ☐
(Including hormones, vitamins, herbs, nonprescription medications)

CURRENT MEDICATIONS	DOSAGE	WHO PRESCRIBED

SECTION 7. MEDICATION ALLERGIES or OTHER ALLERGIES – If none please check here - ☐

ALLERGY	TYPE OF REACTION

PATIENT INTAKE HISTORY (Continued)

PATIENT NAME:	DATE: / /

SECTION 8.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
SEXUAL ORIENTATION: □ HETEROSEXUAL □ HOMOSEXUAL □ BISEXUAL
NUMBER OF PRIOR MARRIAGES FOR YOU AND PARTNER:
HOW LONG HAVE YOU BEEN MARRIED OR LIVING WITH CURRENT PARTNER?
IF YOU ARE EXPERIENCING INFERTILITY, HOW LONG HAVE YOU BEEN TRYING TO BECOME PREGNANT?

IF YOU ARE BEING SEEN FOR INFERTILITY, PLEASE COMPLETE SECTION 9.
SECTION 9. INFERTILITY TESTING AND TREATMENT

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

IF YOU ARE BEING SEEN FOR FIBROIDS PLEASE SKIP TO SECTION 13.
SECTION 10. GYNECOLOGIC HISTORY

	PHYSICIAN/NURSE NOTES
LAST NORMAL MENSTRUAL PERIOD (FIRST DAY):	
AGE PERIODS BEGAN:	
HOW OFTEN DO YOU GET PERIODS:	
LENGTH OF YOUR PERIOD (NUMBER OF DAYS OF BLEEDING):	

	YES	NO	PHYSICIAN/NURSE 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?			
HAVE YOU HAD A SEXUALLY TRANSMITTED DISEASE?			
HAVE YOU HAD PELVIC INFLAMMATORY DISEASE (PID)?			

PATIENT INTAKE HISTORY (Continued)

PATIENT NAME:	DATE: / /

	YES	NO	PHYSICIAN/NURSE NOTES
DATE OF YOUR LAST PAP TEST:			
WAS IT NORMAL?			
HAVE YOU EVER HAD AN ABNORMAL PAP TEST?			
DO YOU HAVE PELVIC PAIN?			
DO YOU HAVE ENDOMETRIOSIS?			
DO YOU HAVE FIBROIDS?			
DO YOU HAVE PAIN WITH INTERCOURSE?			
PLEASE GIVE A ROUGH ESTIMATE OF SEXUAL FREQUENCY:			
PREVIOUS METHOD(S) OF BIRTH CONTROL: □ BIRTH CONTROL PILLS □ IUD □ DEPO PROVERA □ NUVARING □ TUBAL LIGATION □ VASECTOMY □ CONDOMS			

SECTION 11. ENDOCRINE HISTORY

	YES	NO	PHYSICIAN/NURSE NOTES
HAS YOUR WEIGHT CHANGED?			
DO YOU HAVE EXCESS HAIR GROWTH?			
DO YOU HAVE ACNE?			
DO YOU HAVE NIPPLE DISCHARGE?			
DO YOU HAVE HOT FLASHES?			

IF YOU ARE BEING SEEN FOR INFERTILITY PLEASE COMPLETE SECTION 12.
SECTION 12. PARTNER PROFILE N/A □

NAME:
DATE OF BIRTH:
OCCUPATION/JOB:
ETHNICITY: □ CAUCASIAN □ ASHKENAZI JEWISH □ AFRICIAN AMERICAN □ ASIAN □ HISPANIC □ MEDITERRANEAN □ FRENCH CANADIA/CAJUN □ OTHER:

12 A. IF MALE PARTNER, PLEASE COMPLETE THE FOLLOWING:

	YES	NO	PHYSICIAN/NURSE'S NOTES
DID YOU HAVE CHILDREN BY PREVIOUS WIFE OR PARTNER?			
HAVE YOU EVER SEEN AN UROLOGIST?			
WERE YOU BORN WITH UNDESCENDED TESTICLES?			
DID PUBERTY OCCUR AT A NORMAL AGE AS A TEENAGER?			
HAVE YOU EVER HAD CHLAMYDIA OR GONORRHEA?			
HAVE YOU HAD SIGNIFICANT RADIATION EXPOSURE?			
HAVE YOU HAD SIGNIFICANT PESTICIDE OR TOXIC SOLVENT EXPOSURES?			
DO YOU USE BODY BUILDING MEDICATIONS OR SUPPLEMENTS?			
DO YOU USE MARIJUANA?			
DO YOU SUFFER ANY CHRONIC ILLNESSES?			

PATIENT INTAKE HISTORY (Continued)

PATIENT NAME:	DATE: / /

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

CURRENT MEDICATIONS	DOSAGE	WHO PRESCRIBED

12 C. MEDICATION ALLERGIES or OTHER ALLERGIES – If none please check here - □

ALLERGY	TYPE OF REACTION

12 D. PARTNER OPERATIONS/HOSPITALIZATIONS – IF NONE CHECK HERE - □

SURGERY/REASON	DATE OR YEAR	HOSPITAL

12 E. PARTNER 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
INFERTILITY									
BIRTH DEFECTS									

IF YOU ARE A FERTILITY PATIENT YOUR FORM IS COMPLETE.

IF YOU ARE BEING SEEN FOR FIBROIDS PLEASE COMPLETE SECTION 13.

PATIENT INTAKE HISTORY (Continued)

PATIENT NAME:	DATE: / /

SECTION 13. FIBROID HISTORY

13A. CHIEF COMPLAINT(S)

	YES	NO	HOW LONG? (MONTHS)
MENSTRUAL DISTUBANCE			
PELVIC PAIN/PRESSURE			
URINARY SYMPTOMS			
BOWEL SYMPTOMS			
INFERTILITY			
SOCIAL DISTURBANCE			
OTHER			

13B. MENSTRUAL HISTORY

	PHYSICIAN /NURSE NOTES
DATE OF LAST MENSTUAL PERIOD (1ST DAY):	
AGE PERIODS BEGAN:	

HISTORICALLY:	YES	NO	PHYSICIAN/NURSE 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?			
ANY CHANGES IN MENSTRUAL PERIOD?			
CURRENTLY:			
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?			
ANY CHANGES IN MENTRUAL PERIOD?			

13C. GYNECOLOGIC HISTORY

HAVE YOU HAD A SEXUALLY TRANSMITTED DISEASE?			
HAVE YOU HAD PELVIC INFLAMMATORY DISEASE (PID)?			
LAST PAP TEST: RESULTS:			
HISTORY OF ABNORMAL PAP TEST:			
PELVIC PAIN:			
ENDOMETRIOSIS:			
PAINFUL INTERCOURSE:			
PREVIOUS METHODS OF BIRTH CONTROL:			

END OF FIBROID SECTION.