

Name: _____

DOB: ___/___/___



Alabama Center for Reproductive Medicine

Female New Patient Medical History

Name: _____ Age: _____ SSN: _____

Initial Apt Date: _____ Marital Status: _____ Height: _____

Religion: _____ Occupation: _____ Weight: _____

Primary Contact #: _____ Secondary Contact #: _____

Email: _____ Race: _____

Address: _____ City, State: _____

Preferred Pharmacy Name: _____

Pharmacy City, State: _____ Pharmacy Phone #: _____

Partner name (if applicable): _____ Partner occupation: _____

Partner phone #: _____ Partner DOB: _____

Emergency contact: _____ Phone #: _____

Reason for Visit (Check all that apply)

Infertility

Repeated Miscarriages

Endometriosis

In Vitro Fertilization

Pelvic Pain

Irregular Periods

Other: _____

Menstrual History

What age did your menstruation begin? _____ Regularity: _____

Average length of cycle (from 1st day of period to the 1st day of the next) _____ days

Bleeding between periods? _____ Pain between periods? _____

Pain during: None Mild Moderate Severe

Do you have vaginal discharge? _____ Do you bleed after intercourse? _____

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Last normal period ___/___/___

How many times do you have intercourse per week? _____

Do you experience any pain during intercourse? _____

When was your most recent: Mammogram ___/___/___ Pap Smear ___/___/___

Past Medical History

List any injuries/illnesses requiring hospitalization:

Date	Reason
_____	_____
_____	_____
_____	_____

List any surgeries you have had:

Date	Reason
_____	_____
_____	_____
_____	_____

List any sexually transmitted diseases you have had (such as syphilis, gonorrhea, herpes, genital warts, PID, tubal infections, ect.)

Alcohol consumption: Current _____ beverages/week Past _____ beverages/week

Cigarette use: Current _____ packs/day Past _____ packs/day

Recreational/illegal drug use (please specify): Current: _____ Past: _____

How many caffeinated beverages do you have per day? _____

Have you ever undergone chemotherapy or radiation? (If yes, please explain)

What allergies do you have? _____

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Medications

Medication	Frequency	Indication
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you currently take a prenatal or multi-vitamin? _____ Type: _____

Contraceptive History

Please check all the types of birth control methods you have used (past or current)

Type	Dates	Type	Dates
___ Birth Control Pills (_____ - _____)		___ Condoms (_____ - _____)	
___ IUD (_____ - _____)		___ Other _____ (_____ - _____)	

Obstetrical History

Please list all pregnancies (including ectopic, abortions, miscarriages, and deliveries):

#	Date	Type	Birth WT	Sex	Alive (Y/N)	Complications

Family History

Are you adopted? _____ Please check in the appropriate following boxes:

Problem	Mother	Father	Sibling	Grandparent	Children
Breast Cancer					
Ovarian Cancer					
Other Cancer					
Thyroid disease					
Heart Disease					
Diabetes					

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Please check in the appropriate following boxes:

Problem	Mother	Father	Sibling	Grandparent	Children
High blood pressure					
Irregular periods					
Infertility					
Uterine fibroids					
Endometriosis					
Birth defects					
Other					

Previous Infertility Evaluation and Treatment

Female: Please note the date and results of the following tests you have had:

Test	Date	Results
Basal Body Temperature Charting		
Hysterosalpingogram (HSG)		
Laparoscopy		
Hysteroscopy		
Hormone Tests		
Progesterone Level		

Please note any infertility medications you have taken:

Medication	Date	# Cycles	Dose	Did you conceive?
Clomiphine Citrate (Clomid)				
Letrozole				
hCG (Trigger) Injections				
Fertility Injections				
Metformin (Glucophage)				
Other (_____)				

Please note any fertility treatments you have had:

Medication	Date	# Cycles	Where	Did you conceive?
Artificial Insemination (IUI)				
In Vitro Fertilization				
Other (_____)				

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Review of Systems

General

- Weight loss or gain
- Fatigue
- Fever or chills
- Weakness
- Trouble Sleeping

Skin

- Rashes
- Lumps
- Itching
- Dryness
- Hair and nail changes

Ears

- Decreased Hearing
- Ringing in ears
- Earache
- Drainage

Eyes

- Glasses or contacts
- Pain
- Redness
- Blurry or double vision
- Flashing lights
- Specks
- Cataracts
- Glaucoma
- Last eye exam _____

Neck

- Lumps
- Swollen glands
- Stiffness
- Pain

Nose

- Stuffiness
- Discharge
- Itching
- Hay fever
- Nosebleeds
- Sinus pain

Throat

- Dry mouth
- Bleeding gums
- Dentures
- Sore throat
- Dry mouth
- Hoarseness
- Thrush
- Non-healing sores
- Last dental exam _____

Breasts

- Lumps
- Pain
- Discharge
- Self-exams
- Breast-feeding

Respiratory

- Sputum
- Wheezing
- Painful breathing
- Coughing up blood
- Shortness of breath
- Cough

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Review of Systems Cont.

Urinary

- Increased frequency
- Urgency
- Burning or pain
- Blood in urine
- Incontinent
- Change in urinary strength

Genital

- Pain with sex
- Vaginal dryness
- Hot flashes
- Vaginal discharge
- Itching or rash
- STDs

Musculoskeletal

- Muscle or joint pain
- Stiffness
- Back pain
- Redness of joints
- Swelling of joints
- Trauma

Vascular

- Calf pain with walking (claudication)
- Leg cramping

Endocrine

- Head or cold intolerance
- Sweating
- Excessive thirst (polydipsia)

Neurological

- Dizziness
- Fainting
- Seizures
- Weakness
- Numbness
- Tingling
- Tremors

Hematologic

- Ease of bruising
- Ease of bleeding

Gastrointestinal

- Swallowing difficulties
- Change in appetite
- Nausea
- Constipation
- Rectal bleeding
- Change in bowel habits
- Heartburn
- Yellow eyes/skin
- Diarrhea

Psychiatric

- Nervousness
- Depression
- Memory loss
- Stress

Cardiovascular

- Difficulty breathing lying down
- Chest pain/discomfort
- Tightness
- Palpitations
- Swelling (adema)