

Name: _____
Medical Record Number: _____
Date of Birth: _____

NEW PATIENT HISTORY FORM

Date: _____ Physician who referred you _____ Fax: _____
Phone: _____
Would you like a copy of your visit sent to this doctor? ___ Yes ___ No

DEMOGRAPHIC INFORMATION

Patient's Legal Name: _____ Preferred Name, Pronoun: _____
Birth date: _____ Age _____ Occupation _____
Partner's best phone number: _____
Is your real age different from your legal age? ___ Yes ___ No

If applicable:

Partner's Legal Name: _____ Preferred Name, Pronoun: _____
Birth date: _____ Age _____ Occupation _____ Relationship duration _____
Partner's best phone number: _____

REASON FOR VISIT

INFERTILITY HISTORY

How long have you been trying to get pregnant? _____ years _____ months

Have you attempted pregnancy prior to this relationship? ___ Yes ___ No

Past Fertility Evaluation

Semen Analysis	___ No ___ Yes	Result / date	_____
HSG (X-ray of tubes)	___ No ___ Yes	Result / date	_____
Ovulation Predictor	___ No ___ Yes	Result / date	_____
Pelvic Ultrasound	___ No ___ Yes	Result / date	_____
TSH	___ No ___ Yes	Result / date	_____
Day 3 FSH, Estradiol	___ No ___ Yes	Result / date	_____
AMH	___ No ___ Yes	Result / date	_____

Have you had any of the following treatments?

Clomiphene (Clomid) or Letrozole (Femara) _____
Gonadotropins _____
Prior Inseminations (IUIs) _____

Prior in vitro fertilization (IVF)

Location	Date	Dose	Peak Estrogen	# Eggs Retrieved	% Fertilization (Embryos available)	# Embryos Transferred, Stage	Outcome	Frozen Embryos?

OBSTETRICAL HISTORY

Date	Time to conceive	Length of pregnancy (weeks)	Gender	Birth weight	Outcome (e.g. miscarriage, ectopic, abortion, vaginal delivery, C-section)	Pregnancy Complications

GYNECOLOGIC and MENSTRUAL HISTORY

Age of onset of periods _____ Date of last menstrual period (LMP) _____

Length of menses _____ days Number of days between menses _____ days/months

How many pads/tampons do you use on the heaviest day of your period? _____

Do you have pain during your period? ___ No ___ Yes

If yes, does it affect your daily activities? ___ No ___ Yes

Do you have pain between periods? ___ No ___ Yes

Do you bleed between periods? ___ No ___ Yes

Any history of any sexually transmitted infections? ___ No ___ Yes If yes, when? _____

Date and result of last Pap Smear _____

Any history of abnormal Pap Smears? ___ No ___ Yes If yes, when? _____

Have you had surgery or laser of the cervix? ___ No ___ Yes

Date and result of last mammogram _____

Do you have any problems with intercourse? ___ No ___ Yes

Do you bleed during or after intercourse? ___ No ___ Yes

Do you have pain during or after intercourse? ___ No ___ Yes

Have you had a tubal ligation? ___ No ___ Yes

PAST MEDICAL HISTORY (Please list any medical problems below)

- 1. _____
- 2. _____
- 3. _____
- 4. _____

SURGICAL HISTORY (Please list all surgeries including dates, hospitalization duration, and location)

- 1. _____
- 2. _____
- 3. _____
- 4. _____

MEDICATIONS (including complementary and alternative therapy, herbs, vitamins)

- 1. Vitamin/Folate Yes No
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____

ALLERGIES TO MEDICATIONS; TYPE OF REACTIONS

SOCIAL HISTORY

Married Widowed Separated Divorced Single Single in a committed relationship

How much caffeine do you drink per day? _____ cups coffee / tea / soda

How many cigarettes do you smoke per day? _____ For how long? _____ years

How much alcohol do you drink per week? _____ What kind? _____

Do you use marijuana? _____ If yes, how often? _____

Any other substances? _____

Patient's ethnicity:

Non- Hispanic White Non- Hispanic Black Asian/ Pacific Islander Hispanic Jewish

Partner's ethnicity (if applicable):

Non- Hispanic White Non- Hispanic Black Asian/ Pacific Islander Hispanic Jewish

Are you interested in pre-genetic conception screening? Yes No

(This could help determine if you may be at risk of having a baby with an inherited genetic disease)

REVIEW OF SYSTEMS

Please mark any of the following disorders YOU currently have or have a history of:

<p>Central Nervous System</p> <ul style="list-style-type: none"><input type="checkbox"/> Seizures<input type="checkbox"/> Migraine Headaches<input type="checkbox"/> Difficulty with memory <p>ENT:</p> <ul style="list-style-type: none"><input type="checkbox"/> Visual disturbances<input type="checkbox"/> Sinus problems <p>Cardiovascular:</p> <ul style="list-style-type: none"><input type="checkbox"/> High blood pressure<input type="checkbox"/> High blood pressure in pregnancy<input type="checkbox"/> Chest pain<input type="checkbox"/> Palpitations<input type="checkbox"/> Dizziness<input type="checkbox"/> History of Rheumatic Fever<input type="checkbox"/> Heart valve disease<input type="checkbox"/> Given prophylactic antibiotics<input type="checkbox"/> Mitral valve prolapse <p>Respiratory</p> <ul style="list-style-type: none"><input type="checkbox"/> Shortness of breath<input type="checkbox"/> Asthma<input type="checkbox"/> Bronchitis<input type="checkbox"/> Pneumonia<input type="checkbox"/> Cough<input type="checkbox"/> Tuberculosis <p>Gastrointestinal</p> <ul style="list-style-type: none"><input type="checkbox"/> Nausea/Vomiting<input type="checkbox"/> Blood in stool<input type="checkbox"/> Ulcers<input type="checkbox"/> Hepatitis/Liver disease<input type="checkbox"/> Diarrhea<input type="checkbox"/> Constipation <p>Psychiatric</p> <ul style="list-style-type: none"><input type="checkbox"/> Anxiety<input type="checkbox"/> Panic attacks<input type="checkbox"/> Depression<input type="checkbox"/> Eating disorders	<p>Gynecologic</p> <ul style="list-style-type: none"><input type="checkbox"/> Bladder infections (cystitis)<input type="checkbox"/> Incontinence<input type="checkbox"/> Kidney infections<input type="checkbox"/> Gonorrhea<input type="checkbox"/> Chlamydia<input type="checkbox"/> Herpes<input type="checkbox"/> Syphilis<input type="checkbox"/> Warts (HPV)<input type="checkbox"/> Decreased sex drive<input type="checkbox"/> Pelvic inflammatory disease (PID)<input type="checkbox"/> Pelvic pain<input type="checkbox"/> Endometriosis<input type="checkbox"/> Breast discharge<input type="checkbox"/> Hot flashes / Night sweats <p>Musculo-Skeletal</p> <ul style="list-style-type: none"><input type="checkbox"/> Rheumatoid arthritis<input type="checkbox"/> Lupus erythematosus<input type="checkbox"/> Bone fractures <p>Hematological</p> <ul style="list-style-type: none"><input type="checkbox"/> Anemia<input type="checkbox"/> Blood clotting disorder<input type="checkbox"/> Bleeding tendency<input type="checkbox"/> Sickle cell anemia or trait <p>Endocrine</p> <ul style="list-style-type: none"><input type="checkbox"/> Diabetes<input type="checkbox"/> Diabetes in pregnancy<input type="checkbox"/> Thyroid disease<input type="checkbox"/> Heat or Cold intolerance (circle)<input type="checkbox"/> Excessive hair growth<input type="checkbox"/> Other: Rapid weight gain/loss (circle)<input type="checkbox"/> Excessive thirst or hunger (circle)<input type="checkbox"/> Acne/Skin Problems <p>Constitutional</p> <ul style="list-style-type: none"><input type="checkbox"/> Flu-like symptoms<input type="checkbox"/> Increase or decrease in appetite (circle)<input type="checkbox"/> Weight gain or loss (circle)<input type="checkbox"/> Fevers or chills<input type="checkbox"/> Fatigue
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FAMILY HISTORY

Fill in the appropriate circles to identify all illnesses or conditions which you know have occurred in your blood relatives or partner.

	Self	Father	Mother	Brothers	Sisters	Sons	Daughters	Grandparents	Partner
Uterine Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon Cancer/Rectal Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon Polyp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis (TB)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke/TIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal Bleeding (Bleeding Disorder)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Psychiatric/Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anesthesia complications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Miscarriages	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Down Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stillbirth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thalassemia/Sickle cell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cleft Lip or Palate, Spina bifida	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tay Sachs, Guacher, Canavans Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurofibromatosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PARTNER HISTORY

Has your partner initiated a pregnancy in a previous relationship? ___No ___Yes

If yes, please give outcome of pregnancy (live birth/ miscarriage, termination) _____

Any pregnancy with birth defects/Genetic disorder/stillbirth/ miscarriage? _____

Has your partner had infertility in a previous relationship? ___No ___Yes

PARTNER MEDICAL HISTORY

Weight_____ Height _____

PAST MEDICAL HISTORY (Please list any medical problems below)

1. _____

2. _____

3. _____

PAST SURGICAL HISTORY (Please list any surgical procedures including dates and location)

1. _____

2. _____

MEDICATIONS (including supplements, hormones, steroids)

	Medication	Reason	Dates/Duration/Last time taken
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

ALLERGIES

SOCIAL HISTORY

How much caffeine does you partner drink per day? _____ cups coffee / tea / soda

How many cigarettes does you partner smoke per day? _____ For how long? _____ years

How much alcohol does you partner drink per week? _____ What kind? _____

Does your partner use marijuana? _____ If yes, how often? _____

Any other substances? _____

PARTNER'S MEDICAL HISTORY Continued

For Male Partners

Any history of the following? (Urological)

Prostatitis	___ No ___ Yes
Epididymitis	___ No ___ Yes
Orchitis	___ No ___ Yes
Previous vasectomy	___ No ___ Yes
Testicular tumor	___ No ___ Yes
Injury to testes	___ No ___ Yes
Undescended testicles	___ No ___ Yes
Gonorrhea	___ No ___ Yes
Chlamydia	___ No ___ Yes
Syphilis	___ No ___ Yes
Nonspecific urethritis	___ No ___ Yes
Difficulty with erection	___ No ___ Yes
Difficulty with ejaculation	___ No ___ Yes
Exposure to radiation	___ No ___ Yes
Exposure to chemicals	___ No ___ Yes
Exposure to toxic substances	___ No ___ Yes
Exposure to high temperatures	___ No ___ Yes

For Female Partners

Gynecological history

Age of onset of periods _____	
Date of last menstrual period (LMP) _____	
Length of menses ___ days	
Number of days between menses _____ days/months	
How many pads/tampons do you use on the heaviest day of your period? _____	
Do you have pain during your period?	___ No ___ Yes
If yes, does it affect your daily activities?	___ No ___ Yes
Do you have pain between periods?	___ No ___ Yes
Do you bleed between periods?	___ No ___ Yes
Any history of any sexually transmitted infections?	___ No ___ Yes
Date and result of last Pap Smear _____	
Any history of abnormal Pap Smears?	___ No ___ Yes
Have you had surgery or laser of the cervix?	___ No ___ Yes
Date and result of last mammogram _____	
Do you have any problems with intercourse?	___ No ___ Yes
Do you bleed during or after intercourse?	___ No ___ Yes
Do you have pain during or after intercourse?	___ No ___ Yes
Have you had a tubal ligation?	___ No ___ Yes

MD NOTES: