

**Female Patients-please complete the following three pages to the best of your ability.**

Name: \_\_\_\_\_ AGE: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First

Were you referred to us by a physician? If YES, please complete information to the right----->  
If NO, please indicate below how you found us?

Referring Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Phone No: \_\_\_\_\_

At what number can you be reached during the day: \_\_\_\_\_

Trying to Conceive?  Yes  No If yes, how long without protection? \_\_\_\_ Years \_\_\_\_ months

**Please answer the following questions. Do not write in shaded area**

**Menstrual History**

Date of last menstrual period \_\_\_\_/\_\_\_\_/\_\_\_\_

Age you started to have periods \_\_\_\_yrs

Are your periods regular?  Yes  No

If cycles irregular,

Number cycles/year \_\_\_\_cycles

On average, how many days from the start of one period

To the start of the next? \_\_\_\_\_Days

How long do your periods last? \_\_\_\_days

Menstrual flow:  Normal  Light  Heavy

**Gynecological History**

- |                    |  |                  |  |
|--------------------|--|------------------|--|
| Gonorrhea          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chlamydia        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pelvic Infections  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Painful Periods    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prior IUD use    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Painful sex        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mom took DES     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Birth control pill | <input type="checkbox"/> Yes <input type="checkbox"/> No | Excessive hair   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breast discharge   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Abnormal Pap     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Abnormal Bleeding  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Date of last Pap | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Physical Abuse     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mammogram        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sexual Abuse       | <input type="checkbox"/> Yes <input type="checkbox"/> No |                  |  |

*Comments:*

**Prior Infertility Treatments (if applicable)**

- |                       |  | Year  |                |
|-----------------------|--|-------|----------------|
| Clomid or Serophene   | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ | # cycles _____ |
| Intrauterine insemin. | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ | # cycles _____ |
| FSH injectible meds   | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ | # cycles _____ |
| HCG injectible med.   | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ | # cycles _____ |
| IVF                   | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ | # cycles _____ |



**Family History**

Has anyone in your family had any of the following?

Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive hair growth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Early menopause	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscular dystrophy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ovarian Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle-cell anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cystic fibrosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mental retardation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tay Sachs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberous sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Down's syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No	Deafness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recurrent miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chromosome problem	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Review of Systems**

Have you ever had **any** of the following

Hot flashes, sweats	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heat/cold intolerance	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest pains	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast discharge	<input type="checkbox"/> Yes <input type="checkbox"/> No	Urinary infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Palpitations	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mitral valve prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fibroids	<input type="checkbox"/> Yes <input type="checkbox"/> No
Abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	German measles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chicken pox	<input type="checkbox"/> Yes <input type="checkbox"/> No
Excess. Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Endometriosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood in stools	<input type="checkbox"/> Yes <input type="checkbox"/> No	ALL OTHERS NEG.	<input type="checkbox"/>

*Comments:*

**MALE PARTNER'S HISTORY(Husband-Partner's information only)**

Name \_\_\_\_\_

Age \_\_\_\_\_

Occupation \_\_\_\_\_

Number of years married \_\_\_\_\_

Number of pregnancies with current partner \_\_\_\_\_

Numbers of pregnancies with previous partner \_\_\_\_\_

Age(s) of children, if any \_\_\_\_\_

Does he have any medical problems \_\_\_\_\_

List medications he is taking \_\_\_\_\_

Does he have any drug allergies \_\_\_\_\_

Previous surgeries? \_\_\_\_\_ Please list \_\_\_\_\_

Does he smoke? \_\_\_\_\_

How many drinks of alcohol per week \_\_\_\_\_

Has he had a semen analysis? \_\_\_\_\_

What were the results \_\_\_\_\_

I have reviewed the above with the patient.

Physician's Signature \_\_\_\_\_ Today's date \_\_\_\_\_

