New Patient Medical History (Female)

Allergies

Please list any allergies to medications (or latex) that you may have. What type of reaction?

Past Medical History

Please select the box if you have had one of these:

- ☐ High blood pressure
- ☐ Heart disease
- ☐ Diabetes
- ☐ Asthma or Lung disease
- ☐ Stomach/Intestinal disease
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Anemia
- ☐ Breast disease
- ☐ Lupus or autoimmune disease
- ☐ Thyroid disease
- ☐ Seizures or epilepsy history
- ☐ Neurologic problems
- ☐ Cancer
- ☐ History of trauma / car accident
- ☐ Blood clots
- ☐ Depression
- ☐ Schizophrenia / Bipolar Disorder
- ☐ Eating Disorder
- ☐ Chicken pox
- ☐ Other

If you have selected any of the boxes, enter details below:

Past Surgical History

List Year/Surgery

Hospitalizations

If you have been hospitalized for any reason (excluding surgeries listed above and deliveries), please describe here:

Medications

Please list your current medications, including vitamins and herbs, and their respective doses:

Pregnancy History

Number of Pregnancies

Age at first pregnancy

Full term pregnancies

Premature deliveries

Number of miscarriages

Number of abortions

Number of live children

Details of pregnancies: Date, gender, type of delivery, weeks at birth, fertility treatments, time to conceive for each pregnancy. Please include miscarriages, abortions, ectopic pregnancies etc.

Gynecologic History

Age when periods began:

Last menstrual period:

Nature of cycles:

Average length of menstrual flow:

Length of cycle: to days (1st day of period to 1st day of next period)

Range of days (shortest to longest)

Have you ever been diagnosed with the following:

- [ ] Endometriosis
- [ ] Polycystic Ovarian Syndrome (PCOS)
- [ ] Vaginal Infections

Have you ever had breast or gynecologic surgery? Yes

If yes, please describe.

Have you ever had cervical treatment? No

If yes, please describe.

Family Planning History

Please check all that you have taken or used:

- [ ] None
- [ ] Abstinence
- [ ] Oral Contraceptive Pill
- [ ] Condoms
- [ ] NFP
- [ ] DepoProvera
- [ ] IUD
- [ ] NuvaRing
- [ ] Other

Please add details (dates of use, types or names) below:

Are you currently sexually active?

Family History

Has anyone in your family had the following?

- [ ] High blood pressure
- [ ] Diabetes
- [ ] Heart Disease
- [ ] Breast Cancer
- [ ] Ovarian Cancer
- [ ] Colon Cancer
- [ ] Other Cancer
- [ ] Other

If you chose any of the previous options, please describe the condition and the family member's relationship to you:

Social History

Occupation or Training:

Marital Status: Religious/Conse

If married, number of years married:

Exercise type and Frequency:

Caffeine Intake:

Dairy Intake:

Fruits and Vegetables:

Gluten intake:

Have you used any of the following?

Alcohol

If yes, servings/day and type

Tobacco

If yes, how much or how many packs per day, and how many years have you been smoking?

Recreational drugs:

- ☐ Heroin
- ☐ Cocaine
- ☐ Marijuana
- ☐ Methampetamines
- ☐ Narcotics/Opioids
- ☐ Sleeping pills
- ☐ Other

If checked, please describe below:

Health Maintenance

Most recent pap smear and its result:	
Have you ever had an abnormal result?	
If yes, please explain.	
Have you ever had the following?	☐ **Mammogram** ☐ **Colonoscopy** ☐ **Bone density test** ☐ **Cholesterol screening** ☐ **Thyroid testing** ☐ **Stool Blood testing**

	☐ **Sigmoidoscopy** *For each option chosen above, please enter the date each test was taken and its result below.*

Would you like to take an HIV test?	
Would you like to take a test for Hepatitis C?	

Review of Systems

Check any of the following that you are **CURRENTLY** experiencing:

General
- ☐ Weight loss
- ☐ Weight gain
- ☐ Fatigue
- ☐ Night sweats
- ☐ Change in strength or exercise tolerance

Skin
- ☐ Rash
- ☐ Bothersome hair growth
- ☐ Hair loss
- ☐ Itching
- ☐ Dry skin

Head, Eyes, Ears, Nose and Throat
- ☐ Headaches
- ☐ Changes in vision
- ☐ Excessive tearing
- ☐ Changes in hearing
- ☐ Ringing in ears
- ☐ Dizziness or vertigo
- ☐ Nosebleeds
- ☐ Difficulty swallowing

	☐ Bleeding gums
	☐ Neck pain
Breast	☐ New lumps
	☐ Nipple discharge
	☐ Tenderness or swelling
Chest	☐ Shortness of breath
	☐ Wheezing
	☐ Cough
Cardiovascular	☐ Chest pains
	☐ Heart palpitations
	☐ Fainting
	☐ Swelling
	☐ Dizziness
Gastrointestinal	☐ Nausea
	☐ Vomiting
	☐ Constipation
	☐ Diarrhea
	☐ Bloody stools
	☐ Black tarry stools
	☐ Change in appetite
	☐ Abdominal pain
Genitourinary	☐ Pain with urination
	☐ Frequent urination at night
	☐ Blood in urine
	☐ Vaginal discharge
	☐ Vaginal itching
	☐ Joint or muscle pain

Gynecologic Review of Systems

Have you ever charted your cycles? If so, what method?	
Do you have abnormal bleeding?	
If yes:	

Other *Can describe abnormal bleeding here:*

How many days of brown spotting do you have at the end of your flow?
How many days of very light bleeding do you have before the first day of heavy flow?

Do you have painful periods or cramps?

Do you have other pain?

- ☐ Pelvic pain at other times in your cycle
- ☐ Bowel pain or problems during your period
- ☐ Pain with intercourse
- ☐ Lower back pain with periods

How severe are your premenstrual symptoms?
How long before your period do PMS symptoms start?

Please check any of the following symptoms if you notice them more than 3 days before your period:

- ☐ Irritability
- ☐ Breast Tenderness
- ☐ Bloating
- ☐ Weight gain
- ☐ Salt/Sweet cravings
- ☐ Cry easily
- ☐ Depression
- ☐ Headache
- ☐ Fatigue
- ☐ Insomnia
- ☐ Other – can *describe below*

How long before period does PMS start?

Do you have:

- ☐ Persistent low energy/fatigue
- ☐ Difficulty sleeping
- ☐ Persistent low mood
- ☐ Excessive anxiety

Do you have:

- ☐ Unwanted and excessive hair growth
- ☐ Acne
- ☐ Irregular or infrequent periods

Have you ever had a sexually transmitted infection?

- ☐ None
- ☐ HPV (Human Papilloma Virus)
- ☐ Chlamydia
- ☐ Gonorrhea
- ☐ Syphilis
- ☐ HIV
- ☐ Hepatitis
- ☐ Genital warts
- ☐ PID (pelvic inflammatory disease)
- ☐ Trichomonas

Other – *please describe below:*

Prior Fertility Testing

How long have you been trying to achieve?

Prior investigations

- ☐ Hormonal lab tests
- ☐ Ultrasounds

- [ ] Hysterosalpingoram
- [ ] Saline Sonohysterography
- [ ] Basal body temperature
- [ ] Hysteroscopy
- [ ] Endometrial biopsy
- [ ] MRI
- [ ] Urine LH Kit Testing
- [ ] Other – *describe tests, dates, and results below:*

Prior Treatment

- [ ] IVF
- [ ] Insemination
- [ ] Ovulation induction with oral medicines
- [ ] Ovulation induction with injectable medicines
- [ ] Other – *describe below. Please provide number of cycles of all treatments and other helpful details below.*