

Please complete this form online or print and complete by hand using a pen. Your assistance is greatly appreciated.

NEW PATIENT EVALUATION FORM

Name: _____ Age: _____ Partner: _____ Age: _____

Reason for Referral: _____ Date of Appt: _____

Have you ever seen any other physician(s) for this problem?

Name: _____ Dates seen: _____ Telephone: _____

Address: _____ Send medical progress reports to this doctor Yes No

Name: _____ Dates seen: _____ Telephone: _____

Address: _____ Send medical progress reports to this doctor Yes No

Name: _____ Dates seen: _____ Telephone: _____

Address: _____ Send medical progress reports to this doctor Yes No

MENSTRUAL HISTORY:

Age of first period: _____ Are your periods regular? Yes No Number of periods/year off medication? _____

How many days between the first day of one period and the first day of the next? _____

Date last menstrual period started: _____ For how many days do you normally bleed? _____

Do you have cramps with menses? no mild severe Do you have diarrhea with your period? Yes No

Do you take medication for cramps? Yes No (specify medication and number of days) _____

Do you bleed or spot between your periods? Yes No Do you spot before your periods? Yes No

I have other relatives with abnormal menstrual periods Yes No Don't Know

Did your mother take DES when she was pregnant with you? Yes No Don't Know

Did she smoke during her pregnancy? Yes No Don't Know

Date of last Pap smear _____ Result: _____ Date of last mammogram _____ Result: _____

CONTRACEPTION:

Have you ever used an IUD? Yes No When? _____

Contraception	Dates used	Reason for stopping
_____	_____	_____
_____	_____	_____
_____	_____	_____

PREGNANCY HISTORY:

Total pregnancies: _____ Full term deliveries: _____ Premature deliveries: _____ Miscarriages: _____ Abortions: _____ Ectopics: _____

Date	Type of delivery	Name	Weight	Weeks gestation	Infertility	Time to conceive	Present partner	Complications
					<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	

PAST MEDICAL HISTORY

List allergies to medications: _____

List current medications: _____

Do you have or have you ever had any of the following? *(check all that apply)*

- | | | | | |
|---|---|--|---|---|
| <input type="checkbox"/> AIDS or positive HIV | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Anemia/thalassemia | <input type="checkbox"/> Seizures/epilepsy | <input type="checkbox"/> Ovarian cysts |
| <input type="checkbox"/> Blood transfusions | <input type="checkbox"/> Genetic disorder | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Measles: regular | <input type="checkbox"/> Birth defects | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Pelvic infection (PID) |
| <input type="checkbox"/> Measles: German | <input type="checkbox"/> Liver problems | <input type="checkbox"/> Sickle cell or trait | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Depression | <input type="checkbox"/> Gonorrhea |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Ulcers/colitis | <input type="checkbox"/> Kidney infection | <input type="checkbox"/> Drug addiction | <input type="checkbox"/> Chlamydia |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Gallbladder problems | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Ureaplasma infection |
| <input type="checkbox"/> Diabetes (juvenile) | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Migraines | <input type="checkbox"/> Lupus | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Diabetes (pregnancy) | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Neurological problems | <input type="checkbox"/> Abnormal Pap smear | <input type="checkbox"/> Sexual abuse/rape |

SURGERY

Date	Hospital	MD	Operation	Findings	Complications

REVIEW OF SYSTEMS

Do you *now* have any of the following? *(check all that apply)*

- | | | | | |
|--|--|--|--|---|
| <input type="checkbox"/> Abnormal hair growth | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Acne | <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Breast lumps/discharge |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Nausea | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Heat/cold intolerance | <input type="checkbox"/> Loss of sexual desire | <input type="checkbox"/> Sexual problems | <input type="checkbox"/> Loss of taste/smell | <input type="checkbox"/> Painful intercourse |
| <input type="checkbox"/> Skin rash | <input type="checkbox"/> Urinary frequency | <input type="checkbox"/> Painful urination | <input type="checkbox"/> Urinary leakage | <input type="checkbox"/> Visual problems |
| <input type="checkbox"/> Chronic headaches | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Fever | <input type="checkbox"/> Weight changes | <input type="checkbox"/> Other symptoms |

SOCIAL HISTORY

Patient's Occupation: _____

Education: _____

Hobbies: _____

Exposure to chemicals *(list)* _____

Tobacco use ___packs/day___age started___age quit

Alcohol ___drinks/wk Street drugs _____

Aerobic exercise ___hrs/wk Running___miles/wk

Is this your first marriage Yes No N/A

If no how many times have you been married?____

How long have you been married?____

Partner's Occupation: _____

Education: _____

Hobbies: _____

Exposure to hot tub, sauna, chemicals *(list)* _____

Tobacco use ___packs/day___age started___age quit

Alcohol ___drinks/wk Street drugs _____

Aerobic exercise ___hrs/wk Running___miles/wk

Is this your first marriage Yes No N/A

If no how many times have you been married?____

Do you have children with a prior partner? Yes No

GENETIC HISTORY FEMALE

Has anyone in your family had one or more infants with serious birth defects? Yes No

comment _____

Has anyone in your family had two or more miscarriages? Yes No

comment _____

Do you or anyone of your family have any of the following conditions? *(check all that apply)*

- | | | | | |
|---|---|---|---|--|
| <input type="checkbox"/> Down syndrome | <input type="checkbox"/> Kidney or bladder malformation | <input type="checkbox"/> Congenital heart disease | <input type="checkbox"/> Loss of muscle function | <input type="checkbox"/> Spina bifida meningocele |
| <input type="checkbox"/> Club foot | <input type="checkbox"/> Cystic fibrosis | <input type="checkbox"/> Cleft lip or palate | <input type="checkbox"/> Diabetes (<i>juvenile</i>) | <input type="checkbox"/> Diabetes (<i>adult</i>) |
| <input type="checkbox"/> Tay Sach's disease | <input type="checkbox"/> Pyloric stenosis | <input type="checkbox"/> Neural tube defect | <input type="checkbox"/> Huntington's disease | <input type="checkbox"/> Early senility |
| <input type="checkbox"/> Early menopause | <input type="checkbox"/> Polycystic ovaries | <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Premature death | <input type="checkbox"/> Mental retardation |

FAMILY HISTORY FEMALE

Paternal Ancestry

Father's age (if living) _____ Health status: _____

If deceased, age at death _____ Cause of death: _____

Paternal grandfather's age (if living) _____ Health status: _____

If deceased, age at death _____ Cause of death: _____

Paternal grandmother's age (if living) _____ Health status: _____

If deceased, age at death _____ Cause of death: _____

Paternal Aunts and Uncles, Living	Sex	Age	Health
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Paternal Aunts and Uncles, Deceased <i>(include neonatal and childhood deaths)</i>	Sex	Age at Death	Cause of Death
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Paternal First Cousins, <i>Birth defects or Deceased</i>	Sex	Age	Birth defect/Cause of Death
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Maternal Ancestry

Mother's age (if living) _____ Health status: _____

If deceased, age at death _____ Cause of death: _____

Maternal grandfather's age (if living) _____ Health status: _____

If deceased, age at death _____ Cause of death: _____

Maternal grandmother's age (if living) _____ Health status: _____

If deceased, age at death _____ Cause of death: _____

Maternal Aunts and Uncles, Living	Sex	Age	Health
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Maternal Aunts and Uncles, Deceased <i>(include neonatal and childhood deaths)</i>	Sex	Age at Death	Cause of Death
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Maternal First Cousins, <i>Birth defects or Deceased</i>	Sex	Age	Birth defect/Cause of Death
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Brothers and Sisters	Sex	Age	Health
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Deceased siblings <i>(include neonatal and childhood deaths)</i>	Sex	Age at Death	Cause of Death
_____	_____	_____	_____
_____	_____	_____	_____

Children	Sex	Age	Health
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Deceased children <i>(include neonatal and childhood deaths)</i>	Sex	Age at Death	Cause of Death
_____	_____	_____	_____
_____	_____	_____	_____

Please complete the following pages if applicable to your problem or you are seeking to become pregnant soon.

INFERTILITY HISTORY

How long have you been trying to become pregnant? ____years

How often do you have intercourse? Usually ____times/wk.

Do you douche before or after intercourse Yes No

Is intercourse painful? Yes No _____

Does your husband have problems with erection or ejaculation? Yes No _____

Does you have problems with arousal or lubrication? Yes No _____

PREVIOUS TESTING (check all tests that have been performed)

- BBT (temperature chart) Normal Abnl
Day 3 FSH Normal Abnl date____result____
Female Hormones Normal Abnl date____
Postcoital test Normal Abnl date____
HSG (X-Ray) Normal Abnl date____
Endometrial biopsy Normal Abnl date____
Laparoscopy Normal Abnl date____
Immune testing Normal Abnl date____
Chromosome tests Normal Abnl date____
Semenanalysis Normal Abnl date____
Sperm Antibody Normal Abnl date____
My blood type____ Partner's blood type____

PREVIOUS TREATMENTS (check all previous treatments)

- Laparoscopy (recent) dates____ comment____
Ectopic pregnancy dates____ comment____
Tubal reversal dates____ comment____
Clomid or Serophene dates____ Dose and # month treated____
Fertinex/Humegon dates____ Dose and # month treated____
Depot Lupron dates____ Dose and # month treated____
Parlodel dates____ Dose and # month treated____
Intrauterine insemination Dates and # month treated____
Donor sperm Dates and # month treated____
Heparin & aspirin dates____ Dose and # month treated____
IVIG dates____ Dose and # month treated____
IVF/Donor egg dates____ comment____

ADDITIONAL COMMENTS

Five horizontal lines for additional comments.

PARTNER'S PAST MEDICAL HISTORY

List allergies to medications: _____

List current medications: _____

Do you have or have you ever had any of the following? *(check all that apply)*

- | | | | | |
|---|---|---|--|---|
| <input type="checkbox"/> AIDS or positive HIV | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Neurological problems | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Blood transfusions | <input type="checkbox"/> Genetic disorder | <input type="checkbox"/> Anemia/thalassemia | <input type="checkbox"/> Seizures/epilepsy | <input type="checkbox"/> Prostate problems |
| <input type="checkbox"/> Measles: regular | <input type="checkbox"/> Birth defects | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Measles: German | <input type="checkbox"/> Liver problems | <input type="checkbox"/> Sickle cell or trait | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Depression | <input type="checkbox"/> Gonorrhea |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Ulcers/colitis | <input type="checkbox"/> Kidney infection | <input type="checkbox"/> Drug addiction | <input type="checkbox"/> Chlamydia |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Gallbladder problems | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Ureaplasma infection |
| <input type="checkbox"/> Diabetes (juvenile) | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Migraines | <input type="checkbox"/> Lupus | |

Are you under a physicians care Yes No *If so, please give names and specify condition treated* _____

PREVIOUS MALE FERTILITY TREATMENTS *(check all previous treatments)*

- | | | |
|--|-------------|---------------|
| <input type="checkbox"/> Vasectomy reversal | dates _____ | comment _____ |
| <input type="checkbox"/> Fertility medications | dates _____ | comment _____ |
| <input type="checkbox"/> Varicocele surgery | dates _____ | comment _____ |

FAMILY HISTORY MALE

Paternal Ancestry

Father's age (if living) _____ Health status: _____

If deceased, age at death _____ Cause of death: _____

Paternal grandfather's age (if living) _____ Health status: _____

If deceased, age at death _____ Cause of death: _____

Paternal grandmother's age (if living) _____ Health status: _____

If deceased, age at death _____ Cause of death: _____

Paternal Aunts and Uncles, Living	Sex	Age	Health
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Paternal Aunts and Uncles, Deceased <i>(include neonatal and childhood deaths)</i>	Sex	Age at Death	Cause of Death
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Paternal First Cousins, <i>Birth defects or Deceased</i>	Sex	Age	Birth defect/Cause of Death
_____	_____	_____	_____
_____	_____	_____	_____

_____	_____	_____	_____
_____	_____	_____	_____

Maternal Ancestry

Mother's age (if living) _____ Health status: _____

If deceased, age at death _____ Cause of death: _____

Maternal grandfather's age (if living) _____ Health status: _____

If deceased, age at death _____ Cause of death: _____

Maternal grandmother's age (if living) _____ Health status: _____

If deceased, age at death _____ Cause of death: _____

Maternal Aunts and Uncles, Living	Sex	Age	Health
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Maternal Aunts and Uncles, Deceased <i>(include neonatal and childhood deaths)</i>	Sex	Age at Death	Cause of Death
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Maternal First Cousins, <i>Birth defects or Deceased</i>	Sex	Age	Birth defect/Cause of Death
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Brothers and Sisters	Sex	Age	Health
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Deceased siblings <i>(include neonatal and childhood deaths)</i>	Sex	Age at Death	Cause of Death
_____	_____	_____	_____
_____	_____	_____	_____

Children with previous partners	Sex	Age	Health
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Deceased children <i>(include neonatal and childhood deaths)</i>	Sex	Age at Death	Cause of Death
_____	_____	_____	_____
_____	_____	_____	_____