NEW PATIENT HISTORY

Today's date_____/_____/_____ Date of appointment_____/_____/_____

PATIENT:

(Legal) Last name: _____ **(Legal)** First name: _____ Middle initial _____

Age: _____ Date of Birth: _____/_____/_____ Preferred Name: _____

Preferred Pronouns: ☐ She/Her ☐ He/Him ☐ They/Them ☐ _____

Sex assigned at birth: ☐ Female ☐ Male

Relationship Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Length of Relationship: _____ years

MAILING ADDRESS:

Street: _____ City: _____

State/Providence: _____ Zip/Postal Code: _____ Country: _____

	OK to leave message?		Best # to reach you:
Cell Phone Number: (_____)_____-_____	☐ Yes	☐ No	☐
Work Phone Number: (_____)_____-_____	☐ Yes	☐ No	☐
Home Phone Number: (_____)_____-_____	☐ Yes	☐ No	☐

Email Address: _____

How did you hear about SRM?

- ☐ Family/Friend
- ☐ Internet
- ☐ Radio
- ☐ Medical office/physician referral (Name of office/physician): _____
- ☐ Other _____

Would you like medical notes sent to your other healthcare providers?

- ☐ Yes
- ☐ No

If yes, please indicate which provider(s) you would like us to send medical notes to:

Provider Name	Address	Please indicate provider type: Primary care	OB/Gyn	Other

Reason for visit: _____

_____

What are your expectations for this visit? _____

What questions do you want answered at this visit? _____

_____

Please fill out the sections that apply to you:

FERTILITY HISTORY

Do you have any theories as to why you have been unable to conceive?_____

List all pregnancies, specifying under outcome whether liveborn, stillborn, ectopic, miscarriage or elective termination (abortion)

Pregnancy #	Preg. Ended (mo./yr.)	Preg. Length (weeks, months)	Outcome	(check one)	
				Present partner	Previous partner

Time since contraception last used?_____

How long have you been trying to conceive? _____

If you previously have been pregnant, how long has it been since the most recent pregnancy? _____

Do you have a history of delayed conception with any prior partner? ☐Yes ☐No

PREVIOUS FERTILITY EVALUATION:

Have you ever seen a fertility specialist? ☐ Yes ☐ No

Have you had any of the following tests performed?

Fertility Test:	Yes	No	Date	Result normal? Yes	No	If no, describe:
Semen Analysis	☐	☐	____/____/____	☐	☐	_____
Antimullerian Hormone	☐	☐	____/____/____	☐	☐	_____
Day 3 FSH level	☐	☐	____/____/____	☐	☐	_____
Day 3 Estradiol level	☐	☐	____/____/____	☐	☐	_____

Progesterone level(s)	☐ ☐	____/____/____	☐	☐	_____
Thyroid blood test	☐ ☐	____/____/____	☐	☐	_____
Prolactin blood test	☐ ☐	____/____/____	☐	☐	_____
Blood Type	☐ ☐	____/____/____	☐	☐	_____
Hysterosalpingogram (HSG)	☐ ☐	____/____/____	☐	☐	_____
Antral Follicle Count (AFC)	☐ ☐	____/____/____	☐	☐	_____
Have you had genetic screening for autosomal recessive disorders?	☐ ☐	____/_____/_____	☐	☐	_____

PRIOR TREATMENTS: (check all that apply)

Treatment	**#of cycles**	**Dates: (mo./year) to (mo./year)**	**Outcome (baby, miscarriage, etc.)**
Intrauterine inseminations (no medication):	_____	from:____/____ to:____/____	
Clomiphene/Clomid- dose per day _____ with timed intercourse with intrauterine inseminations	 _____ _____	 from:____/____to:____/_____ from:____/____to:____/_____	
Letrozole/Femara- dose per day_____ with timed intercourse with intrauterine inseminations	 _____ _____	 from:____/____to:____/_____ from:____/____to:____/_____	
Gonadotropins (Follistim, Gonal F, Menopur) with intrauterine inseminations	 _____ _____	 from:____/____to:____/_____ from:____/____to:____/_____	
Acupuncture	_____	from:____/____to:____/_____	
Chinese Herbs	_____	from:____/____to:____/_____	
Complete in vitro fertilization (IVF) cycle(s): 1. # eggs _____ # fertilized _____ # transferred_____ # frozen _____ 2. # eggs_____ # fertilized_____ # transferred ____ # frozen _____ 3. # eggs _____ # fertilized _____ # transferred ____ # frozen _____	_____	 from:____/____to:____/_____ from:___/____ to: ____/_____ from:___/____ to: ___/_____	

Frozen embryo transfers: 1. #embryos transferred _____ 2. #embryos transferred _____ 3. #embryos transferred _____	_____	_____/_____ _____/_____ _____/_____	
Canceled in vitro fertilization attempt(s)	_____	from:____/____to:____/_____	

GYNECOLOGIC HISTORY

MENSTRUAL HISTORY:

Age when you had your first menstrual period: _____ years old

The first day of your most recent menstrual period: _____ / _____ / _____

Menstrual cycle pattern without hormones or oral contraceptive pills (OCP's) - (check all that apply):

☐ Regular periods ☐ Irregular periods ☐ No periods
☐ Spotting between periods ☐ Heavy periods ☐ Light periods

How many days from the first day of one period to the first day of the next? _____days

How many days of bleeding do you usually have? _____days

Do you need medication to bring on a period? ☐No ☐Yes If yes, what type? _____

Do you have cramping or pelvic pain with your periods? (check one)

☐ Always ☐ Sometimes ☐ Recently ☐ In the past ☐ No

Degree of pain (1 to 10, with 10 being most severe): _____

Over the past few years, is the pain: ☐ getting better ☐ getting worse ☐ staying the same

If you do not have periods, at what age did you stop having them? _____ years old

When was your last Pap smear? _____ / _____ Was it normal? ☐Yes ☐No

Have you ever had an abnormal Pap smear? ☐Yes ☐No If "Yes," date and treatment:_____

Have you ever had a mammogram? ☐Yes ☐No If yes, when was the last one? _____/_____

Was your mammogram normal? ☐Yes ☐No

CONTRACEPTIVE METHOD HISTORY:

Type	Years Used
☐ Birth Control Pill / Patch	
☐ Depo-Provera	
☐ Nuva Ring	
☐ Norplant/Nexplanam	
☐ Diaphragm	
☐ IUD	
☐ Condoms	
☐ Tubal Sterilization	
☐ Vasectomy	
☐ Rhythm (natural method)	
☐ Other	

SEXUAL HISTORY

(IF APPLICABLE):

How many times per week do you have intercourse?_____

Any pain with intercourse? ☐Yes ☐No

Do you regularly use lubricant with intercourse? ☐Yes ☐No If yes, what type?_____

Have you used ovulation predictor kits? ☐Yes ☐No If yes, do they work?_____

Do you track your cycles? ☐Yes ☐No If yes, how (App, BBT)?_____

Have you ever had any of the following infections? (please check all that apply)

☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ Genital Warts

☐ Trichomonas ☐ HIV ☐ HPV ☐ Hepatitis

☐ Tuberculosis (TB) ☐ Other: _____

Have you ever had pelvic inflammatory disease? ☐Yes ☐No

If yes, when?_____ Were you hospitalized?_____

GENERAL MEDICAL HISTORY

Have you and/or your partner traveled to a country, territory, or city where there has been active Zika virus transmission in the last 6 months? If so, please specify place(s) and dates. _____

Are you and/or your partner planning travel to a country, territory, or city where there has been active Zika virus transmission? If so, please specify place(s) and dates. _____

What is your current weight? _____ Height? _____ Usual weight? _____

Recent weight loss or gain in the past 6 months? _____

Approximately how much did you weigh at age 18? _____

Heaviest lifetime weight? _____

If applicable, have you been successful with weight loss in the past? How? _____

Do you have any medical problem(s)? ____ Yes (Please list type, dates, and treatments) ____ No

1. _____
2. _____
3. _____
4. _____
5. _____

Have you had any surgeries? ☐Yes (Please list in chronological order) ☐ No

1. _____
2. _____
3. _____
4. _____
5. _____

Did you have any problems with anesthesia? ☐Yes (Please describe) ☐ No

_____

REVIEW OF SYSTEMS:

General:

- ☐ Recent weight gain or loss
- ☐ Anorexia/bulimia
- ☐ Lack of energy
- ☐ Fever/Chills
- ☐ Other _____
- ☐ None

Head, Eyes, Ears, Nose, and Throat:

- ☐ Dizziness
- ☐ Headaches
- ☐ Loss of sense of smell
- ☐ Chronis nasal congestion
- ☐ Blurred vision
- ☐ Ringing ears
- ☐ Hearing loss/deafness
- ☐ Other _____
- ☐ None

Respiratory:

- ☐ Shortness of breath
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Other _____
- ☐ None

Endocrine/Hormonal:

- ☐ Diabetes
- ☐ Hair loss
- ☐ Thyroid gland problems
- ☐ Rapid weight gain or loss
- ☐ Excessive hunger/thirst
- ☐ Temperature intolerance: hot flashes or feeling cold
- ☐ Other _____
- ☐ None

Gastrointestinal:

- ☐ Nausea/Vomiting
- ☐ Ulcers
- ☐ Hepatitis
- ☐ Diarrhea
- ☐ Blood in your stools
- ☐ Constipation
- ☐ Irritable Bowl Syndrome
- ☐ Other _____
- ☐ None

Musculoskeletal:

- ☐ Unusual muscle weakness
- ☐ Decreased energy/stamina
- ☐ Other _____
- ☐ None

Mental Health Problems:

- ☐ Depression
- ☐ Anxiety disorder
- ☐ Schizophrenia
- ☐ Other _____
- ☐ None

Breasts:

- ☐ Discharge
- ☐ Lumps
- ☐ Pain
- ☐ Cancer
- ☐ Abnormal mammogram
- ☐ Other _____
- ☐ None

Hematologic:

- ☐ Blood clotting disorder
- ☐ Thrombophlebitis
- ☐ Easy bruising
- ☐ Swollen glands/lymph nodes
- ☐ Blood transfusions
- ☐ Other _____
- ☐ None

Genito-Urinary:

- ☐ Bladder infections
- ☐ Kidney infections
- ☐ Vaginal infections
- ☐ Frequent Urination
- ☐ Leaking urine
- ☐ Blood in urine
- ☐ Other _____
- ☐ None

Neurological Problems:

- ☐ Weakness/Loss of balance
- ☐ Seizures/Epilepsy
- ☐ Headaches
- ☐ Migraine headaches
- ☐ Numbness
- ☐ Other _____
- ☐ None

Skin/Extremities:

- ☐ Unexplained rash/inflammation
- ☐ Acne
- ☐ Skin cancer
- ☐ Burn injury
- ☐ Moles changing in appearance
- ☐ Excess hair growth
- ☐ Other _____
- ☐ None

Cardiovascular:

- ☐ Palpitations/skipped beats
- ☐ Chest pain
- ☐ Murmurs
- ☐ High blood pressure
- ☐ Rheumatic fever
- ☐ Mitral valve prolapse
- ☐ Other _____
- ☐ None

Please explain any positive responses:

_____

_____

MEDICATIONS INCLUDING: VITAMINS / HERBS / OVER THE COUNTER MEDICATION (OTC'S)

Please list all medications or treatments you are currently taking:

Medication	Dosage	Frequency	Reason

ALLERGIES:

Latex? ☐Yes ☐No If yes, specify reaction: _____

Iodine? ☐Yes ☐No If yes, specify reaction: _____

Medications? ☐Yes ☐No Which meds, specify reaction:_____

SOCIAL HISTORY

Current Occupation: _____

Prior Occupation(s): _____

Have you or do you use any of the following?

	Never	Not in the last 3 months	Yes	List amount, type and frequency (how often-per day / per week)
Tobacco	☐	☐	☐	
Marijuana	☐	☐	☐	
Alcohol	☐	☐	☐	
Social drugs	☐	☐	☐	
Caffeine	☐	☐	☐	
Exercise	☐	☐	☐	

Describe your diet: _____

How many hours of sleep per night do you get on average? _____

List any significant occupational or other exposures: _____

EMOTIONAL STATUS:

On a scale of 1 to 10, (10 being the highest) what do you estimate your average level of stress to be? _____

Do you feel safe at home and in your relationships? ____ Yes ____ No

PERSONAL AND FAMILY GENETIC HISTORY

Are there any known genetic diseases or conditions that run in your family? ☐ Yes ☐ No

If yes, which one(s) and whom?_____

Are you adopted? ☐ Yes ☐ No

Are you and your partner related? ☐ Yes ☐ No

Are you of the following ethnic backgrounds? *Please check all that apply.*

- ☐ Asian (Chinese, Japanese, Filipino, Indian)
- ☐ Mediterranean
- ☐ Middle Eastern
- ☐ Ashkenazi Jewish
- ☐ African
- ☐ Hispanic or Caribbean
- ☐ French Canadian or Cajun
- ☐ Caucasian

Have you ever had genetic testing? ☐ Yes (Please explain below) ☐ No

_____

Please indicate which of the following conditions may be found in your family:

MEDICAL PROBLEM	Yourself	PARENT(S)	SIBLING (S)	MATERNAL GRANDPARENT(S)	PATERNAL GRANDPARENT(S)	YOUR Children	OTHER Relatives
Autoimmune disorder, such as lupus or rheumatoid arthritis							
Birth defects requiring surgery (cleft lip, etc)							
Bleeding disorders (hemophilia, etc.)							
Blindness							
Bone disorders							
Cancer before age 50 (specify)							
Chromosome Problems (Down syndrome, Klinefelter syndrome)							
Clotting disorders (Factor V Leiden, etc.)							

Deafness							
Developmental delay, autism spectrum disorder, or learning disabilities							
Diabetes (Insulin dependent)							
Endocrine Disorders (adrenal gland, parathyroid, thyroid disorders, Adrenal Hyperplasia)							
Epilepsy (seizures)							
Heart defects (“hole in the heart”, etc)							
Heart Disease							
High Blood Pressure							
High Cholesterol							
Hydrocephaly (“water on the brain”)							
Kidney Disease							
Limb defects (missing or extra fingers, toes, shorten arms or legs)							
Marfan Syndrome							
Menopause before age 40							
Mental Illness (schizophrenia, bipolar, etc)							
Multiple miscarriages							
Muscular Dystrophy							
Neurofibromatosis							
Neurologic or neurodegenerative diseases (Alzheimer, Huntington, etc)							
Neuromuscular diseases (muscular dystrophies, etc.)							
Polycystic Kidney disease							
Stillbirth or children who have died as infants							
Stroke							
Thalassemia (Cooley’s anemia)							
Unusual genitals							
Urinary Tract abnormalities							
Other serious health issues							

Do you have any other family history concerns you would like to discuss?

_____