



# Overlake Reproductive Health

## NEW FERTILITY PATIENT QUESTIONNAIRE

**IDENTIFYING INFORMATION:**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ (of first visit)

Name: \_\_\_\_\_

Age: \_\_\_\_\_ yrs      Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

City/State/Zip: \_\_\_\_\_

Telephone (day): (\_\_\_\_) \_\_\_\_\_ (evening): (\_\_\_\_) \_\_\_\_\_

Occupation: \_\_\_\_\_ Company: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

What are your expectations for this visit? \_\_\_\_\_

What questions do you want answered at this visit? \_\_\_\_\_

How did you hear about us? (Please be as specific as possible)

Physician

Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

Former Patient/Friend \_\_\_\_\_

Web Site \_\_\_\_\_  Advertisement \_\_\_\_\_

Insurance (Name of Insurance) \_\_\_\_\_

Who is your OB/GYN?

Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

Who is your Primary Care Physician?

Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

**ETHNICITY:** [See Genetics Table](#)

**Are you of Caucasian ancestry?** ..... yes .....no

If yes, have you been tested as a carrier of Cystic Fibrosis? ..... yes .....no

Results:  carrier  non-carrier

**Are you of French Canadian ancestry?** ..... yes .....no

If yes, have you been tested for Tay Sachs disease? ..... yes .....no

Results:  carrier  non-carrier

**Are you of Jewish ancestry?** ..... yes .....no

If yes, (info at [www.jewishgeneticscenter.org/what/](http://www.jewishgeneticscenter.org/what/)) have you been tested as a carrier of the following:

—Tay Sachs disease? .....  carrier  non-carrier

—Gaucher’s disease? .....  carrier  non-carrier

—Nieman-Pick? .....  carrier  non-carrier

—Canavan’s disease? .....  carrier  non-carrier

—Fanconi Anemia? .....  carrier  non-carrier

—Bloom Syndrome? .....  carrier  non-carrier

—Dysautonomia ? .....  carrier  non-carrier

**Are you of Black ancestry?** ..... yes .....no

If yes, have you been tested for Sickle Cell disease? ..... yes .....no

Results:  carrier  non-carrier

**Are you of Mediterranean (Greek or Italian) ancestry?** ..... yes .....no

**Are you of Asian ancestry?** ..... yes .....no

**Are you of Middle Eastern ancestry?** ..... yes .....no

**Are you of Caribbean, Mexican, or Central American ancestry?** ..... yes .....no

If yes to any of the above 4 questions, have you been tested as a carrier of Thalassemia?

..... yes .....no

Results:  carrier  non-carrier

I do not wish to proceed with further testing. \_\_\_\_\_

The appropriate available prenatal screens have been discussed (initial) \_\_\_\_\_

**I. FERTILITY HISTORY:  
FEMALE: (Menstrual and Pregnancy History)**

How long have you been having intercourse without using contraception? \_\_\_\_\_

How long have you been "working" at becoming pregnant? \_\_\_\_\_

When did you first see a doctor for infertility? \_\_\_\_\_

Total # of all pregnancies: \_\_\_\_\_

Please list all pregnancies (include all miscarriages, abortions, tubals, etc)

| Date Pregnancy ended or delivered | Length of Pregnancy | How long to conceive | Result | Infertility Therapy? | Current Partner?   |
|-----------------------------------|---------------------|----------------------|--------|----------------------|--|
| 1.                                | wks                 |                      |        |                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2.                                | wks                 |                      |        |                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3.                                | wks                 |                      |        |                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4.                                | wks                 |                      |        |                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5.                                | wks                 |                      |        |                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Were there any complications or problems during, including high blood pressure, preeclampsia, intrauterine growth retardation, or gestational diabetes?

- Explain:
1. \_\_\_\_\_
  2. \_\_\_\_\_
  3. \_\_\_\_\_
  4. \_\_\_\_\_

Did you require? (circle pregnancies that apply):

- C-section                    1   2   3   4   5
- Surgery                      1   2   3   4   5
- Blood transfusion        1   2   3   4   5
- Antibiotics                 1   2   3   4   5
- D & C                         1   2   3   4   5
- Other                         1   2   3   4   5

- Explain:
1. \_\_\_\_\_
  2. \_\_\_\_\_
  3. \_\_\_\_\_
  4. \_\_\_\_\_

Patient Name \_\_\_\_\_

Age at first period \_\_\_\_\_yrs.

Age when you first noticed: Breast development \_\_\_yrs Pubic hair \_\_\_yrs Underarm hair \_\_\_yrs

Date of the first day of your last period \_\_\_\_/\_\_\_\_/\_\_\_\_

If your menstrual cycles are regular, what is the usual number of days from the first day of one period to the first day of the next? \_\_\_\_\_

How many days does your menstrual flow last? \_\_\_\_\_

Do you consider your menstrual flow abnormal? Yes No  
(circle): light heavy short long painful other \_\_\_\_\_

Do you have severe cramping or pelvic pain with your periods?  
Yes: \_\_\_ Always \_\_\_ Sometimes \_\_\_ Recently \_\_\_ In the past No

Do you have pain with intercourse? Yes No

Do you spot or bleed between periods? Yes No

Do you have pelvic pain between periods? (If it is a significant problem, please complete pelvic pain questionnaire)  
Yes No

Do you have premenstrual symptoms other than cramps? Yes No

Do you need medication to bring on a period? Yes No

Are your periods now, or have they ever been irregular or unpredictable? Yes No

If yes:

1. When \_\_\_\_\_
2. Average # of periods in a year \_\_\_\_\_
3. Shortest time in between periods \_\_\_\_\_
4. Longest time spent without menstruating \_\_\_\_\_

(M.D. use only) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have acne or oily skin? Yes No

Do you have a breast discharge? Yes No

Are you currently breast feeding? Yes No

Do you have extra body hair? Yes: Where? \_\_\_\_\_ No

What has been your maximum weight? \_\_\_\_\_ When? \_\_\_\_\_

What has been your minimum adult weight? \_\_\_\_\_ When? \_\_\_\_\_

Have you ever had a sudden weight change? Yes: When? \_\_\_\_\_ No

Do you feel that you are underweight? Yes No

Do you feel that you are overweight? Yes No

Patient Name \_\_\_\_\_

How many meals do you usually eat per day? \_\_\_\_\_

Do you follow a particular food diet or have any special dietary habits? Yes No

Have you ever been diagnosed with an eating disorder, such as anorexia or bulimia?  
Yes No

Have you ever used self-induced vomiting to control overeating? Yes No

Do you regularly participate in any vigorous exercise? Yes No

What: \_\_\_\_\_

Number of hours \_\_\_\_\_/week      Number of miles \_\_\_\_\_/week

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### FEMALE: (Contraceptive History)

Have you ever taken oral contraceptives ("Pill")?

Name \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

Name \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

Name \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

Did you or your doctor note any problems? Yes No

Explain \_\_\_\_\_

Was it stopped because of a problem? Yes No

Explain \_\_\_\_\_

Were there any problems with your cycles after stopping the "pills"? Yes No

Explain \_\_\_\_\_

Have you ever used injectable contraception (Depo-Provera®, Lunelle™, etc.)?

Yes: Dates of use \_\_\_\_\_ Complications? \_\_\_\_\_ No

Have you ever used an IUD? Yes No

Name \_\_\_\_\_; From \_\_\_\_\_ To \_\_\_\_\_

Name \_\_\_\_\_; From \_\_\_\_\_ To \_\_\_\_\_

Did you note any problems? Yes No

(Circle) Pain Bleeding Fever Infection

Was it removed because of a problem? Yes No

Explain \_\_\_\_\_

Have you had tubal sterilization procedure (tubes tied)? Yes: \_\_\_\_\_ Date (mnth/yr) No

If yes, have you had a tubal reversal (tubes untied)? Yes: \_\_\_\_\_ Date (mnth/yr) No

**FEMALE: (Uterine, Tubal, Pelvic)**

Have you ever had any of the following sexually transmitted diseases or pelvic infections?

|  |  |  |  |                            |    |
|--|--|--|--|----------------------------|----|
|  |  |  |  | Yes (check all that apply) | No |
| <input type="checkbox"/> Chlamydia: date _____ | <input type="checkbox"/> Gonorrhea: date _____ | <input type="checkbox"/> Herpes: date _____    | <input type="checkbox"/> Genital warts/HPV: date _____ |                            |    |
| <input type="checkbox"/> Syphilis: date _____  | <input type="checkbox"/> HIV/AIDS: date _____  | <input type="checkbox"/> Hepatitis: date _____ | <input type="checkbox"/> Other _____: date _____       |                            |    |

Have you had your appendix removed? Yes      No  
 (Circle one):    Uncomplicated      Ruptured      Complicated      Infection

Did your mother take any hormones when she was pregnant with you? Yes      No

Have you ever had a D&C for an abortion, to end a miscarriage, following childbirth, or for abnormal bleeding? Yes      No

Explain: \_\_\_\_\_  
 \_\_\_\_\_

**FEMALE: (Testing and Treatment)**

Please indicate the tests you have had to check for ovulation and a normal cycle. Also briefly indicate the test results.

| TEST  | RESULTS |
|---|---------|
| _____ Basal Temperatures                        | _____   |
| _____ Urine L.H. Tests<br>(ovulation predictor) | _____   |
| _____ Follicle Ultrasound                       | _____   |
| _____ Progesterone Level                        | _____   |
| _____ Endometrial Biopsy                        | _____   |
| _____ Post-Coital Test                          | _____   |

Have you ever had any of the following?

| Procedure             | Dates | Results |
|-----------------------|-------|---------|
| Hysterosalpingogram:  |       |         |
| Hysteroscopy:         |       |         |
| Laparoscopy:          |       |         |
| Tubal Surgery:        |       |         |
| Abdominal Surgery:    |       |         |
| Other Pelvic Surgery: |       |         |

Patient Name \_\_\_\_\_

Have you ever been noted to have or been treated for endometriosis?      Yes      No

Treatment: \_\_\_\_\_

**Prior Treatment:**

Have you ever taken any of the following medications to induce ovulation or normalize your cycle? (circle)

|            |              |          |          |      |
|------------|--------------|----------|----------|------|
| Clomid     | Serophene    | Parlodel | Repronex | HCG  |
| Letrozole  | Progesterone | Bravelle | Pergonal | GNRH |
| Prednisone | Lupron       | Other    |          |      |

| Dates | Medication | Dose | Results | Comments |
|-------|------------|------|---------|----------|
|-------|------------|------|---------|----------|

**Prior Treatment:** Check all that apply:

|   | # of cycles | Dates (mo/yr) (mo/yr)   | Outcome   |
|---|-------------|-------------------------|---|
| <input type="checkbox"/> Intrauterine insemination:   | _____       | From ___/___ to ___/___ | ___Pregnant: ___Delivered ___Ectopic ___Miscarriage ___Not Pregnant |
| <input type="checkbox"/> Clomiphene citrate with timed intercourse:<br>Maximum # tablets/day? _____       | _____       | From ___/___ to ___/___ | ___Pregnant: ___Delivered ___Ectopic ___Miscarriage ___Not Pregnant |
| <input type="checkbox"/> Clomiphene citrate with insemination:<br>Maximum # tablets/day? _____            | _____       | From ___/___ to ___/___ | ___Pregnant: ___Delivered ___Ectopic ___Miscarriage ___Not Pregnant |
| <input type="checkbox"/> Daily fertility drug injections with insemination:<br>Maximum # vials/day? _____ | _____       | From ___/___ to ___/___ | ___Pregnant: ___Delivered ___Ectopic ___Miscarriage ___Not Pregnant |
| <input type="checkbox"/> Completed in vitro fertilization cycle(s):                                       |             |                         | ___Pregnant: ___Delivered ___Ectopic ___Miscarriage ___Not Pregnant |
| 1. #eggs___ #embryos transferred___#frozen___   | _____       | _____/____/_____        | ___Pregnant: ___Delivered ___Ectopic ___Miscarriage ___Not Pregnant |
| 2. #eggs___ #embryos transferred___#frozen___   | _____       | _____/____/_____        | ___Pregnant: ___Delivered ___Ectopic ___Miscarriage ___Not Pregnant |
| 3. #eggs___ #embryos transferred___#frozen___   | _____       | _____/____/_____        | ___Pregnant: ___Delivered ___Ectopic ___Miscarriage ___Not Pregnant |
| 4. #eggs___ #embryos transferred___#frozen___   | _____       | _____/____/_____        | ___Pregnant: ___Delivered ___Ectopic ___Miscarriage ___Not Pregnant |
| <input type="checkbox"/> Frozen embryo transfers:   |             |                         | ___Pregnant: ___Delivered ___Ectopic ___Miscarriage ___Not Pregnant |
| 1. #embryos transferred_____  | _____       | _____/____/_____        | ___Pregnant: ___Delivered ___Ectopic ___Miscarriage ___Not Pregnant |
| 2. #embryos transferred_____  | _____       | _____/____/_____        | ___Pregnant: ___Delivered ___Ectopic ___Miscarriage ___Not Pregnant |
| 3. #embryos transferred_____  | _____       | _____/____/_____        | ___Pregnant: ___Delivered ___Ectopic ___Miscarriage ___Not Pregnant |
| 4. #embryos transferred_____  | _____       | _____/____/_____        | ___Pregnant: ___Delivered ___Ectopic ___Miscarriage ___Not Pregnant |
| Cancelled in vitro fertilization attempt(s):  | _____       |                         |   |
| Any other prior treatment (describe): _____   |             |                         |   |

Additional Information/Complications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MALE FACTORS**

Partner's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_

**ETHNICITY OF PARTNER:** [See Genetics Table](#)

**Is your partner of Caucasian ancestry?** ..... yes .....no

If yes, has he been tested as a carrier of Cystic Fibrosis? ..... yes .....no

Results:  carrier  non-carrier

**Is he of French Canadian ancestry?** ..... yes .....no

If yes, has he been tested for Tay Sachs disease? ..... yes .....no

Results:  carrier  non-carrier

**Is he of Jewish ancestry?** ..... yes .....no

If Yes, (info at [www.jewishgeneticscenter.org/what/](http://www.jewishgeneticscenter.org/what/)) has he been tested as a carrier of the following:

—Tay Sachs disease? .....  carrier  non-carrier

—Gaucher's disease? .....  carrier  non-carrier

—Nieman-Pick? .....  carrier  non-carrier

—Canavan's disease? .....  carrier  non-carrier

—Fanconi Anemia? .....  carrier  non-carrier

—Bloom Syndrome? .....  carrier  non-carrier

—Dysautonomia ? .....  carrier  non-carrier

**Is he of Black ancestry?** ..... yes .....no

If yes, has he been tested for Sickle Cell disease? ..... yes .....no

Results:  carrier  non-carrier

**Is he of Mediterranean (Greek or Italian) ancestry?** ..... yes .....no

**Is he of Asian ancestry?** ..... yes .....no

**Is he of Middle Eastern ancestry?** ..... yes .....no

**Is he of Caribbean, Mexican, or Central American ancestry?** ..... yes .....no

If yes to any of the above 4 questions, has he been tested as a carrier of Thalassemia? .

..... yes ..... no

Results:  carrier  non-carrier

My partner does not wish to proceed with further testing (initial) \_\_\_\_\_

The appropriate prenatal screens have been discussed (initial) \_\_\_\_\_

Has your partner previously conceived with another woman? Yes - how many times? \_\_\_ No

If no, was birth control used? Yes No

Has your partner had a semen analysis? Yes No

**Dates** **Results**

Has your partner been seen by a urologist? Yes No

**Dates** **Results**

Patient Name \_\_\_\_\_

Has your partner had difficulty with erections? Yes No  
 Does he have retrograde ejaculation of sperm into the bladder? Yes No  
 Has he had any of the following sexually transmitted diseases or pelvic infections?  
 Yes (check all that apply) No

Chlamydia: date \_\_\_\_\_  Gonorrhea: date \_\_\_\_\_  Herpes: date \_\_\_\_\_  Genital warts/HPV: date \_\_\_\_\_  
 Syphilis: date \_\_\_\_\_  HIV/AIDS: date \_\_\_\_\_  Hepatitis: date \_\_\_\_\_  Other \_\_\_\_\_: date \_\_\_\_\_

Has your partner had a history of undescended testicles? Yes - one side \_\_\_ both \_\_\_ No  
 Does he have scrotal or testicular pain? Yes No  
 Did he have the mumps after puberty? Yes No  
 Has he had prior injury to his testicles requiring hospitalization? Yes No

Has your partner been diagnosed with any of the following diseases?  
 Yes (check all that apply) No  
 Diabetes Mellitus  Prostatic Infections  Cancer  
 Multiple Sclerosis  Urinary Infections  Other neurologic problems  
 High Blood Pressure - if yes, any medications: \_\_\_\_\_

Has your partner had any fever in the last 3 months? Yes No  
 Has he had a vasectomy? Yes - date \_\_\_\_\_ No  
 If yes, has he had a vasectomy reversal? Yes - date \_\_\_\_\_ No  
 Has he had surgery for varicocele repair? Yes No  
 Has he had hernia surgery? Yes No  
 Did your partner undergo any bladder or penis surgery as a child? Yes No  
 Is he exposed to prolonged heat in the workplace? Yes No  
 Is he exposed to any radiation or harmful chemicals in the workplace? Yes No  
 Has he had chemotherapy for cancer? Yes No

Is he allergic to any medications? Yes (please list and describe reactions) No  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List his current medications: \_\_\_\_\_

List any current medical problem(s): \_\_\_\_\_

Has your partner had treatment to improve his fertility? Yes No  

| Dates | Results |
|-------|---------|
|       |         |

How many caffeinated beverages does he drink per day? \_\_\_\_\_ None

Does he use or has he ever used:

- |  |     |    |
|--|-----|----|
| 1. Alcohol, (# of glasses per week)        | Yes | No |
| Wine _____ Beer _____ Cocktails _____      |     |    |
| 2. Cigarettes, (present _____ prior _____) | Yes | No |
| # packs per day _____ # of years _____     |     |    |
| 3. Illicit or recreational drugs (specify) | Yes | No |
| _____                                      |     |    |
| _____                                      |     |    |

Have you or your partner ever been in a program for limiting or discontinuing use of drugs or alcohol? Yes No

Does your partner use herbal medicines/vitamins or health food store supplements? Yes (describe) \_\_\_\_\_ No

Are you aware of any radiation/toxic materials exposure? Yes No

Does your partner use hot tubs regularly? Yes No

Did his mother take DES during pregnancy to prevent miscarriage? Yes No

Have any of his immediate family members had difficulty conceiving a child? Yes (describe) \_\_\_\_\_ No

### COUPLE FACTORS

How frequently do you have sexual intercourse?

- More than once a day \_\_\_\_\_
- Daily or almost daily \_\_\_\_\_
- 3-5 times a week \_\_\_\_\_
- 1-2 time a week \_\_\_\_\_
- Less than once a week \_\_\_\_\_
- Irregularly \_\_\_\_\_

Which of the following best describes how you feel about your sex life?

- Very satisfied \_\_\_\_\_
- Fairly satisfied \_\_\_\_\_
- Fairly unsatisfied \_\_\_\_\_
- Very unsatisfied \_\_\_\_\_

Which of the following best describes how you think your partner feels about your mutual sex life?

- Very satisfied \_\_\_\_\_
- Fairly satisfied \_\_\_\_\_
- Fairly unsatisfied \_\_\_\_\_
- Very unsatisfied \_\_\_\_\_

Patient Name \_\_\_\_\_

Do any of these statements describe sex with your partner?

- It is sometimes difficult \_\_\_\_\_
- It is almost always difficult \_\_\_\_\_
- It is sometimes painful \_\_\_\_\_
- It is almost always painful \_\_\_\_\_
- It is sometimes unpleasant \_\_\_\_\_
- It is almost always unpleasant \_\_\_\_\_
- It is sometimes enjoyable \_\_\_\_\_
- It is almost always enjoyable \_\_\_\_\_

Do you or your partner have problems with initiating or completing sexual intercourse?

Yes No

Do you plan intercourse for a specific time of your cycle?

Yes No

When: \_\_\_\_\_

Do you use lubricant for intercourse?

Yes No

Do you douche before or after intercourse?

Yes No

Do you feel that your fertility problem is:

- 1. Causing personal stress Yes No
- 2. Causing stress between you and your husband Yes No
- 3. Interfering with a satisfactory sex life Yes No

## II. FAMILY HISTORY: MALE FAMILY HISTORY

| Relative          | Alive/Dead | Age   |
|-------------------|------------|-------|
| Mother _____      | A/D _____  | _____ |
| Father _____      | A/D _____  | _____ |
| Sisters/Brothers: |            |       |
| 1. S / B _____    | A/D _____  | _____ |
| 2. S / B _____    | A/D _____  | _____ |
| 3. S / B _____    | A/D _____  | _____ |
| 4. S / B _____    | A/D _____  | _____ |

Patient Name \_\_\_\_\_

Have any of your partner's relatives ever had the diseases or conditions listed below?

| Condition                | Mother | Father | Brother/Sister | Other |
|--------------------------|--------|--------|----------------|-------|
| Alcoholism               | M      | F      | S              | O     |
| Anemia                   | M      | F      | S              | O     |
| Diabetes                 | M      | F      | S              | O     |
| Cancer                   | M      | F      | S              | O     |
| Bleeding disorders       | M      | F      | S              | O     |
| Heart disease            | M      | F      | S              | O     |
| High blood pressure      | M      | F      | S              | O     |
| Kidney disease           | M      | F      | S              | O     |
| Stroke                   | M      | F      | S              | O     |
| Blood clots              | M      | F      | S              | O     |
| Thyroid disease          | M      | F      | S              | O     |
| Excess hair growth       | M      | F      | S              | O     |
| Epilepsy                 | M      | F      | S              | O     |
| Birth defects            | M      | F      | S              | O     |
| Muscular dystrophy       | M      | F      | S              | O     |
| Cystic fibrosis          | M      | F      | S              | O     |
| Mental retardation       | M      | F      | S              | O     |
| Physical retardation     | M      | F      | S              | O     |
| Downs syndrome           | M      | F      | S              | O     |
| Other chromosome defects | M      | F      | S              | O     |
| Obesity                  | M      | F      | S              | O     |
| Psychiatric problems     | M      | F      | S              | O     |

Do any hereditary diseases or abnormal conditions run in his family? Yes    No

### FEMALE FAMILY HISTORY

| Relative          | Alive/Dead | Age   |
|-------------------|------------|-------|
| Mother _____      | A/D _____  | _____ |
| Father _____      | A/D _____  | _____ |
| Sisters/Brothers: |            |       |
| 1. S / B _____    | A/D _____  | _____ |
| 2. S / B _____    | A/D _____  | _____ |
| 3. S / B _____    | A/D _____  | _____ |
| 4. S / B _____    | A/D _____  | _____ |

Have any of your blood relatives ever had the diseases or conditions listed below?

| Condition                       | Mother | Father | Brother/Sister | Other |
|---------------------------------|--------|--------|----------------|-------|
| Alcoholism                      | M      | F      | S              | O     |
| Anemia                          | M      | F      | S              | O     |
| Diabetes                        | M      | F      | S              | O     |
| Cancer                          | M      | F      | S              | O     |
| Bleeding disorders              | M      | F      | S              | O     |
| Heart disease                   | M      | F      | S              | O     |
| High blood pressure             | M      | F      | S              | O     |
| Kidney disease                  | M      | F      | S              | O     |
| Stroke                          | M      | F      | S              | O     |
| Blood clots                     | M      | F      | S              | O     |
| Thyroid disease                 | M      | F      | S              | O     |
| Excess hair growth              | M      | F      | S              | O     |
| Epilepsy                        | M      | F      | S              | O     |
| Birth defects                   | M      | F      | S              | O     |
| Muscular dystrophy              | M      | F      | S              | O     |
| Cystic fibrosis                 | M      | F      | S              | O     |
| Mental retardation              | M      | F      | S              | O     |
| Physical retardation            | M      | F      | S              | O     |
| Downs syndrome                  | M      | F      | S              | O     |
| Other chromosome defects        | M      | F      | S              | O     |
| Frequent miscarriages           | M      | F      | S              | O     |
| Stillbirths                     | M      | F      | S              | O     |
| Twins                           | M      | F      | S              | O     |
| Early menopause (before age 40) | M      | F      | S              | O     |
| Endometriosis                   | M      | F      | S              | O     |
| Infertility                     | M      | F      | S              | O     |
| Irregular periods               | M      | F      | S              | O     |
| Obesity                         | M      | F      | S              | O     |
| Psychiatric problems            | M      | F      | S              | O     |

Do any hereditary diseases or abnormal conditions run in your family (including breast, bowel or ovarian cancer)? Yes    No

### III. FEMALE MEDICAL HISTORY:

Do you have or have you ever had (circle all that apply):

- |                  |                      |                       |
|------------------|----------------------|-----------------------|
| Scarlet fever    | High blood pressure  | Neurological problems |
| Rheumatic fever  | Gallbladder problems | Seizures              |
| Tuberculosis     | Liver problems       | Epilepsy              |
| Hepatitis        | Ulcers               | Dizziness             |
| Heart murmur     | Appendicitis         | Loss of balance       |
| Pelvic infection | Colitis              | Chronic headaches     |
| Chicken pox      | Anemia               | Vaginitis             |
| Thyroid problems | Arthritis            | Pneumonia             |
| Cancer           | Breast lump          | Parasites             |
| Kidney infection | Breast problems      | Ovarian cysts         |
| Heart disease    | Breast discharge     | Other _____           |

Comments \_\_\_\_\_

Patient Name \_\_\_\_\_

**PAP SMEAR HISTORY**

When was your last pap smear? (month/year) \_\_\_\_/\_\_\_\_  Normal  Abnormal

When was your last abnormal pap smear? \_\_\_\_/\_\_\_\_  Not applicable

Have you undergone any procedures as a result of an abnormal pap smear?

Yes (check all that apply)  No

Colposcopy  Cryosurgery (freezing)  Laser treatment  Conization  LEEP procedure

**BREAST SCREENING HISTORY**

Have you ever had a mammogram?

Yes - date \_\_\_\_\_ Result:  normal  abnormal - explain \_\_\_\_\_ No

Do you perform breast self exams? Yes No

Have you ever had Rubella (German measles)? Yes No

Have you received Rubella immunization? Yes No

Have you ever undergone surgery? Yes No

| Date | Type | Hospital |
|------|------|----------|
|      |      |          |
|      |      |          |
|      |      |          |

Were there:

Complications? Yes No

Anesthesia problems? Yes No

Bleeding problems? Yes No

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you allergic to any medication, drugs, foods, metals, other? Yes (list and describe reactions) No

\_\_\_\_\_  
\_\_\_\_\_

Do you regularly take medications? Yes No

1. Over the counter (list) Yes No

\_\_\_\_\_  
2. Prescriptions (list) Yes No  
\_\_\_\_\_  
\_\_\_\_\_

3. Are you taking any now (list) Yes No

\_\_\_\_\_  
\_\_\_\_\_

Do you use or have you ever used:

1. Alcohol, (# of glasses per week) Wine \_\_\_\_ Beer \_\_\_\_ Cocktails \_\_\_\_ Yes No

2. Cigarettes, (present \_\_\_\_\_ prior \_\_\_\_\_) Yes No  
# packs per day \_\_\_\_\_ # of years \_\_\_\_\_

3. Illicit or recreational drugs (specify) Yes No

\_\_\_\_\_  
\_\_\_\_\_ **Past / Present (circle)**

### IV. REVIEW OF SYSTEMS

**General:**

- Recent weight gain or loss
- Anorexia/Bulimia
- Lack of energy
- Fever/Chills
- 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 Bowel Syndrome
- Change in bowel habits
- Colitis (Ulcerative or Crohn's)
- Other \_\_\_\_\_
- none

**Musculoskeletal:**

- Unusual muscle weakness
- Decreased energy/stamina
- Rheumatoid arthritis
- Lupus Erythematosus
- Myasthenia gravis
- Other \_\_\_\_\_
- none

**Mental Health Problems:**

- Depression     Anxiety disorder
- Schizophrenia
- Other \_\_\_\_\_
- none

**Head, Eyes, Ears, Nose and Throat:**

- Dizziness     Loss of sense of smell
- Headaches     Chronic nasal congestion
- Blurred vision     Ringing ears
- Hearing loss/deafness
- Other \_\_\_\_\_
- none

**Breasts:**

- Discharge: clear \_\_\_ bloody \_\_\_ milky \_\_\_
- Lumps     Pain     Cancer
- Abnormal mammogram
- Reduction
- Augmentation/Breast implants  
Saline \_\_\_ Silicone \_\_\_
- Other \_\_\_\_\_
- none

**Genito-Urinary:**

- Bladder infections
- Kidney infections
- Vaginal infections
- Frequent urination     Leaking urine
- Blood in the urine
- Herpes
- Other \_\_\_\_\_
- none

**Hematologic:**

- Blood clotting disorder/Blood clot
- Sickle Cell Anemia     Thrombophlebitis
- Easy bruising
- Swollen glands/lymph nodes
- Blood transfusions (dates/reasons \_\_\_\_\_)
- Other \_\_\_\_\_
- none

**Respiratory:**

- Shortness of breath
- Asthma     Bronchitis
- Pneumonia     Tuberculosis
- Bloody cough
- Other \_\_\_\_\_
- none

**Neurological Problems:**

- Weakness/Loss of balance
- Seizures/Epilepsy
- Headaches
- Migraine headaches
- Numbness
- Memory loss
- 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     Heart attack
- Stroke     Murmurs
- High blood pressure
- Rheumatic fever
- Mitral valve prolapse (need antibiotics before dental procedures? Yes \_\_\_ No \_\_\_)
- Other \_\_\_\_\_
- none

**Physician Notes (for office use only)** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**V. PHYSICAL EXAM:****Office Use Only**

Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ B.P. \_\_\_\_\_

Stature \_\_\_\_\_ Race \_\_\_\_\_

General Appearance:  Well developed  Well nourished  Normal mood/affect  Oriented x3  
 No acute distressSkin:  Acne  XS Sebum  Hirsutism (facial, chest, back, areolar, abd., thigh)  
 No lesions  No abnormal molesNeck:  Supple  Without massesThyroid:  WNL  No masses  Without thyromegalyBreast:  No dominant masses  No skin changes  No nipple dischargeLungs:  Clear to auscultation bilaterally  Normal respiratory effortHeart:  Regular rhythm and rate  No murmurs/gallopsAbdomen:  Soft, non-distended  No masses/HSM  No herniasBack:  No CVA tendernessLymphatic:  No neck  No axillary  No groin lymphadenopathyExtremities:  Without varicosities  Without edema  Nontender calvesPelvic Exam:  Normal external genitalia  Adnexa NTUrethral meatus/urethra:  Without lesions, tenderness or prolapseBladder:  Without masses, tenderness  Well supportedVagina:  Well supported  No lesions  No abnormal dischargeCervix:  Without lesions  No CMTUterus Position:  Normal size & shape  Nontender  Without descentAdnexa:  Normal size  No adnexal masses  No tendernessAnus/Perineum:  No lesionsRectal:  Normal sphincter tone  No hemorrhoids  No tenderness

Other Findings:

The above was discussed with the patient at the New Patient Consultation.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

### *WHAT OTHER GROUPS OF PEOPLE HAVE SPECIFIC GENETIC DISEASES?*

It is estimated that we all carry 6 - 8 disease-producing genes which would be harmful if passed on to our children by both mother and father.

Many other racial and ethnic groups have "their own" genetic disorders - disorders which are not unique to the group, but which are more common in the group.

| Ancestry                 | Disease                  | Carrier Frequency  | Disease Incidence |
|--------------------------|--------------------------|--------------------|-------------------|
| Blacks .....             | Sickle Cell Anemia ..... | 1 in 12.....       | 1 in 600          |
| Ashkenazi Jews .....     | Tay-Sachs disease .....  | 1 in 30.....       | 1 in 3,600        |
| Ashkenazi Jews .....     | Canavan disease .....    | 1 in 35 - 40 ..... | 1 in 6,000        |
| Greeks, Italians.....    | beta-thalassemia.....    | 1 in 30.....       | 1 in 3,600        |
| SE Asians, Chinese ..... | alpha-thalassemia .....  | 1 in 25.....       | 1 in 2,500        |
| N. Europeans.....        | Cystic fibrosis .....    | 1 in 25.....       | 1 in 2,500        |

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