INTAKE FORM

PATIENT INFORMATION

Patient's Name: ________________________ Date: ____________________

Date of Birth: ____________________ Marital Status: _____________

Address: ____

Phone: May we leave a message? Email address

Phone	May we leave a message?		Email address
Home:_______________________	__yes	__no	_____________________
Work:_______________________	__yes	__no	
Cell:_______________________	__yes	__no	

Spouse/partner: _______________________ Contact info: _______________________
Date of Birth: ____________________

Primary Care Physician: ______________________________ Phone: ____________________
Address: ____

Primary Ob/Gyn Physician: ____________________________ Phone: ____________________
Address: ____

Emergency Contact Name: ____________________________ Relationship: ________________
Phone: ____

Pharmacy Name: ______________________ Phone: _______________ Fax: ________________
Address (cross streets and city): ____

Who referred you to us? (or how did you hear about us?):________________________________

Reason for initial visit: ____

FEMALE HISTORY

PAST MEDICAL HISTORY – HAVE YOU HAD ANY OF THE FOLLOWING:

Yes		Details / Date of diagnosis if known
___	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	________________________________

Yes Details / Date of diagnosis if known

___ Cancer ______________________________

___ History of trauma / car accident ______________________________

___ Blood clots ______________________________

___ Depression ______________________________

___ Schizophrenia / Bipolar disease ______________________________

___ Chicken pox ______________________________

___ Other ______________________________

PAST SURGICAL HISTORY – PLEASE LIST ANY SURGERIES YOU HAVE HAD:

Year Surgery

________ ______________________________

________ ______________________________

________ ______________________________

________ ______________________________

________ ______________________________

Besides pregnancy and these surgeries, have you ever been hospitalized for any other reasons?

________ ______________________________

________ ______________________________

________ ______________________________

PAST PREGNANCY INFORMATION: (INCLUDE MISCARRIAGES, ABORTIONS, ECTOPIC PREGNANCIES, ETC.)

Date	How many weeks at birth	Vaginal or C-section	Weight	Sex of Baby	Time (months) to conceive	Fertility treatment? (if yes, describe)	Other comments
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							

CURRENT MEDICATIONS AND DOSE – PLEASE LIST ANY MEDICINES YOU ARE TAKING:

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Do you take any supplements or herbal medicines? If yes, please list:

____

ALLERGIES – PLEASE LIST ANY ALLERGIES TO MEDICATIONS / LATEX / OTHER : ________________
____

FAMILY HISTORY – DID ANYONE IN YOUR FAMILY HAVE THE FOLLOWING:

Breast Cancer__________________________ High blood pressure____________________________________
____
Ovarian Cancer________________________ Diabetes____
____
Colon Cancer__________________________ Other____
____

SOCIAL HISTORY: (circle and describe)

alcohol Y N drinks per week__________ occupation:___________________________________
smoking Y N packs per day___________ # of years smoking:__________
recreational drugs (circle): heroin cocaine marijuana methamphetamines narcotics sleeping pills
caffeine Y N cups per day____________

married for how long?____________ How long have you been trying to conceive?___
(ie, intercourse without contraception)
exercise type:_____________________
frequency of exercise:______________
Have you ever had an eating disorder? (Yes or No)___ __________

REVIEW OF SYSTEMS: (Check any of the following symptoms if you are currently having them)

General
__ weight loss
__ weight gain
__ fatigue
__ night sweats

Skin
__ rash
__ bothersome hair growth
__ hair loss
__ itching
__ dry skin

HEENT
__ change in vision
__ change in hearing
__ difficulty swallowing
__ headaches
__ nosebleeds
__ neck pain

Breast
__ new lumps / masses
__ nipple discharge

Chest
__ shortness of breath
__ wheezing
__ cough

Cardiovascular
__ chest pain
__ fainting
__ swelling
__ dizziness
__ heart palpitations
__ irregular periods

Gastrointestinal
__ nausea
__ vomiting
__ constipation
__ diarrhea
__ bloody stools
__ decreased appetite

Genitourinary
__ pain with urination
__night frequent urination at night
__ blood in urine
__ vaginal discharge
__ vaginal itching
__ pain with intercourse
__abnormal vaginal bleeding

Extremities
__ joint / muscle pain

Neuro
__ seizures
__ depression

Other:

GYNECOLOGIC HISTORY

Menstrual History

Age when menstrual periods began __________ **(Years old)** **Last Menstrual Period (LMP):**________
How many days of bleeding _______ **(Days)** How long is the Cycle in total (Range of Days) ____to____
Shortest Longest

Abnormal Bleeding

Do you have bleeding between your periods?____
Do you have very heavy periods?____
How many days of brown spotting do you have at the end of your blood flow?____________________
How many days of very light bleeding do you have before the first heavy day of your flow?________________________

Have you ever charted your menstrual cycles? Yes No What system?_______________________

Pain

Do you have painful periods or cramps? (circle) None Mild Moderate Severe
Do you have pelvic pain at other times in your cycle? (circle) Yes No
Do you have bowel pain or problems during your period? (circle) Yes No
Do you have pain with intercourse? (circle) Yes No
Do you have low back pain with your periods? (circle) Yes No

Premenstrual Symptoms

How severe are your PMS symptoms? (circle)

Please check any of the following symptoms if you notice them >3 days before your period:
(a) Irritability __ (b) Breast tenderness __ (c) Bloating __ (d) Weight gain ___ (e) Salt/Sweet cravings __
(f) Cry easily__ (g) Depression ___ (h) Headache ___ (i) Fatigue ___ (j) Insomnia ____ (k) Other ____

Other Symptoms:

Do you have persistent low energy/fatigue? Yes No ___ Do you have difficulty sleeping? Yes No ___
Do you have persistent low mood? Yes No ___ Do you have excessive anxiety? Yes No __

Symptoms of Polycystic Ovaries

Do you have unwanted/excessive hair growth? Yes No__ ______________________
Do you suffer from acne? Yes No__ ______________________
Are you overweight? Yes No__ ______________________
Do you have irregular / infrequent menses? Yes No__ ______________________
Have you ever had an eating disorder? Yes No ________________________________

Have you ever had a sexually transmitted infection? (Circle) Yes No

Diagnosis (circle): HPV chlamydia gonorrhea syphilis HIV hepatitis

genital warts pelvic inflammatory disease (PID) trichomonas other:

PLEASE LIST ANY OTHER INFORMATION REGARDING YOUR MENSTRUAL CYCLES THAT YOU THINK MIGHT BE IMPORTANT:

Family Planning History

1. None Since _______________ **(Date)**
2. Abstinence Since________________ **(Date)**
3. Oral Contraceptive Pill (Name ________________) Until ________ **(Date)** Total no. of months____
4. Oral Contraceptive Pill (Name ________________) Until ________ **(Date)** Total no. of months____
5. Condoms Until _________________ **(Date)** Total number of months _________
6. NFP Until _________________ **(Date)** Total number of months _________
7. DepoProvera Until _________________ **(Date)** Total number of months _________
8. IUD ("The coil") Until _________________ **(Date)** Total number of months _________
9. Other (____________) Until _________________ **(Date)** Total number of months _________

Are you currently sexually active?______________ If not, have you ever been sexually active?____________________

Pap Test Information

Most recent **Pap Smear Test** (ate) __________________ Result _________
Ever had an abnormal result? _________________________ Details ______________________
Previous treatment for abnormal PAP? ____

Mammogram Information

Most recent **Mammogram** (date) __________________ Result _________
Ever had an abnormal result? _________________________ Details ______________________

Colon Screening Information

Circle if you've had: Colonoscopy Sigmoidoscopy Stool blood testing yes no
Date:_____________

Bone Density

When was the last test?_________________ Result?_____________________

PRIOR INVESTIGATIONS: (CHECK ALL THAT APPLY)

TESTS	DETAILS
___ Hormonal lab tests	____________________________
___ Ultrasound	____________________________
___ HSG	____________________________
___ BBT	____________________________
___ Hysteroscopy	____________________________
___ Endometrial biopsy	____________________________
___ MRI	____________________________
___ Urine LH Kit testing	____________________________
___ Other	____________________________

PRIOR FERTILITY TREATMENT:

Cycles of IVF______ Cycles of insemination______

Total cycles of ovulation induction: oral medicines ________ injectable medicines _________

MALE HISTORY

REVIEW OF SYSTEMS: (Check any of the following symptoms if you are currently having them)

General

__ weight loss
__ weight gain
__ fevers
__ night sweats
__ difficulty swallowing
__ headaches
__ nosebleeds
__ neck pain
__ fainting
__ swelling
__ dizziness
__ heart palpitations
__ freq. urination at night
__ blood in urine
__ pain with intercourse

Skin

__ rash
__ hair loss
__ change in moles
__ itching
__ dry skin

HEENT

__ change in vision
__ change in hearing

Breast

__ new lumps / masses
__ nipple discharge

Chest

__ shortness of breath
__ wheezing
__ cough

Cardiovascular

__ chest pain

Gastrointestinal

__ nausea
__ vomiting
__ constipation
__ diarrhea
__ bloody stools
__ decreased appetite

Genitourinary

__ pain with urination

Extremities

__ joint / muscle pain

Neuro

__ seizures
__ depression

Other:

PAST MEDICAL HISTORY

Yes		Details / Date of Diagnosis	Family History?
____	High blood pressure	______	______
____	Heart disease	______	______
____	Diabetes	______	______
____	Asthma or lung disease	______	______
____	Kidney disease	______	______
____	Liver disease	______	______
____	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 disease	______	______
____	Chicken pox	______	______
____	Other	______	______

PAST SURGICAL HISTORY:

Year	Surgery
________	________________
________	________________
________	________________
________	________________
________	________________

Besides these surgeries, have you ever been hospitalized for any other reasons?

________	________________
________	________________

Have you ever had an STI (Sexually Transmitted Infection)? **Man** (Yes or No) ____

Diagnosis: (circle) chlamydia gonorrhea syphilis HIV hepatitis genital warts

pelvic inflammatory disease (PID) trichomonas other:

CURRENT MEDICATIONS AND DOSE:

____ ____
____ ____
____ ____
____ ____

Do you take any supplements or herbal medicines? If yes, please list:

____

____

ALLERGIES (MEDICATIONS / LATEX / OTHER) : ____

____

SOCIAL HISTORY: (circle and describe)

alcohol Y N drinks per week___________ occupation:_______________________________________
smoking Y N packs per day____________ # of years smoking:___________
recreational drugs (circle): heroin cocaine marijuana methamphetamines narcotics sleeping pills
caffeine Y N cups per day_____________

married for how long?______________ trying to conceive for how long?______________
(ie, intercourse without contraception)
exercise type:_______________________ frequency:______________________

PRIOR INVESTIGATIONS: (CHECK ALL THAT APPLY)

TESTS	DETAILS
___ Hormonal lab tests	______________________________
___ Semen analysis	______________________________
___ Surgery (ie, varicocele)	______________________________
___ Other	______________________________