Patient Intake & History

Identifying Data Date:_____

Your Name:_____ Partner's Name _____
Age: _____ Birth date: _____ Height: _____ Weight: _____
Length of Marriage or Relationship _____
How long have you been trying unsuccessfully to get pregnant? _____
Have you previously been pregnant? _____
Have you previously tried to get pregnant? _____
What is the reason for your visit, and how can we help you? _____
_____

Pregnancy History

Number of Pregnancies _____ Term Births _____ Premature Births _____
Miscarriages _____ Elective Abortions _____ Adopted Children _____
Please list dates if you've had any of the following:
Miscarriage? _____
Elective Abortion? _____
Ectopic? _____
Term Birth _____
Months to conceive? Weight & Sex C-Section? Complications? Is current partner father?

Contraceptive Use

	Type	From when to when	Reason Discontinued
1.			
2.			
3.			

Operations and Hospitalizations

	Date	Diagnosis	Operation	Where Performed	Physician
1.					
2.					
3.					

Medications

*Please list all prescriptions and over-the-counter drugs used during the past year.

	Date	Dosage and Frequency	from when to when	Reason for taking
1.				
2.				
3.				
4.				

5. _____

Allergies

Drug or Substance	When	What type of reaction?
1.		
2.		
3.		

Menstrual History

The first day of your last cycle? _____
Age at first period? _____
Are your periods regular? _____
How many days between periods? _____
How many days does your period last? _____
Do you bleed between periods? _____
You have premenstrual symptoms: ☐ Almost always ☐ Rarely ☐ Never
Vigorous exercise: Type _____ hours/week _____
Type _____ hours/week _____

If you have a hormonal disorder, please specify type and treatment _____
_____

Pelvic pain/cramps: ☐none ☐ during your period ☐ before your period ☐ after your period
☐ at mid cycle ☐ during intercourse ☐ with urination ☐ with bowel movements
☐ cause you to miss usual activities ☐ cause you to miss work

Pelvic pain/cramps are: ☐ mild ☐ moderate ☐ severe ☐ getting ☐ worse ☐ improving
Medications you take for pain/cramps? _____

Circle if you have had:

Hot Flashes	Increased Facial or body hair
Breast Discharge	Increased Acne
Vision Problems	Weight Gain (>10 pounds)
Poor sense of smell	Weight Loss (>10 pounds)
Chronic Headache	Special Dietary Habits
Head Injury	Vomiting
Seizures	Diabetes
Thyroid Disorder	Autoimmune disease
Excessive Stress	Psychiatric treatment

Please explain any you've circled _____
_____
_____

Partners Medical History Name: _____

Age _____ Occupation _____
List serious or chronic illness or injuries _____

_____
Medications _____

_____
Cigarettes-packs smoked/day _____
Alcohol-type and # drinks/week _____
Marijuana-amount _____
Other drugs-type and amount _____
Ever used IV drugs? _____
Caffeine drinks per day _____
Radiation Exposure _____
Toxic Exposure _____
Video display terminal-hours/day _____
Electric Blanket Use _____
Hot tub or sauna use _____
Any problems with erection or ejaculation? _____
Have semen analysis ever been abnormal? _____
Has your partner seen a doctor for infertility evaluation? _____
Doctor _____
Diagnosis _____
Treatment _____
Has your partner ever fathered a pregnancy with another woman? _____
Any inherited diseases in your partner's family? _____

Circle if your partner has had:

Vasectomy	Psychiatric	Penile Discharge
Vasectomy Reversal	Treatment	Undescended testicle
Varicocele	Excessive Stress	Injury to testicle
Varicocele Surgery	Strenuous exercise	Mumps
Biopsy of Testicles	Tight underwear	Prostatis
Hernia Surgery	Chlamydia	Epididymitis
Abdominal Surgery	Gonorrhea	Ureaplasma
Cancer	Genital Herpes	Mycoplasma
High Blood Pressure	Genital Warts	Seizures
Diabetes	Colitis	Penis pain