

RUTEK CENTER FOR REPRODUCTIVE MEDICINE, P.A.

Please complete to the best of your knowledge, print clearly in black ink

New Patient Medical Health History Questionnaire (Female) Today's Date _____

First Name: _____ Middle Initials _____ Last Name _____

Age: _____ Date of Birth _____ Marital Status: _____

Primary Care Physician: _____ Gynecologist: _____

Referred by: _____ Occupation: _____

Partners Name: _____ Age: _____ Date of Birth: _____

Reason for Visit: _____

Gynecological History:

Are you trying to get pregnant? Yes No If yes, how long trying? _____

Age when periods began: _____ First day of last period: _____

How many days from the beginning of one period to the beginning of the next period (usual)? _____

What is the usual duration of your periods? _____

Do you have regular or irregular periods? _____

Do you spot or bleed between periods? No Yes

Do you bleed heavily, pass clots, experience pain, cramps, mood changes or breast tenderness during menstruation? (Circle all that apply to you).

Date of last PAP/Results: _____

Ever had an abnormal PAP? No Yes, Date: _____

Sexual preference: Heterosexual sexual Homosexual Bisexual

Do you experience painful intercourse? No Yes

How often do you have intercourse? Usually _____ times/wk.

Do you douche before or after intercourse Yes No

Do you have problems with arousal or lubrication? No Yes. If yes, what type of lubricant do you use? _____

Does your husband have problems with erection or ejaculation? ___No ___Yes
If yes explain _____

What type of birth control do you use/and ever used?

Do you have excessive facial or body hair? ___ No ___ Yes; Acne: ___ No ___ Yes;
Thyroid disease: ___ No ___Yes (state_____) Breast discharge: ___ No ___Yes;
Last Mammogram/Results: _____

Have you ever had? Pelvic infections: ___No ___Yes; Gonorrhea: ___No ___Yes,
Chlamydia: ___ No ___ Yes; Genital Herpes: ___ No ___Yes; Endometriosis: ___No ___Yes
Infertility: ___No ___Yes, Pelvic pain: ___No ___Yes; Used an IUD: ___No ___ Yes
Did your mother take DES when she was pregnant with you? ___No ___Yes

Comments: _____

Previous Infertility Evaluation/Treatments: ___ Yes ___No

Partners Semen analysis: ___normal, ___abnormal, Date: _____
___none

Hysteroslapingogram (HSG) dye test: ___ normal, ___abnormal, Date: _____
___none

Sonohysterography: ___normal, ___abnormal, Date: _____
___none

Laparoscopy ___Normal, ___abnormal, Date: _____
___none

Hysteroscopy ___Normal, ___abnormal, Date: _____
___none

Pelvic surgery ___Normal, ___abnormal, Date: _____
___none

Clomiphene cycles: _____; ___none; # Gonadotropins cycles: _____
___none

Dates _____

Intrauterine Inseminations: ___ ; ___with husband's sperm; ___with donor sperm; ___ none

Dates _____

IVF cycles: _____ ___with your own eggs; ___ with donor eggs; ___none

Dates _____

Other Infertility Treatments: _____; ___none

Have you had any of the following tests? if yes list any results and dates of tests

Syphilis: ___ No ___Yes, Date _____ Normal ___Abnormal

Rubella: ___No ___Yes, Date _____; Normal ___Abnormal

HIV: ___No ___Yes, Date _____; Normal ___Abnormal

Hepatitis B & C: ___No ___Yes, Date _____ Normal ___Abnormal

Blood Type: ___ No ___Yes, Date _____ Result _____

Cystic Fibrosis: ___ No ___Yes, Date _____ Normal ___Abnormal

Hemoglobin Electrophoresis: ___ No ___Yes, Date _____ Normal ___Abnormal

Have you had the Chicken Pox? ___ No ___Yes; Date _____

Thyroid (TSH): ___ No ___Yes, Date _____ Normal ___Abnormal

Prolactin: ___ No ___Yes, Date _____ Normal ___Abnormal

FSH/Estradiol day 3 of cycle: ___ No ___Yes, Date _____ Normal ___Abnormal

Chromosomes tests ___ No ___Yes, Date _____ Normal ___Abnormal

Endometrial biopsy ___ No ___Yes, Date _____ Normal ___Abnormal

Obstetrical History: Have you ever been pregnant? ___ No, ___Yes. if yes, list all pregnancies, dates, and outcomes:

1 _____ current, or ___previous partner

2 _____ current, or ___previous partner

3 _____ current, or ___previous partner

4 _____ current, or ___previous partner

5 _____ current, or __previous partner

6 _____ current, or __previous partner

7 _____ current, or __previous partner

Past Medical History:

List Allergies to any medications: _____None Known

1) _____ 3) _____

2) _____ 4) _____

List Allergies to any food (for example, peanuts, eggs, etc.) _____None Known

1) _____ 3) _____

2) _____ 4) _____

List Hospitalizations: _____None

1) _____ 3) _____

2) _____ 4) _____

List Medical conditions: _____None

1) _____ 2) _____

3) _____ 4) _____

List previous surgeries _____None

1) _____ 2) _____

3) _____ 4) _____

List current prescription medicines (include dosage) _____None

1) _____ 2) _____
3) _____ 4) _____

List current over the counter medicines, vitamins and food supplements that you take _____ None

1) _____ 2) _____
3) _____ 4) _____

Social History:

Do you smoke cigarettes? ___No ___Yes; If yes, number of packs/day and years of use: _____

Do you drink alcohol? ___ No ___Yes; If yes, glasses/day: _____

Do you use cocaine or similar drug? ___No ___Yes; If yes, list drugs _____

Intravenous drugs: ___No ___Yes; If yes, list drugs _____

Number of life sexual partners: _____

Do you exercise regularly? ___No ___Yes; If yes, How often/How much: _____

Describe your diet _____

Family History

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

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Paternal Aunts and Uncles, Deceased	Sex	Age at Death	Cause of Death
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Paternal First Cousins,	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 Status
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Maternal Aunts and Uncles Deceased

Sex

Age at Death

Cause of Death

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Maternal First Cousins,
Birth defects or Deceased

Sex

Age

Birth defects/Cause of Death

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Brothers and Sisters

Sex

Age

Health Status

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Deceased siblings

Sex

Age at Death

Cause of Death

_____	_____	_____	_____
_____	_____	_____	_____

Children with previous partners

Sex

Age

Health Status

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Deceased children

Sex

Age

Cause of Death

_____	_____	_____	_____
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How will you describe yourself? ___Caucasian; ___African American; ___Ashkenazi Jewish; ___Hispanic; ___Asian; ___Other (specify_____)

List Genetic Disorders in your Family_____

Would you like to be screened for?

Cystic Fibrosis ___Yes ___No

Sickle Cell Anemia ___Yes ___No

Tay-Sachs Disease ___Yes ___No

Thalasemia ___Yes ___No

Where do/did you work? _____

Describe your educational level_____

Do you have any of the following physical symptoms? (Please check all that apply)

Physical Symptoms	Yes	No	Physical Symptoms	Yes	No
Weight Loss			Cough		
Weight Gain			Shortness of Breath		
Fatigue			Coughing up Blood		
Skin Rashes			Chest Pain		
Change in Height			Wheezing		
Double vision			Palpitations		
Headaches			Swollen Feet		
Dizziness			Calf muscle pain		
Ringing noise in ears					
Hearing Loss			Heat/cold Intolerance		
Nose Bleed			Excessive Sweating		
Sore Throat			Excessive Thirst or Hunger		

Easy Bruising			Poor Appetite		
Swollen Glands			Nausea & Vomiting		
Frequent Infection			Difficulty Swallowing		
Physical Symptoms	Yes	No	Physical Symptoms	Yes	No
Painful Swallowing			Seizures		
Diarrhea			Memory Loss		
Constipation			Fainting spells		
Vomiting Blood			Depression		
Black Tarry Stools			Psychiatric disorders		
Bloody stools					
Heart Burn			Backache		
			Joint Pain or swelling		
Urinating Frequently			Muscle pain		
Difficulty Urinating					
Urgency of Urination			Hot flushes		
Blood in Urine			Sleeplessness		
Pus in urine					
Passing stones in urine			Breast Lump		
Involuntary loss of urine			Breast discharge		

Additional Comments
