



## Women's History

1. Patient Name \_\_\_\_\_ 2. \_\_\_\_\_  
3. Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_<sup>Last</sup> 4. Age \_\_\_\_ 5. Height \_\_\_\_<sup>First</sup> 6. Weight \_\_\_\_ 7. Occupation \_\_\_\_\_

### 8. Medical Problems Please check as many as are appropriate

- |                               |   |
|-------------------------------|---|
| a. never had periods          | i. have never been pregnant                                   |
| b. stopped having periods     | j. have been pregnant before, but not now                     |
| c. irregular periods          | k. can get pregnant, but lose the pregnancy                   |
| d. pelvic pain                | l. have had tubes tied, cut, or burnt, and want them reversed |
| e. bleeding between periods   | m. breast problems (discharge, lumps, or pain)                |
| f. heavy periods (usually so) | n. overweight   |
| g. usually light periods      | o. underweight (according to your relatives or friends)       |
| h. cannot get pregnant        | p. excess hair on face and/or body                            |
|                               | q. other gynecological problems (see below)                   |

9. If you checked q. please give details

---

---

### Other Relevant History Please select any appropriate answers

10. Do you exercise not at all occasionally moderately strenuously and regularly?
11. Do you train strenuously for competitive sports (including dance)? yes no
12. Do you smoke tobacco? use marijuana? drink at least one alcoholic beverage per day?
13. Medications that you are currently taking (including vitamins)
- 
14. List any other physicians you see, along with their specialty
- 
- 
15. List any known allergies
- 
16. Age you first noticed breast development \_\_\_\_\_
17. Age you first noticed pubic hair \_\_\_\_\_
18. Age when you had your first period \_\_\_\_\_
19. Did your mother take hormones when she was pregnant with you? yes no  
If yes, which hormone? \_\_\_\_\_

20. How many days from the beginning of one period to the next (usually)? \_\_\_\_\_
21. Can you tell a period is coming? \_\_\_\_\_ [
22. If yes, how?



- a. breast tenderness                      d. swelling of ankles or wrists
- b. personality changes                      e. headaches
- c. pelvic fullness

23. Do you have    bleeding between periods?    heavy flow, making you weak?    scanty, almost absent flow?

24. Date of last menstrual period (month/date/year) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

25. Typically, how many days between each period? \_\_\_\_\_

2Ā . If periods are irregular, how many months can you go without one? \_\_\_\_\_

2Ī . If you have pain, is it worse            before the period?    during?            or after?

2Ĳ . What medication do you take to help the pain? \_\_\_\_\_ Does it help? \_\_\_\_\_

2J. If your problem is lack of periods, do you have,

- a. hot flashes
- b. vaginal dryness (discomfort with intercourse)
- c. vaginal spotting

H€ Do you take hormones?    yes    no    If yes, which hormones? \_\_\_\_\_

3F. Other comments on your periods, not covered above

3G. Name of regular gynecologist? \_\_\_\_\_

3H. Have you had an abnormal "Pap" smear?                      yes                      no

If yes, was this treated by    biopsy    antibiotics    freezing of cervix    cautery of cervix    other surgery?

3I . Date of last "Pap" smear    \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_    Normal?    yes    no

3Ā . Have you ever had a tubal infection?                      yes                      no

3Ī . If more than once, how many times? \_\_\_\_\_

3Ĳ . Were you treated with antibiotics?                      yes                      no

3ĳ . Were you ever hospitalized for a tubal infection(s)?                      yes                      no

3J. How old were you when you had the infection(s)? \_\_\_\_\_

I€ Have you had gonorrhea?    yes    no    If yes, at what age? \_\_\_\_\_

4F. Have you had syphilis?    yes    no    If yes, at what age? \_\_\_\_\_

## Previous Pregnancies

Please list all, including miscarriages and abortions. List the date of delivery or abortion, the number of months pregnant, select the outcome (vaginal, cesarean section, miscarriage, or voluntary abortion) and whether or not there were postpartum complications, such as infection or fever.

Date	Months	Outcome	Complications
4G. ___ / ___ / ___	4H. _____	4I. _____	4Ā. _____
4Ā. ___ / ___ / ___	4Ī. _____	4Ĳ. _____	4J. _____
4Ĳ. ___ / ___ / ___	5F. _____	5G. _____	5H. _____

5I . Comments, if not able to list above

- 5Í . Pills, if used, were taken
- less than one year
  - 1-2 years
  - 2-5 years
  - greater than five years
- 5Î . Did you have complications attributed to the pill
- irregular or absent periods
  - stroke or heart disease
  - high blood pressure
  - diabetes
  - other \_\_\_\_\_
- 5Ï . IUD, if used, was in place from  
 \_\_\_ / \_\_\_ / \_\_\_ to \_\_\_ / \_\_\_ / \_\_\_ and;  
 \_\_\_ / \_\_\_ / \_\_\_ to \_\_\_ / \_\_\_ / \_\_\_ and;
- 5Ï . Problems with IUD included:
- abnormal bleeding requiring removal of IUD
  - perforation of the uterus, requiring surgery
  - pregnancy with the IUD, carried to term (delivery)
  - infection requiring removal of IUD
  - pregnancy with the IUD with subsequent abortion
  - none
- 5J. Other methods of contraception used include:
- diaphragm
  - condom
  - foam
  - cervical cap
  - rhythm
60. Previous abdominal surgeries (please select any which are appropriate and fill in the date)
- tuboplasty \_\_\_ / \_\_\_ / \_\_\_
  - removal of fibroids \_\_\_ / \_\_\_ / \_\_\_
  - hysterectomy \_\_\_ / \_\_\_ / \_\_\_
  - removal of biopsy of ovary(s) \_\_\_ / \_\_\_ / \_\_\_
  - appendectomy \_\_\_ / \_\_\_ / \_\_\_
  - intestinal surgery \_\_\_ / \_\_\_ / \_\_\_
  - removal of tube \_\_\_ / \_\_\_ / \_\_\_
  - clearing of adhesions (scar tissue) \_\_\_ / \_\_\_ / \_\_\_
  - sterilization by laparoscopy \_\_\_ / \_\_\_ / \_\_\_
  - sterilization by other technique \_\_\_ / \_\_\_ / \_\_\_
61. Other surgery, not listed above \_\_\_\_\_
62. List all medications you take, prescription and non-prescription  
 \_\_\_\_\_  
 \_\_\_\_\_
63. List any significant medical conditions for which you are being treated  
 \_\_\_\_\_  
 \_\_\_\_\_
64. If you have problems with any of the following, please select the appropriate letter
- headache, convulsions, stroke
  - sinus problems, nosebleed, hearing problems
  - difficulty swallowing or talking
  - asthma, TB, coughing blood, pneumonia, chronic cough
  - heart problems, murmurs, irregular heartbeat, rheumatic fever
  - digestion problems, nausea, vomiting, ulcers, jaundice, diarrhea, black bowel movements, constipation
  - kidney infections, bladder infections, kidney stones, blood in your urine
  - loss of urine (incontinence)
  - bone or joint pain (arthritis)
  - skin problems (acne, excess hair)
  - nervous problem (anxiety, depression)
  - easy bruising, bleeding doesn't stop easily
  - diabetes, thyroid problems
65. How many times a week do you have intercourse (on average) \_\_\_\_\_
66. Intercourse is painful \_\_\_\_\_ occasionally \_\_\_\_\_ frequently \_\_\_\_\_ usually \_\_\_\_\_ never \_\_\_\_\_
67. If you have pain, is it: \_\_\_\_\_ in the vagina \_\_\_\_\_ deeper inside, towards the front \_\_\_\_\_ inside, toward the back (near the rectum)
68. The pain has been present \_\_\_\_\_ less than one year \_\_\_\_\_ 1-3 years \_\_\_\_\_ 4-5 years \_\_\_\_\_ greater than 5 years \_\_\_\_\_
69. Have you been treated with medicine or surgery for the pain \_\_\_\_\_ yes \_\_\_\_\_ no \_\_\_\_\_ If yes, with what? \_\_\_\_\_
70. Percent of time you have orgasm with intercourse \_\_\_\_\_ 0% \_\_\_\_\_ 25% \_\_\_\_\_ 50% \_\_\_\_\_ 75% \_\_\_\_\_ greater than 75% \_\_\_\_\_
71. Other issues you wish to discuss \_\_\_\_\_  
 \_\_\_\_\_



## Man's History

1. Patient Name \_\_\_\_\_ 2. \_\_\_\_\_

3. Birthdate \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_<sup>Last</sup> 4. Age \_\_\_\_\_ 5. Height \_\_\_\_\_<sup>First</sup> 6. Weight \_\_\_\_\_ 7. Occupation \_\_\_\_\_

8. Have you father pregnancies (including abortions) before?    yes    no    If yes, age of most recent \_\_\_\_\_

9. Do you have a history of: (select the appropriate letters)

- a. mumps involving the testicles
- b. injury to the testicles
- c. undescended testicle(s)
- d. failures of the testicles to develop normally
- e. abnormality of the penis
- f. sperm count showing decreased motility or abnormal shapes or decreased count
- g. sperm counts showing all dead sperm
- h. sperm counts whoing no sperm at all

10. Have you had a sterilization procedure (vas ligation)    yes    no

11. If yes, how many years ago? \_\_\_\_\_

12. Have you had surgery to have it reversed?    yes    no

13. If yes, did the sperm count return to normal?    yes    no

14. How often does intercourse result in ejaculation?    0%    25%    50%    75%    greater than 75%

15. Do you have physical abnormality which makes ejaculation impossible    yes    no

16. Have you been treated for poor sperm by:

- a. varicocele surgery
- b. clomid
- c. sperm freezing and concentration
- d. hormone injection (HCG)
- e. vitamins or other hormones
- f. using your sperm for artificial insemination

17. Do you use marijuana?    yes    no    If yes,    occasionally    moderately    heavy

18. Alcoholic beverages per day    \_\_\_\_\_    beers    \_\_\_\_\_    glasses of wine    \_\_\_\_\_    shots of hard liquor

19. Do you exercise    not at all    occasionally    moderately    strenuously and regularly?

20. Do you train strenuously for competitive sports (marathons, etc)?    yes    no

21. List any significant medical illnesses for which you have been treated in the last five years

---

---

22. List all drugs taken in the last year \_\_\_\_\_

23. List any chemicals you come into contact with on a regular basis

---

---

