

COLORADO REPRODUCTIVE ENDOCRINOLOGY
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PATIENT HISTORY FORM

PATIENT NAME:

MRN:

PHYSICIAN:

Please answer the following questions to the best of your ability. The information obtained will enable us to provide you with optimal medical care. If you do not know the answer to any questions, you may leave it blank. This form should take about 15-20 minutes to complete. It can be completed on the computer and then printed out or printed out and filled in by hand. To fill this out online, simply use your mouse and click on the grey shaded areas. Clicking on a "check box" will put an "X" in that box or will remove an "X" placed there by mistake. The rectangular grey shaded boxes require you to type in the information. Click on that box and begin typing.

IDENTIFYING INFORMATION

DATE OF VISIT:

Name:

SSN:

Date of birth:

Age:

Marital status: Married Separated Divorced Remarried Single

Phone number: (Home)

(Work)

(Cell)

Home address: Street:

City:

State:

Zip code:

Emergency contact, alternate address and phone number (where we can reach you if any tests come back abnormal or in an emergency, if different than above):

Physician who referred you:

Referring physician's address:

Referring physician's phone #:

Gynecologist's name:

PLEASE DESCRIBE AS THOROUGHLY AS POSSIBLE YOUR PRESENT PROBLEM:

MENSTRUAL HISTORY

Age at first period:

When did your **most** recent period begin?

Are your periods regular?

Yes No

If No, how many times per year do you have your period?

Have you ever gone more than 3 months without a period (except for pregnancy)?

Yes No

If Yes, list approximate dates:

How long is your entire menstrual cycle (i.e. from the beginning of one period to the beginning of the next)?

How many days do you usually bleed during your period? Days of bleeding:

Days of spotting:

How many pads or tampons do you use on your heaviest day?

Do you have cramps or pain before, during, or after your period?

Yes No

Are your cramps: Mild Moderate Severe

Do you have to take pain medication for cramps?

Yes No

What pain medication do you take?

Do you have premenstrual symptoms such as breast tenderness, bloating, etc. that let you know your period is due?

Yes No

Have you noticed a change in your periods recently?

Yes No

Do you bleed or spot between periods or after intercourse?

Yes No

Have other members of your family had difficulty with conception or pregnancy? Unknown Yes No

CONTRACEPTIVE/SEXUAL/MARITAL HISTORY

Are you currently trying to get pregnant?

Yes No

If Yes, how long have you tried to conceive?

Years

Months

What form of contraceptive have you used in the past? (check all that apply)

- None
- Foam/jellies
- Birth control pills
- Mucous check
- Birth control patches
- IUD

- Sponge
- Rhythm
- Withdrawal
- Tubal ligation
- Diaphragm
- Condom

- Norplant/implants
- Depo Provera injection
- Male sterilization (vasectomy)
- Other:

Have you ever have problems using birth control (i.e., high blood pressure, allergy to condoms, etc.)? Yes No

What was the problem?

How often did you and your partner have sexual relations during the past month? _____ times

Have you ever had unprotected intercourse (for more than 6months) with another partner and failed to achieve pregnancy? Yes No

How many sexual partners have you had in the past 2 years?
 none 1 2 fewer than 5 fewer than 10 greater than 10

Is your sexual partner male or female?

Do you notice any pain with intercourse? Yes No

Do you use lubricants for intercourse? Yes No

Have you had changes in your libido? Yes No

Have you ever had a sexually transmitted disease or pelvic inflammatory disease? Yes No

Please check which one: Herpes Chlamydia Gonorrhea HPV Other

Do you have regular gynecologic exams? Yes No

Date of last PAP smear: _____ Was this PAP smear normal? Yes No

Have you ever had an abnormal PAP smear? Yes No

If yes, did have: coloposcopy LEEP cone biopsy Other

Do you have any pain you wish to discuss with your doctor? Yes No

Where is the pain?

PREGNANCY HISTORY

How many times have you been pregnant (including miscarriages and abortions)?

of term deliveries: _____ # of premature deliveries: _____ # of miscarriages: _____
 # of ectopic (tubal) pregnancies: _____ # of abortions: _____

PLEASE COMPLETE THE FOLLOWING CHART:

	YEAR	OUTCOME (SEE CHOICES BELOW*)	WAS INFERTILITY THERAPY NEEDED	HOW LONG TO CONCEIVE	IS THE CURRENT OR PAST PARTNER THE FATHER OF THE CHILD?	SEX	WEIGHT
1 st Pregnancy			<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ months	<input type="checkbox"/> Current <input type="checkbox"/> Past	<input type="checkbox"/> M <input type="checkbox"/> F	lb. _____ oz.
2 nd Pregnancy			<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ months	<input type="checkbox"/> Current <input type="checkbox"/> Past	<input type="checkbox"/> M <input type="checkbox"/> F	lb. _____ oz.
3 rd Pregnancy			<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ months	<input type="checkbox"/> Current <input type="checkbox"/> Past	<input type="checkbox"/> M <input type="checkbox"/> F	lb. _____ oz.
4 th Pregnancy			<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ months	<input type="checkbox"/> Current <input type="checkbox"/> Past	<input type="checkbox"/> M <input type="checkbox"/> F	lb. _____ oz.

*VAGINAL DELIVERY (V), C-SECTION (CS), MISCARRIAGE (M), ABORTION (A), ECTOPIC PREGNANCY (EP)

Were there any complications during or after your pregnancies? Yes No

If Yes, explain (i.e., preterm labor, bleeding, gestational diabetes, high blood pressure):

HISTORY OF FERTILITY TESTING AND THERAPY

If applicable, check all of the following medications that you have taken in the past in an attempt to conceive:

Clomiphene Citrate (Serophene, Clomid)
How many cycles?

Progesterone suppositories/oral progesterone/progesterone injection

Gonadotropin Injections (Pergonal, Humegon, Repronex, Follistim, Gonal-F, Bravelle)
How many cycles?

Other:

Bromocriptine (Parlodel)

Never utilized fertility therapy

Have you had any of the following tests performed (check all that apply):

PROCEDURE	DATE	RESULTS
<input type="checkbox"/> Husband semen analysis		
<input type="checkbox"/> Temperature charts		
<input type="checkbox"/> Clomid Challenge Test		
<input type="checkbox"/> Postcoital tests		
<input type="checkbox"/> Endometrial biopsy		
<input type="checkbox"/> X-ray of tubes (Hysterosalpingogram, HSG)		
<input type="checkbox"/> Laparoscopy		
<input type="checkbox"/> Hysteroscopy		
<input type="checkbox"/> Day 3 FSH/estradiol level		
<input type="checkbox"/> Blood tests		
<input type="checkbox"/> Chromosomal analysis		

VAGINAL SYMPTOMS

Have you had problems with vaginal dryness or irritation? Yes No
 Have you noticed a vaginal discharge recently? Yes No
 Do you have frequent or recurrent vaginal infections? Yes No

MEDICAL HISTORY

Height: Weight: Blood type (if known):

Do you have any allergies to medications? Yes No

If Yes, list:

Within the last year, have you taken any prescription medications? Yes No

If Yes, list all the medications and problems for which you were taking them.

MEDICATION	DOSAGE	DATE STARTED	DATE STOPPED

Are you taking any non-prescription medications on a regular basis (including medicines such as aspirin, Tylenol, ibuprofen, water pills, laxatives, herbal medications, dietary supplements, vitamins, etc.)? Yes No

If Yes, please list name of medication and dose.

MEDICATION	DOSAGE

SURGICAL HISTORY

Have you ever had surgery? Yes No

If Yes, specify year, type of surgery performed, and location of surgery:

YEAR	TYPE OF SURGERY	HOSPITAL/CITY

Have you ever been hospitalized for something other than childbirth or surgery? Yes No

If Yes, specify the reason for admission.

DATE (MONTH/YEAR)	REASON FOR ADMISSION	HOSPITAL/CITY

FEMALE PARTNER'S FAMILY HISTORY

Is there a family history of: (check all that apply)

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Diabetes/sugar | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Breast cancer | <input type="checkbox"/> Colon cancer | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Prostate cancer | <input type="checkbox"/> Hypertension/high blood pressure | <input type="checkbox"/> Excessive hair growth | |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Ovarian cancer | <input type="checkbox"/> Osteoporosis/bone fractures | |

Is there a family history of hereditary disorders (in yourself, your parents, or your children): (check all that apply)

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Chromosomal defects | <input type="checkbox"/> Neural tube defects (open spine) | <input type="checkbox"/> Cystic fibrosis | <input type="checkbox"/> Muscular dystrophy |
| <input type="checkbox"/> Tay Sach's disease | <input type="checkbox"/> Extra fingers/toes | <input type="checkbox"/> Recurrent miscarriages | <input type="checkbox"/> Huntington's chorea |
| <input type="checkbox"/> Sickle cell disease | <input type="checkbox"/> Down syndrome | <input type="checkbox"/> Hearing defects | <input type="checkbox"/> Other birth defects: |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Mental retardation | <input type="checkbox"/> Cleft lip/palate | |

SOCIAL AND DIETARY HISTORY

(Your answers to the below questions are confidential.)

Do you use or have you ever used: (check all that apply)

Alcohol Yes No

How many glasses per week do you usually drink? Wine: Beer: Cocktails:

Cigarettes Yes No

Number of cigarettes per day: Number of years you have smoked:

Caffeine Yes No Number of cups per day you drink now:

Are you currently employed? Yes No

If Yes, what type of work do you do?

In your current or previous employment, have you ever been exposed to toxins, chemicals or radiation? Yes No

Have you used illicit or recreational drugs in the last year? Yes No

Has your weight changed more than 15 lbs. in the last year? Yes No

Do you follow a particular food diet? Yes No

If Yes, specify (i.e., vegetarian, low salt, low cholesterol):

Do you feel that you eat a well-balanced diet? Yes No

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

List the forms and frequency of regular vigorous exercise (swimming, cycling, running; if you do not exercise on a regular basis, check "none"): None

Do you often feel sad, depressed, or irritable? Yes No

Do you have difficulty sleeping? Yes No

REVIEW OF SYSTEMS	
DO YOU HAVE OR HAVE YOU EVER HAD: (check all that apply)	
NEUROLOGICAL PROBLEMS: <input type="checkbox"/> Seizure <input type="checkbox"/> Migraines or frequent headaches <input type="checkbox"/> Stroke <input type="checkbox"/> Paralysis <input type="checkbox"/> Other:	HORMONE PROBLEMS: <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid disease <input type="checkbox"/> Excessive hair growth or hair loss <input type="checkbox"/> Rapid weight gain or loss <input type="checkbox"/> Excessive hunger or thirst <input type="checkbox"/> Hot flashes or unexplained cold spells <input type="checkbox"/> Other:

EYE/EAR/NOSE/THROAT PROBLEMS: <input type="checkbox"/> Eye disorders <input type="checkbox"/> Blurry or double vision <input type="checkbox"/> Problem with the sense of smell <input type="checkbox"/> Hearing problems <input type="checkbox"/> Ringing in the ears <input type="checkbox"/> Other:	MUSCLE OR BONE PROBLEMS: <input type="checkbox"/> Unusual muscle weakness <input type="checkbox"/> Muscle aches/joint pain <input type="checkbox"/> Decreased stamina <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Lupus erythematosus <input type="checkbox"/> Other:
HEART OR BLOOD VESSEL PROBLEMS: <input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Heart valve disorders <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmur <input type="checkbox"/> Other:	STOMACH OR INTESTINAL PROBLEMS: <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Blood/mucus in stool/rectal bleeding <input type="checkbox"/> Liver disease/hepatitis/jaundice <input type="checkbox"/> Unusual amounts of constipation or diarrhea <input type="checkbox"/> Gastric or intestinal ulcers <input type="checkbox"/> Gallbladder disease <input type="checkbox"/> Spastic colon/ulcerative colitis <input type="checkbox"/> Hernia <input type="checkbox"/> Other:
LUNG/BREATHING PROBLEMS <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Tuberculosis/TB exposure <input type="checkbox"/> Cough producing blood <input type="checkbox"/> Other:	BLOOD DISORDERS: <input type="checkbox"/> Blood clotting disorder <input type="checkbox"/> Anemia/blood disorder <input type="checkbox"/> Sickle cell trait or disease <input type="checkbox"/> Thrombophlebitis <input type="checkbox"/> Blood transfusion <input type="checkbox"/> AIDS/HIV infection <input type="checkbox"/> Other:
PELVIC OR URINARY PROBLEMS: <input type="checkbox"/> Bladder infections <input type="checkbox"/> Kidney infections <input type="checkbox"/> Vaginal infections <input type="checkbox"/> Frequent or painful urination <input type="checkbox"/> Endometriosis <input type="checkbox"/> Ovarian cysts <input type="checkbox"/> Chlamydia/gonorrhea/venereal disease/PID <input type="checkbox"/> Syphilis/herpes <input type="checkbox"/> Genital warts/HPV <input type="checkbox"/> Other:	SKIN <input type="checkbox"/> Unexplained rashes <input type="checkbox"/> Acne <input type="checkbox"/> Skin cancer <input type="checkbox"/> Burns/injuries <input type="checkbox"/> Dermatitis/infections <input type="checkbox"/> Other:
MENTAL HEALTH <input type="checkbox"/> Depression <input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Anxiety disorder <input type="checkbox"/> Hospitalizations for mental illness <input type="checkbox"/> Other:	ALLERGIC/AUTOIMMUNE <input type="checkbox"/> Autoimmune diseases <input type="checkbox"/> Hay fever/allergic rhinitis <input type="checkbox"/> Shellfish allergy <input type="checkbox"/> Other:
OTHER <input type="checkbox"/> Cancer <input type="checkbox"/> Other:	<input type="checkbox"/> NONE OF THE ABOVE

PARTNER'S HISTORY

Please have your partner complete these questions.

PARTNER'S IDENTIFYING INFORMATION

Name: _____ SSN: _____
Date of birth: _____ Age: _____
Do you get exposed to toxins or radiation at your job? Yes No

MEDICAL HISTORY

Weight: _____ Height: _____ Blood type (if known): _____
Allergies:
Do you have any medical problems? Yes No
If Yes, list: _____

Have you ever had surgery?

Yes No

If Yes, specify year, type of surgery, and location of surgery:

YEAR	TYPE OF SURGERY	HOSPITAL/CITY

Have you ever had x-rays of the pelvic area?

Yes No

If Yes, explain:

Your occupation:

Are you or have you been exposed to any of the following during recreation, employment, or military service?

- Extreme heat (since trying to conceive)
 Toxic fumes
 Sauna/steam baths/hot tubs (since trying to conceive)
 Chemicals
 Nuclear radiation

Have you ever been diagnosed with a sexually transmitted disease?

Yes No

Please check which one: Herpes Chlamydia Gonorrhea HPV Other

Within the last year, have you taken any prescription medications?

Yes No

If Yes, list all prescriptions and problems for which you were taking them:

MEDICATION	DOSAGE	DATE STARTED	REASON FOR TAKING

Are you taking any nonprescription medications on a regular basis?

Yes No

(including medicines such as aspirin, Tylenol, laxatives, etc.)

If Yes, list all medications:

Do you use or have you ever used: (check all that apply)

- Alcohol How many glasses per week do you usually drink? Wine: Beer: Cocktails:
 Cigarettes Number of cigarettes per day: Number of years you have smoked:
 Caffeine Number of cups per day:
 Illicit or recreational drugs (marijuana, cocaine, etc.) since trying to conceive

Have you ever been treated for cancer?

Yes No

If Yes, explain:

Have you had a high fever (over 102°F) during the past three months?

Yes No

PARTNER'S FAMILY HISTORY

Is there a family history of infertility?

Is there a family history of hereditary disorders (in yourself, your parents, your partner, or your children): (check all that apply)

- Chromosomal defects
 Neural tube defects (open spine)
 Cystic fibrosis
 Muscular dystrophy
 Tay Sach's disease
 Extra fingers/toes
 Recurrent miscarriages
 Huntington's chorea
 Sickle cell disease
 Down syndrome
 Hearing defects
 Other birth defects:
 Bleeding disorders
 Mental retardation
 Cleft lip/palate

If your partner is male, please fill out this section too:

SEXUAL HISTORY

When you were a child, were both testes descended into the scrotum?

Yes No

How many times have you been married?

How many pregnancies have you produced with your current partner? Yes No
 Have you ever produced a pregnancy with another partner? Yes No
 If Yes, how long did it take to conceive?
 Did that pregnancy result in: child miscarriage abortion
 Did you ever have infertility or difficulty conceiving with a previous partner? Yes No
 Do you have trouble getting an erection? Yes No
 Do you have trouble maintaining an erection? Yes No
 Do you have any discharge from the penis? Yes No
 Have you ever had any rashes or sores on your penis? Yes No
 Have you noticed a change in your sexual drive recently? Yes No

HISTORY OF FERTILITY THERAPY

Have you ever been treated for urological problems or infertility before? Yes No
 If Yes, who was your physician?
 What problem was diagnosed?
 Have you taken any of these drugs in the past? (check all that apply)
 Clomiphene citrate hCG (Profasi, APL) Bromocriptine
 hMG (Pergonal) Fluoxymesterone (Halotestin) Urofollitropin/FSH/Metrodin
 Tamoxifen GnRH or LHRH (Factrel) None
 Testolactone Testosterone or male hormones

Have you ever had varicocele repair? Yes No
 Have you ever had a vasectomy, vasectomy reversal or repair? Yes No

Which of the following tests have you had performed? (check all that apply)
 Semen analysis Chromosome tests Hamster egg test
 Chlamydia test Testicular biopsy Thyroid tests
 Mycoplasma test X-ray or ultrasound of testes Other:
 Sperm antibody test Hormonal tests

OTHER ISSUES YOU OR YOUR PARTNER WISH TO ADDRESS WITH YOUR PHYSICIAN: