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: Date of birth: Age:
Marital status: ☐ Married ☐ Separated ☐ Divorced ☐ Remarried ☐ Committed Relationship ☐ 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 phone #:

Gynecologist's name (if different from referring doctor):

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?
How long is your entire cycle (i.e. from the first day of one period to the first day of the next period)?
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 or patches
☐ Mucous check
☐ Condom
☐ IUD
☐ Rhythm
☐ Withdrawal
☐ Tubal ligation
☐ Diaphragm
☐ Norplant/implants
☐ Depo Provera injection
☐ Male sterilization (vasectomy)
☐ Other:

Have you ever had 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 sex drive? ☐ 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 you have: ☐ colposcopy ☐ LEEP ☐ cone biopsy ☐ Freezing (cryosurgery) ☐ 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 full-term deliveries: # of premature deliveries: # of miscarriages:

# of ectopic (tubal) pregnancies: # of abortions:

PLEASE COMPLETE THE FOLLOWING CHART:

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

	YEAR	OUTCOME (SEE CHOICES ABOVE*)	WAS INFERTILITY THERAPY NEEDED	HOW LONG TO CONCEIVE	IS THE CURRENT OR PAST PARTNER THE FATHER OF THE CHILD?	SEX OF CHILD	WEIGHT OF CHILD AT BIRTH
1st Pregnancy			☐ Yes ☐ No	months	☐ Current ☐ Past	☐ M ☐ F	lb. oz.
2nd Pregnancy			☐ Yes ☐ No	months	☐ Current ☐ Past	☐ M ☐ F	lb. oz
3rd Pregnancy			☐ Yes ☐ No	months	☐ Current ☐ Past	☐ M ☐ F	lb. oz.
4th Pregnancy			☐ Yes ☐ No	months	☐ Current ☐ Past	☐ M ☐ F	lb. oz.

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?

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

☐ Bromocriptine (Parlodel)

☐ Progesterone suppositories/oral progesterone/progesterone injection

☐ Other:

☐ Never utilized fertility therapy

MEDICAL HISTORY

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)

☐ Infertility
☐ Endometriosis
☐ Sickle cell disease
☐ Tay Sach's disease
☐ Muscular dystrophy
☐ Huntington's chorea
☐ Cystic fibrosis
☐ Breast cancer
☐ Chromosome defects
☐ Ovarian cancer
☐ Neural tube defects (open spine)
☐ Cleft lip/palate
☐ Diabetes/sugar
☐ Recurrent miscarriages
☐ Excessive hair growth
☐ Bleeding disorders
☐ Cystic fibrosis
☐ Hearing defects
☐ Mental retardation
☐ Other birth defects:
☐ Other:

SOCIAL AND DIETARY HISTORY

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

PARTNER'S HISTORY

If you are seeing the doctor for fertility, please have your partner complete these questions.

PARTNER'S IDENTIFYING INFORMATION

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

MEDICAL HISTORY

Weight: Height: Blood type (if known):

Allergies (medications and environmental):

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:

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

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:

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?

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
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
☐ hMG (Pergonal)
☐ Tamoxifen
☐ Testolactone
☐ hCG (Profasi, APL)
☐ Fluoxymesterone (Halotestin)
☐ GnRH or LHRH (Factrel)
☐ Testosterone or male hormones
☐ Bromocriptine
☐ Urofollitropin/FSH/Metrodin
☐ None

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