# PATIENT INTAKE HISTORY

| PATIENT INFORMATION | PARTNER'S INFORMATION |
|---|---|
| NAME: _____ | NAME: _____ |
| ADDRESS:_____<br>_____ | ADDRESS:_____<br>_____ |
| DATE OF BIRTH: _____/_____/_____ | DATE OF BIRTH: _____/_____/_____ |
| HOME #: ( ) _____<br>**IS IT OKAY TO LEAVE A MESSAGE? ☐YES ☐ NO** | HOME #: ( ) _____<br>**IS IT OKAY TO LEAVE A MESSAGE? ☐YES ☐ NO** |
| WORK #: ( ) _____<br>**MAY WE CONTACT YOU AT WORK? ☐ YES ☐ NO**<br>**IS IT OKAY TO LEAVE A MESSAGE? ☐ YES ☐ NO** | WORK #: ( ) _____<br>**MAY WE CONTACT YOU AT WORK? ☐ YES ☐ NO**<br>**IS IT OKAY TO LEAVE A MESSAGE? ☐ YES ☐ NO** |
| MOBILE # ( ) _____<br>**IS IT OKAY TO LEAVE A MESSAGE? ☐YES ☐ NO** | MOBILE # ( ) _____<br>**IS IT OKAY TO LEAVE A MESSAGE? ☐YES ☐ NO** |
| EMPLOYER: _____ | EMPLOYER: _____ |
| *PLEASE ANSWER & SIGN:*<br>**MAY WE DISCUSS YOUR TEST RESULTS WITH YOUR PARTNER/SPOUSE?**<br>☐YES ☐NO<br>SIGNATURE:_____ | *PLEASE ANSWER & SIGN:*<br>**MAY WE DISCUSS YOUR TEST RESULTS WITH YOUR PARTNER/SPOUSE?**<br>☐ YES ☐ NO<br>SIGNATURE:_____ |
| REFERRING PHYSICIAN: | |
| WHO WILL BE MANAGING YOUR PREGNANCY? | |
| PREFERRED PHARMACY: | |
| E-MAIL ADDRESS: | |

IF YOU OR YOUR PARTNER IDENTIFY AS A GENDER OTHER THAN THE GENDER ASSIGNED AT BIRTH, PLEASE EXPLAIN AND LIST YOUR PREFERRED NAME AND PRONOUNS:

WHAT ARE YOUR GOALS FOR OUR FIRST VISIT?

# PATIENT INTAKE HISTORY (Continued)

| PATIENT NAME: | DATE: |
|---|---|

**If you are uncomfortable answering any questions, please leave them blank; you can discuss them with your provider**

## SECTION 1. PERSONAL PAST HISTORY OF ILLNESSES

| MAJOR ILLNESSES | YES (DATE) | NO | NOTES |
|---|---|---|---|
| ASTHMA | | | |
| PNEUMONIA/LUNG DISEASE | | | |
| HEART ATTACK/ HEART PROBLEMS | | | |
| HIGH BLOOD PRESSURE | | | |
| STROKE | | | |
| BLOOD CLOTS IN LUNGS OR LEGS | | | |
| HIV/AIDS | | | |
| THYROID DISEASE | | | |
| DIABETES | | | |
| EATING DISORDERS | | | |
| DEPRESSION/ANXIETY | | | |
| ARTHRITIS/JOINT PAIN/BACK PROBLEMS | | | |
| COLLAGEN VASCULAR DISEASE (LUPUS) | | | |
| CANCER | | | |
| HEPATITIS/JAUNDICE/LIVER DISEASE | | | |
| COLITIS/CROHN'S DISEASE | | | |
| ANEMIA | | | |
| BLOOD TRANSFUSIONS | | | |
| BLEEDING DISORDERS | | | |
| MIGRAINE HEADACHES | | | |
| SEIZURES/CONVULSIONS/EPILEPSY | | | |
| CHICKENPOX/SHINGLES/VARICELLA VACINATION | | | |
| OTHER | | | |

## SECTION 2. OPERATIONS/HOSPITALIZATIONS – IF NONE CHECK HERE - ☐

| SURGERY/REASON | DATE OR YEAR | HOSPITAL |
|---|---|---|
| | | |
| | | |
| | | |

# PATIENT INTAKE HISTORY (Continued)

| PATIENT NAME: | DATE: |
|---|---|

## SECTION 3. FAMILY HISTORY

**If a family member has an illness, please check the box and list their age at diagnosis**

| ILLNESS | Mother | Father | Brother | Sister | Child | Maternal Grandmother | Maternal Grandfather | Paternal Grandmother | Paternal Grandfather |
|---|---|---|---|---|---|---|---|---|---|
| BREAST CANCER | | | | | | | | | |
| COLON CANCER | | | | | | | | | |
| DIABETES | | | | | | | | | |
| HYPERTENSION | | | | | | | | | |
| OVARAIN CANCER | | | | | | | | | |
| HIGH CHOLESTEROL | | | | | | | | | |
| RECURRENT MISCARRIAGE | | | | | | | | | |
| STROKE | | | | | | | | | |
| GENETIC DISORDER | | | | | | | | | |
| BIRTH DEFECTS | | | | | | | | | |
| BLOOD CLOTS IN LUNGS OR LEGS | | | | | | | | | |
| DECEASED | | | | | | | | | |
| OTHER | | | | | | | | | |

## SECTION 4. SOCIAL HISTORY

| | NOTES |
|---|---|
| EVER SMOKE? ☐ YES ☐ NO | |
| IF YOU ARE CURRENTLY SMOKING: PACKS PER DAY: HOW MANY YEARS: | |
| IF YOU ARE CURRENTLY SMOKING, ARE YOU READY TO QUIT? ☐ YES ☐ NO | |
| ALCOHOL: DRINKS PER DAY: DRINKS PER WEEK: | |
| RECREATIONAL DRUG USE? ☐ YES ☐ NO | |
| HAVE YOU BEEN SEXUALLY ABUSED, THREATENED, OR HURT BY ANYONE? ☐ YES ☐ NO | |
| OCCUPATION/JOB: | |

## SECTION 5. OBSTETRIC HISTORY – If no pregnancies please check here - ☐

| # | DATE (Month/Year) | WEEKS PREGNANT | OUTCOME (MISCARRIAGE, ECTOPIC PREGNANCY, TERMINATION, STILLBIRTH, VAGINAL DELIVERY, CESAREAN SECTION) | IF THE PREGNANCY RESULTED IN A BIRTH, PLEASE LIST THE CHILD'S SEX AND BIRTH WEIGHT | COMPLICATIONS |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |
| 4 | | | | | |
| 5 | | | | | |
| 6 | | | | | |

# PATIENT INTAKE HISTORY (Continued)

| PATIENT NAME: | DATE: |
|---|---|

## SECTION 6. GYNECOLOGIC HISTORY

| | NOTES | | |
|---|---|---|---|
| AGE AT FIRST PERIOD: | | | |
| HOW OFTEN DO YOU GET PERIODS? | | | |
| LENGTH OF YOUR PERIOD (NUMBER OF DAYS OF BLEEDING): | | | |
| | **YES** | **NO** | **NOTES** |
| ANY RECENT CHANGES IN YOUR PERIODS? | ☐ | ☐ | |
| ARE YOUR PERIODS HEAVY? | ☐ | ☐ | |
| DO YOU BLEED BETWEEN PERIODS? | ☐ | ☐ | |
| DO YOU BLEED AFTER INTERCOURSE? | ☐ | ☐ | |
| DO YOU HAVE PAINFUL PERIODS? | ☐ | ☐ | |
| | | | |
| DATE OF YOUR LAST PAP TEST (YEAR ALONE IS OK): | ☐ | ☐ | |
| WAS IT NORMAL? | ☐ | ☐ | |
| HAVE YOU EVER HAD AN ABNORMAL PAP TEST? | ☐ | ☐ | |
| | | | |
| HAVE YOU HAD A SEXUALLY TRANSMITTED DISEASE? | ☐ | ☐ | |
| HAVE YOU HAD PELVIC INFLAMMATORY DISEASE (PID)? | ☐ | ☐ | |
| | | | |
| DO YOU HAVE ENDOMETRIOSIS? | ☐ | ☐ | |
| DO YOU HAVE FIBROIDS? | ☐ | ☐ | |
| DO YOU HAVE PAIN WITH INTERCOURSE? | ☐ | ☐ | |
| ESTIMATE OF SEXUAL FREQUENCY? | | | |
| | | | |
| HAS YOUR WEIGHT CHANGED? | ☐ | ☐ | |
| DO YOU HAVE EXCESS HAIR GROWTH? | ☐ | ☐ | |
| DO YOU HAVE ACNE? | ☐ | ☐ | |
| DO YOU HAVE NIPPLE DISCHARGE? | ☐ | ☐ | |
| DO YOU HAVE HOT FLASHES? | ☐ | ☐ | |

## SECTION 7. CURRENT MEDICATIONS – If none please check here - ☐
**(Including hormones, vitamins, herbs, nonprescription medications)**

| CURRENT MEDICATIONS | DOSAGE | WHO PRESCRIBES |
|---|---|---|
| | | |
| | | |
| | | |

## SECTION 8. MEDICATION ALLERGIES or OTHER ALLERGIES – If none please check here - ☐

# PATIENT INTAKE HISTORY (Continued)

| PATIENT NAME: | DATE: |
|---|---|

| ALLERGY | TYPE OF REACTION |
|---|---|
| | |
| | |
| | |

## SECTION 9. PERSONAL PROFILE

| |
|---|
| ETHNICITY: ☐ CAUCASIAN ☐ ASHKENAZI JEWISH ☐ AFRICIAN AMERICAN ☐ ASIAN ☐ HISPANIC ☐ MEDITERRANEAN ☐ FRENCH CANADIA/CAJUN ☐ OTHER: |
| MARITAL STATUS: ☐ MARRIED ☐ LIVING WITH PARTNER ☐ SINGLE ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED |

## SECTION 10. INFERTILITY HISTORY

IF YOU ARE EXPERIENCING INFERTILITY, HOW LONG HAVE YOU BEEN TRYING TO BECOME PREGNANT?

| | DATE | LOCATION | NOTES |
|---|---|---|---|
| HYSTEROSALPINGOGRAM? | | | |
| SALINE SONOHYSTEROGRAM? | | | |
| LAPAROSCOPY? | | | |
| SEMEN ANALYSIS? | | | |
| HORMONAL STUDIES? | | | |
| CLOMID? | | | |
| LETROZOLE? | | | |
| GONADOTROPINS? (“injectables”) | | | |
| INTRAUTERINE INSEMINATION | | | |
| IN VITRO FERTILIZATION | | | |
| OTHER | | | |

## SECTION 11: MALE PARTNER HISTORY (if applicable):

| |
|---|
| **NAME:** |
| **DATE OF BIRTH:** |
| **OCCUPATION/JOB:** |
| **ETHNICITY:** ☐ CAUCASIAN ☐ ASHKENAZI JEWISH ☐ AFRICIAN AMERICAN ☐ ASIAN ☐ HISPANIC ☐ MEDITERRANEAN ☐ FRENCH CANADIA/CAJUN ☐ OTHER: |

| | YES | NO | NOTES |
|---|---|---|---|
| DO YOU HAVE CHILDREN? | ☐ | ☐ | |
| EVER SEEN A UROLOGIST? | ☐ | ☐ | |
| WERE YOU BORN WITH UNDESCENDED TESTICLES? | ☐ | ☐ | |
| DID PUBERTY OCCUR AT A NORMAL AGE AS A TEENAGER? | ☐ | ☐ | |
| EVER DIAGNOSED WITH CHLAMYDIA OR GONORRHEA? | ☐ | ☐ | |
| EVER EXPOSED TO SIGNIFICANT RADIATION? | ☐ | ☐ | |
| EVER EXPOSED TO SIGNIFICANT PESTICIDE OR TOXIC SOLVENTS? | ☐ | ☐ | |
| EVER TAKE BODY BUILDING MEDICATIONS OR SUPPLEMENTS? | ☐ | ☐ | |

# PATIENT INTAKE HISTORY (Continued)

| PATIENT NAME: | DATE: |
|---|---|

| | | | |
|---|---|---|---|
| EVER SMOKE? | ☐ | ☐ | |
| IF YOU ARE CURRENTLY SMOKING: PACKS PER DAY: HOW MANY YEARS? | ☐ | ☐ | |
| IF YOU ARE CURRENTLY SMOKING, ARE YOU READY TO QUIT? | ☐ | ☐ | |
| ALCOHOL: DRINKS PER DAY: DRINKS PER WEEK: | | | |
| EVER USE RECREATIONAL DRUGS? | ☐ | ☐ | |

**SECTION 12. MALE PARTNER MEDICATIONS – If none please check - ☐**
**(Including vitamins, herbs, nonprescription medications)**

| CURRENT MEDICATIONS | DOSAGE | WHO PRESCRIBES |
|---|---|---|
| | | |
| | | |

**SECTION 13. MALE PARTNER MEDICATION ALLERGIES or OTHER ALLERGIES – If none please check here - ☐**

| ALLERGY | TYPE OF REACTION |
|---|---|
| | |
| | |

**SECTION 14. MALE PARTNER OPERATIONS/HOSPITALIZATIONS – IF NONE CHECK HERE - ☐**

| SURGERY/REASON | DATE OR YEAR | HOSPITAL |
|---|---|---|
| | | |
| | | |

**SECTION 15. PARTNER FAMILY HISTORY**

| ILLNESS | Mother | Father | Brother | Sister | Child | Maternal Grandmother | Maternal Grandfather | Paternal Grandmother | Paternal Grandfather |
|---|---|---|---|---|---|---|---|---|---|
| INFERTILITY | | | | | | | | | |
| BIRTH DEFECTS | | | | | | | | | |
| GENETIC DISORDER | | | | | | | | | |

**YOUR FORM IS COMPLETE. THANK YOU.**