CFA
COLUMBIA FERTILITY ASSOCIATES

NEW PATIENT HEALTH HISTORY FORM
(Please only answer applicable questions)

Provider you will be seeing: _____ Date of visit: _____

Provider/Person who referred you to our practice: _____

Legal Name: _____
Last Name First Middle

Name you wish to be called:_____

Age: _____ **Date of Birth:** _____

First Day of Last Menstrual Period (if applicable): _____

Allergies (medication, latex, food, environmental): _____

Partner/Spouse's Name (if applicable): _____
Last Name First Middle

Age: _____ Date of Birth: _____ Date of Marriage (if applicable): _____

REASON FOR VISIT: Please describe what you would like to address in your visit today. If applicable, please include a brief history of your symptoms and whether they have changed in over time:

_____

_____

_____

_____

_____

_____

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MENSTRUAL AND GENITOURINARY HISTORY

At what age did you begin to menstruate? _____

What was the first day of your two most recent menstrual periods? _____

Are your periods regular or irregular? (circle one)

If irregular, please describe: _____

How many days are between the first day of one period and the first day of the next period? _____

Have you ever gone more than 2 months without a period? O Yes O No When? _____

How long does your menstrual flow last? _____days

Do you consider your flow to be excessive? O Yes O No

If yes, how often do you have to change menstrual products?_____

Do you take medication to alleviate cramping? O Yes O No If yes, what do you take?_____

Do you have bleeding between your periods O Yes O No

If yes, please describe: _____

Do you have any concerns about vaginal discharge? O Yes O No

If yes, please describe (color, consistency, odor, itching, etc.): _____

Do you have a history of frequent UTIs, bacterial vaginosis, or yeast infections? O Yes O No

If yes, please explain: _____

HEALTH MAINTENANCE HISTORY

Date of HPV vaccine: _____ O Never done

Date of last PAP smear: _____ Result (normal/abnormal): _____

Have you ever had an abnormal PAP smear? O Yes O No

If yes, what treatment did you receive? (freezing, laser, surgery) _____

Date of last mammogram: _____ Result: _____

Have you ever had an abnormal mammogram? O Yes O No

SEXUAL HISTORY

How many people have you engaged with sexually in the last month?_____

How many people have you engaged with sexually in the last 6 months?_____

When was your last STI testing completed? _____

Have you been diagnosed and/or treated for any of the following?

Chlamydia	o Yes o No Date: _____	Gonorrhea	o Yes o No Date: _____
Trichomonas	o Yes o No Date: _____	Herpes	o Yes o No Date: _____
Genital warts	o Yes o No Date: _____	Syphilis	o Yes o No Date: _____
Hepatitis B	o Yes o No Date: _____	Hepatitis C	o Yes o No Date: _____
HIV	o Yes o No Date: _____	Pelvic inflammatory disease	o Yes o No

Do you use anything for STD protection (condoms, dental dams, etc.) ? If so, what?_____

Do you bleed during or after penetrative intercourse (if applicable)? o Yes o No o N/A

Do you have any pain during or after penetrative intercourse (if applicable)? o Yes o No o N/A

Do you have difficulty achieving orgasm? o Yes o No o N/A

Do you have any concerns about your libido or sex drive? o Yes o No

CONTRACEPTIVE HISTORY

Please check any of the following methods of contraception you are currently using or have used, even if used for something other than prevention of pregnancy.

o Never used any of these forms of contraception (continue on to next section)

Methods		**Dates of Usage**
o Birth Control Pills	Type: _____	_____
o IUD	Type:_____	_____
o Depo-Provera injection		_____
o Diaphragm w/ spermicide		_____
o Condoms (external or internal)		_____
o Tubal ligation/tying tubes		_____
o Vasectomy		_____

Other: _____

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OBSTETRICAL HISTORY

Do you currently want to become pregnant? o Yes o No
Do you have plans for pregnancy in the future? o Yes o No o Unsure
Do you currently want to avoid pregnancy? o Yes o No

Total Times Pregnant: _____ # of Term Births: _____ # of Premature Births _____

# of Miscarriages: _____ # of Elective Abortions:_____ # of Ectopic: _____

Please list each pregnancy in chronological order in columns below:

PREGNANCY	Preg # 1	Preg #2	Preg #3	Preg #4	Preg #5
Date of pregnancy/delivery					
Miscarriage? How many weeks?					
Elective Abortion? Surgical or medication?					
Ectopic/pregnancy in the tubes? (Y/N)					
How many months did it take to conceive?					
Was infertility treatment required? (Y/N)					
Gestation (weeks) at delivery/birth					
Mode of delivery (vaginal vs. cesarean)					
Weight and sex of baby?					
Is your current partner the biological parent? (Yes, No, N/A)					
Is the child healthy? (Y/N)					
Any complications?					

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FERTILITY HISTORY

(Only complete this page if actively trying or planning to conceive soon)

How long have you been attempting pregnancy?_____

For couples trying to conceive through penetrative sexual intercourse:

How many times per week do you have sexual intercourse? _____

Do you time intercourse with ovulation? _____

Do you douche before or after intercourse? o Yes o No

For those using donor sperm, have you attempted insemination at home? _____

If yes, how many times? _____

Have you monitored to determine the timing of ovulation? o Yes o No

Have you been using an ovulation predictor kit? o Yes o No

Have you monitored your cervical mucus? o Yes o No

Have you monitored basal body temperature? o Yes o No

If yes, please describe your findings_____

Do you use lubricants? o Yes o No If so, what kind? _____

Have you received pre-pregnancy counseling? o Yes o No

Are you currently taking folic acid supplements/prenatal vitamin? o Yes o No

Have you taken gender-affirming hormones? o Yes o No

If yes, are you taking them currently? _____

What type(s) of hormones/dosages/ dates taken? _____

PAST SURGICAL HISTORY

Please list any and all your prior surgeries in columns below in chronological order:

PRODECURE	DATE	SURGEON	DIAGNOSIS

PAST MEDICAL HISTORY

List all medical illnesses/chronic health issues (list hospitalization dates, duration if applicable). This includes things like autoimmune disorders, diabetes, blood clots, high blood pressure, asthma, migraines, mental health concerns, other diagnoses you've been treated for etc.

_____

_____

_____

_____

_____

MEDICATIONS

Please list current prescription medications and dosages:

Medication/Dose	**Start Date**	**Medication/Dose**	**Start Date**
1._____		4._____	
2._____		5._____	
3._____		6._____	

Please list any current nutritional/herbal supplements or over the counter medications:

_____

_____

Allergies: (medications, latex, food) o Yes o No

(Specify allergy and associated reaction): _____

REVIEW OF SYSTEMS

Check any of the following that you currently have or have experienced in the past

Neurological/Psychological

o Seizures
o Migraine headaches
If yes, do you experience aura/blurred vision (not light sensitivity? o Yes o No
o Depression
o Anxiety
o Bipolar disorder
o ADHD
o Eating disorder/chronic dieting
o Other:_____

Eyes, Ears, Nose and Throat

o Wear contact lenses
o Eye disorders
o Problem with sense of smell
o Other:_____

Cardiovascular

o Chest Pain
o Palpitations
o Rheumatic Fever
o Heart valve disease
o High blood pressure
o Mitral valve prolapse
o Take antibiotics before dental work or surgery
o Other:_____

Respiratory

o Shortness of breath
o Asthma (date of last attack: _____)
o Bronchitis
o Pneumonia
o Coughing up blood
o Other:_____

Gastrointestinal

o Nausea/vomiting
o Blood in stool
o Ulcers
o Hepatitis
o Constipation
o Diarrhea
o Irritable bowel syndrome
o Inflammatory bowel disease (Crohn's, ulcerative colitis)
o Decreased appetite
o Other: _____

Genitourinary

o Bladder infections (cystitis)
o Kidney infections
o Incontinence (leakage of urine)
o Vaginal Infections
o Pelvic Pain
o Other:_____

Musculoskeletal

o Unusual muscle weakness
o Decreased energy/fatigue
o Rheumatoid Arthritis
o Lupus erythematosus (SLE)
o Other:_____

Hematologic

o Blood clotting disorder
o Sickle Cell Anemia or trait
o Other:_____

Endocrine

o Diabetes
o Hypoglycemia
o Thyroid disorder
o Increased facial or body hair
o Hair loss
o Nipple discharge (milk, blood, other)
o Rapid weight gain
o Rapid weight loss
o Other:_____

Skin

o Rash
o Eczema
o Vitiligo
o Problems with skin pigmentation
o Acne
o Other: _____

Please check all of the following that apply:

		DATES	RESULTS
	Had or vaccinated for Rubella (German Measles)		
	Had or vaccinated for Varicella (Chicken Pox)		
	Had genetic carrier screening (e.g. cystic fibrosis, sickle cell trait, spinal muscular atrophy, fragile X, tay-sach's, etc.)		

Have you had any of the following infertility tests?

		DATES	RESULTS
	Semen Analysis		
	Hormone Labwork/bloodwork (FSH, AMH, Progesterone, etc.)		
	Hysterosalpingogram (HSG) (x-ray of the uterus and tubes using dye)		
	Saline sonogram / sonohysterogram		
	Laparoscopy / Hysteroscopy		
	Other (please specify)		

Have you had any of the following infertility treatments?

TREATMENT	DATES	# OF CYCLES
Intrauterine insemination (IUI)		
Clomiphene Citrate (Clomid) or Letrozole (Femara)		
Gonadotropin injections (e.g. Follistim, Gonal-F, Bravelle, Menopur)		
Progesterone supplementation		
In Vitro Fertilization (IVF)		
Donor Egg		
Other (please specify)		

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PARTNER HISTORY

(If actively trying to conceive and partner produces sperm)

Has anyone ever become pregnant by you in the past? o Yes o No

Dates of pregnancies: _____

Age/health of children from other partners: _____

Have you ever had a semen analysis (sperm test)? o Yes o No

If yes, include date and results: _____

Do you come in contact with chemicals or toxins at home or work? o Yes o No

If so, please list: _____

Do you have difficulty achieving or maintaining erections? o Yes o No

Do you have difficulty with ejaculation? o Yes o No

Please list any medical problems: _____

Please list any prior surgeries: _____

What is your ***blood type*** (if known): _____

Please list any ***allergies***: _____

Please list all medications or herbal supplements you are currently taking:

_____

Do you drink alcohol? o Yes o No Approximate drinks per week: _____

Do you smoke cigarettes? o Yes o No Packs per day? Duration? _____

Do you use any illicit/recreational drugs? o Yes o No _____

Do you have any family history of infertility, abnormal sperm, or genetic disorders? o Yes o No

Have you ever had any of the following?

Chlamydia	oYes o No	Vasectomy	oYes o No
Gonorrhea	oYes o No	Vasectomy Reversal	oYes o No
Syphilis	oYes o No	Varicocele	oYes o No
Genital Herpes	oYes o No	Varicocele Surgery	oYes o No
Genital Warts	oYes o No	Biopsy of the testicles	oYes o No
Urethritis/epididymitis	oYes o No	Hernia Surgery	oYes o No
Prostatitis	oYes o No	Abdominal Surgery	oYes o No
Penile discharge or pain	oYes o No	Cancer	oYes o No
Undescended testicle	oYes o No	High Blood Pressure	oYes o No
Injury to the testicle (s)	oYes o No	Diabetes	oYes o No
Difficulty smelling/tasting	oYes o No	Colitis	oYes o No
Frequent Headaches	oYes o No	Seizures	oYes o No
Mumps	oYes o No	Psychiatric Treatment	oYes o No
DES exposure in the womb	oYes o No	Strenuous Exercise	oYes o No