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:** _____

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): _____

CHIEF COMPLAINT: Please describe the reason for your visit today. If applicable, please include all symptoms, duration, and whether they have changed in severity over time:

_____

_____

_____

_____

_____

_____

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MENSTRUAL AND GENITOURINARY HISTORY

At what age did you begin to menstruate? _____

What were the start dates of your two most recent menstrual periods? _____

Are your periods regular or irregular? (circle one)

If irregular, please describe _____

Number of days between the first day of one period and the first day of the next? _____

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 are you needing to change your menstrual care products?_____

Do you experience cramps with your period? o Yes o No

Do you take medication to alleviate the cramps? o Yes o No What kind? _____

Do you bleed between your periods? o Yes o No Describe: _____

Do you have any noticeable vaginal discharge? o Yes o No

If so, describe (color, consistency, presence of odor, itching, etc.): _____

Do you have a history of frequent UTIs, Bacterial Vaginosis, or yeast infections? If yes, please describe:

_____

HEALTH MAINTENANCE HISTORY

Date of HPV vaccine: _____ o Never done

Date of last PAP smear: _____ Result: _____

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 partners have you engaged with sexually in the last month?_____

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

Have you been diagnosed and/or treated for any of the following? If yes please include date of treatment and date of last screening. If no please include date of last screening.

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? 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.

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		_____
o Condoms (male or female)		_____
o Spermicidal jellies/Foam		_____
o Sterilization _____male ____female		_____
o Other:_____		

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OBSTETRICAL HISTORY

Do you currently desire 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 desire to avoid pregnancy? o Yes o No

Total Times Pregnant _____ Term Births _____ Premature Births _____

Miscarriages _____ Elective Abortions _____ Ectopic _____

Please list each pregnancy in chronological order in columns below:

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

INFERTILITY HISTORY
(If actively trying to conceive)

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? _____

Have you been attempting to 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? 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 serious medical illnesses or chronic health issues (include hospitalization dates, duration)

_____

_____

_____

_____

_____

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 supplements, herbal preparations, or over the counter medications:

_____

_____

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

(Specify allergy and associated reaction): _____

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SOCIAL HISTORY

Are you on a special diet (vegetarian, lactose-free, low salt, low fat, Kosher, etc.)? o Yes o No

Do you exercise regularly? o Yes o No How often, what type? _____

Have you had any difficulty or recent change in you habits of sleep, diet or exercise? o Yes o No

If so, can you describe?_____

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

Do you currently smoke cigarettes? o Yes o No # packs per day? _____ # years? _____

If you are a former smoker, when did you quit? _____

Do you use any illicit or recreational drugs (i.e., marijuana, cocaine)? o Yes o No

Describe: _____ (you may also discuss this with your provider privately)

Have you ever been exposed to industrial chemicals, toxic substances or radiation? o Yes o No

If so, state the substance and extent of exposure: _____

What is your ***blood type***? _____ o Don't know

Have you ever had a blood transfusion? o Yes o No Date:_____Complications?_____

FAMILY HISTORY

Check all of the following disorders for which you have a family history. Include which <u>blood relative</u> (mother/father/sister(s)/brother(s), maternal/paternal grandmother or grandfather, maternal/paternal aunt(s) or uncle(s), cousins) had the disorder. Do not include yourself.

o Cancer (specify) _____

o Diabetes
o Heart Disease
o Hypertension (high blood pressure)
o Thyroid problems (including goiter)
o Blood Clotting disorders
o Early Menopause
o Osteoporosis
o Recurrent miscarriages
o Polycystic ovarian syndrome
o Irregular menstrual cycles
o Infertility
o Excessive hair growth
o Neurological (nerve) disorders
o Alcoholism or Substance Abuse
o Depression
o Schizophrenia
o Other psychiatric problems
o Birth defects
o Mental retardation
o Cystic fibrosis
o Thalassemia or sickle cell disease/trait
o Fragile X syndrome

- Other:

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REVIEW OF SYSTEMS

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

Central Nervous System
o Seizures
o Migraine headaches
o Depression
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 Blood in sputum
o Other:_____

Gastrointestinal
o Nausea/vomiting
o Blood in stool
o Ulcers
o Hepatitis
o Constipation/diarrhea
o Irritable bowel syndrome
o Inflammatory bowel disease
(Crohn's, ulcerative colitis)
o Decreased appetite/anorexia
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/stamina
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 Baldness
o Breast 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 produce 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? oYes 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
Gonorrhea	oYes o No
Syphilis	oYes o No
Genital Herpes	oYes o No
Genital Warts	oYes o No
Urethritis/epididymitis	oYes o No
Prostatitis	oYes o No
Penile discharge or pain	oYes o No
Undescended testicle	oYes o No
Injury to the testicle (s)	oYes o No
Difficulty smelling/tasting	oYes o No
Frequent Headaches	oYes o No
Mumps	oYes o No
DES exposure in the womb	oYes o No

Vasectomy

oYes o No Vasectomy Reversal

oYes o No Varicocele

oYes o No Varicocele Surgery

oYes o No Biopsy of the testicles

oYes o No Hernia Surgery

oYes o No Abdominal Surgery

oYes o No Cancer

oYes o No High Blood Pressure

oYes o No Diabetes

oYes o No Colitis

oYes o No Seizures

oYes o No Psychiatric Treatment

oYes o No Strenuous Exercise

oYes o No