EMORY
REPRODUCTIVE CENTER

Name:
Medical Record Number:
Date of Birth:

# NEW PATIENT HISTORY FORM

Date: _____ Physician who referred you _____Fax: _____
Phone: _____

Would you like a letter sent? If yes, sign here _____

## DEMOGRAPHIC INFORMATION

Preferred Name, Pronoun: _____
Legal Name: _____ Age: _____ Date of Birth: _____
Occupation: _____ Best Phone: _____

Is your real age different from your legal age? ____ Yes _____ No

## REASON FOR VISIT

_____

_____

## INFERTILITY HISTORY

How long have you been trying to get pregnant? _____ years _____ months

Have you attempted pregnancy prior to this relationship? ____Yes ____No

### Past Fertility Evaluation

| | | |
|---|---|---|
| Semen Analysis | ☐ No ☐ Yes | Result / date _____ |
| HSG (X-ray of tubes) | ☐ No ☐ Yes | Result / date _____ |
| Ovulation Predictor | ☐ No ☐ Yes | Result / date _____ |
| TSH | ☐ No ☐ Yes | Result / date _____ |
| Day 3 FSH, Estradiol | ☐ No ☐ Yes | Result / date _____ |
| AMH | ☐ No ☐ Yes | Result / date _____ |

Have you had any of the following treatments?

Clomiphene (Clomid) or Letrozole (Femara) _____
Gonadotropins _____
Prior Inseminations (IUIs) _____

**Prior in vitro fertilization (IVF)**

| Location | Date | Dose | Peak Estrogen | # Eggs Retrieved | % Fertilization (Embryos available) | # Embryos Transferred, Stage | Outcome | Frozen Embryos? |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

## OBSTETRICAL HISTORY

| Date | Time to conceive | Length of pregnancy (weeks) | Gender | Birth weight | Outcome (e.g. miscarriage, ectopic, abortion, live birth) | Pregnancy Complications |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

## GYNECOLOGIC and MENSTRUAL HISTORY

Age of onset of periods _____ Date of last menstrual period (LMP)_____

Length of menses _____days Number of days between menses_____days/months

How many pads/tampons do you use on the heaviest day of your period? _____

Do you have pain during your period? ___ No ___ Yes

If yes, does it affect your daily activities? ___ No ___ Yes

Do you have pain between periods? ___ No ___ Yes

Do you bleed between periods? ___ No ___ Yes

Any history of any sexually transmitted infections? _____

Date and result of last Pap Smear _____

Any history of abnormal Pap Smears? _____

Have you had surgery or laser of the cervix? ___ No ___ Yes

Date and result of last mammogram _____

Do you have any problems with intercourse? ___ No ___ Yes

Do you bleed during or after intercourse? ___ No ___ Yes

Do you have pain during or after intercourse? ___ No ___ Yes

In-utero exposure to DES (diethylstilbestrol) ___ No ___ Yes

Have you used an IUD? ___ No ___ Yes

Have you had a tubal ligation? ___ No ___ Yes

**PAST MEDICAL HISTORY** (Please list any medical problems below)

1. _____
2. _____
3. _____
4. _____

**SURGICAL HISTORY** *(*Please list all surgeries including dates, hospitalization duration, and location)

1. _____
2. _____
3. _____
4. _____

**MEDICATIONS** (including complementary and alternative therapy, herbs, vitamins)

1. Vitamin/Folate Yes No
2. _____
3. _____
4. _____
5. _____
6. _____

**ALLERGIES TO MEDICATIONS; TYPE OF REACTIONS**

_____
_____
_____

**SOCIAL HISTORY** Please select one

Married Widowed Separated Divorced Single Single in committed relationship

How much caffeine do you drink per day? _____ cups of coffee / tea / soda

Do you smoke? _____ Use any recreational substances? _____

If yes, how much? _____ for ___ years

How much alcohol do you drink per week? _____

What kind? _____

**Patient's ethnicity:**

□ Non- Hispanic White □ Non- Hispanic Black □ Asian/ Pacific Islander □ Hispanic □ Jewish

**Partner's ethnicity (if applicable):**

□ Non- Hispanic White □ Non- Hispanic Black □ Asian/ Pacific Islander □ Hispanic □ Jewish

Are you interested in pre-genetic conception screening? □ Yes □ No

## REVIEW OF SYSTEMS

Please mark any of the following disorders YOU currently have or have a history of:

**Central Nervous System**
- □ Seizures
- □ Migraine Headaches
- □ Difficulty with memory

**ENT:**
- □ Visual disturbances
- □ Sinus problems

**Cardiovascular:**
- □ High blood pressure
- □ High blood pressure in pregnancy
- □ Chest pain
- □ Palpitations
- □ Dizziness
- □ History of Rheumatic Fever
- □ Heart valve disease
- □ Given prophylactic antibiotics
- □ Mitral valve prolapse

**Respiratory**
- □ Shortness of breath
- □ Asthma
- □ Bronchitis
- □ Pneumonia
- □ Cough
- □ Tuberculosis

**Gastrointestinal**
- □ Nausea/Vomiting
- □ Blood in stool
- □ Ulcers
- □ Hepatitis/Liver disease
- □ Diarrhea
- □ Constipation

**Psychiatric**
- □ Anxiety
- □ Panic attacks
- □ Depression
- □ Eating disorders

**Gynecologic**
- □ Bladder infections (cystitis)
- □ Incontinence
- □ Kidney infections
- □ Gonorrhea
- □ Chlamydia
- □ Herpes
- □ Syphilis
- □ Warts (HPV)
- □ Decreased sex drive
- □ Pelvic inflammatory disease (PID)
- □ Pelvic pain
- □ Endometriosis
- □ Breast discharge
- □ Hot flashes / Night sweats

**Musculo-Skeletal**
- □ Rheumatoid arthritis
- □ Lupus erythematous
- □ Bone fractures

**Hematological**
- □ Anemia
- □ Blood clotting disorder
- □ Bleeding tendency
- □ Sickle cell anemia or trait

**Endocrine**
- □ Diabetes
- □ Diabetes in pregnancy
- □ Thyroid disease
- □ Heat or Cold intolerance (circle)
- □ Excessive hair growth
- □ Other: Rapid weight gain/loss (circle)
- □ Excessive thirst or hunger (circle)
- □ Acne/Skin Problems

**Constitutional**
- □ Flu-like symptoms or fatigue
- □ Increase or decrease in appetite (circle)
- □ Weight gain or loss (circle)
- □ Fevers or chills
- □ Fatigue

## FAMILY HISTORY

Fill in the appropriate circles to identify all illnesses or conditions which you know have occurred in your blood relatives or partner.

| | Self | Father | Mother | Brothers | Sisters | Sons | Daughters | Grandparents | Partner |
|---|---|---|---|---|---|---|---|---|---|
| Uterine Cancer | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Colon Cancer/Rectal Cancer | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Colon Polyp | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Breast Cancer | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Prostate Cancer | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Ovarian Cancer | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Other Cancer | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Heart Defects | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Heart Disease | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Diabetes | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Asthma | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Dementia | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Tuberculosis (TB) | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Seizure Disorder | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Stroke/TIA | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| High Cholesterol | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Abnormal Bleeding (Bleeding Disorder) | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Blood clots | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| High blood pressure | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Anemia | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Endometriosis | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Hepatitis | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Liver disease | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Osteoporosis | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Alcohol Abuse | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Depression | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Eating Disorders | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Other Psychiatric/Mental illness | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Anesthesia complications | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Kidney disease | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Miscarriages | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Mental Retardation | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Down Syndrome | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Cystic Fibrosis | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Stillbirth | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Thalassemia/Sickle cell | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Cleft Lip or Palate, Spina bifida | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Tay Sachs, Guacher, Canavans Disease | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Neurofibromatosis | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Other | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

## PARTNER HISTORY

Legal Name: _____ Preferred Name, Pronoun: _____

Birth date: _____ Age_____ Occupation _____ Relationship duration _____

Has partner initiated a pregnancy in a previous relationship? ___No ___Yes

If yes, please give outcome of pregnancy (live birth/ miscarriage, termination) _____

Any pregnancy with birth defects/Genetic disorder/stillbirth/ miscarriage? _____

Has partner had infertility in a previous relationship? ___No ___Yes

**Any history of the following? (Urological)**

| | |
|---|---|
| Prostatitis | ___No ___Yes |
| Epididymitis | ___No ___Yes |
| Orchitis | ___No ___Yes |
| Previous vasectomy | ___No ___Yes |
| Testicular tumor | ___No ___Yes |
| Injury to testes | ___No ___Yes |
| Undescended testicles | ___No ___Yes |
| Gonorrhea | ___No ___Yes |
| Chlamydia | ___No ___Yes |
| Syphilis | ___No ___Yes |
| Nonspecific urethritis | ___No ___Yes |
| Difficulty with erection | ___No ___Yes |
| Difficulty with ejaculation | ___No ___Yes |
| Exposure to radiation | ___No ___Yes |
| Exposure to chemicals | ___No ___Yes |
| Exposure to toxic substances | ___No ___Yes |
| Exposure to high temperatures | ___No ___Yes |

**Gynecological history of female partner**

Age of onset of periods _____
Date of last menstrual period (LMP) _____
Length of menses ____ days
Number of days between menses _____ days/months
How many pads/tampons do you use on the heaviest day of your period? _____

| | |
|---|---|
| Do you have pain during your period? | ___ No ___ Yes |
| If yes, does it affect your daily activities? | ___ No ___ Yes |
| Do you have pain between periods? | ___ No ___ Yes |
| Do you bleed between periods? | ___ No ___ Yes |

Any history of any sexually transmitted infections?
_____

Date and result of last Pap Smear _____
Any history of abnormal Pap Smears? _____

| | |
|---|---|
| Have you had surgery or laser of the cervix? | ___ No ___ Yes |
| Date and result of last mammogram | _____ |
| Do you have any problems with intercourse? | ___ No ___ Yes |
| Do you bleed during or after intercourse? | ___ No ___ Yes |
| Do you have pain during or after intercourse? | ___ No ___ Yes |
| In-utero exposure to DES (diethylstilbestrol) | ___ No ___ Yes |
| Have you used an IUD? | ___ No ___ Yes |
| Have you had a tubal ligation? | ___ No ___ Yes |

## PARTNER MEDICAL HISTORY

Weight_____ Height _____

**PAST MEDICAL HISTORY** (Please list any medical problems below)

1._____

2._____

3._____

**PAST SURGICAL HISTORY** (Please list any surgical procedures including dates and location)

1._____

2._____

**MEDICATIONS (including supplements, hormones, steroids)**

| | Medication | Reason | Dates/Duration/Last time taken |
|---|---|---|---|
| 1. | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ |
| 3. | _____ | _____ | _____ |
| 4. | _____ | _____ | _____ |

**ALLERGIES**

_____

_____

**SOCIAL HISTORY**

How much caffeine does you partner drink per day? _____ cups caffeine / tea / soda

How many cigarettes does you partner smoke per day? _____ cigarettes For how long? ____years

How much alcohol does you partner drink per week? _____ What kind? _____

How often do you use marijuana? _____

Any other substances? _____

**MD NOTES:**