Fertility Leaders New Patient Form

Date Completed: mm/dd/yyyy	Female Information	Spouse/Partner Information
First Name		
Last Name		
Date of Birth	MM DD YYYY	MM DD YYYY
Age in Years	Years	Years
Current Occupation		
Ethnic Background		
Marital Status	Married Engaged Single/Divorced	
Current Weight and Height	lbs inches	lbs inches
Address		Street
		City State

How did you FIRST learn about our practice?

What is the name of your ObGyn or Primary Care Provider?

What is your PRIMARY reason for this consultation?

How long have you attempted to conceive or not used contraception? Years Not applicable for me

Have you used fertility treatments before? Yes No

If yes, types used? Fertility Injections Surgery In Vitro Fertilization Fertility Pills Insemination Other

Have you been pregnant before? Yes No If Yes, please complete table below:

Total number of pregnancies?		Total number of elective abortions?	
Total number of live births delivered?		Total number of ectopic/tubal pregnancies?	
Total number of miscarriages?			

Menstruation and Ovulation History

Are your cycles irregular and unpredictable? Yes No

How many days between the beginning of one menstrual period to the beginning of the next? Days How many days does a typical period last? Days

Do you experience abdominal bloating, PMS or breast tenderness monthly? Yes No

Do you have hot flashes, particularly at night? Yes No

Do you bleed between regular periods? Yes No

Do you have menstrual cramping? Yes No

If yes, what is your menstrual pain level? Mild (No meds required) Moderate (Requires meds) Severe (Limits activity)

Do you have pain during sexual intercourse? Yes No

If yes, how often is it present? Rarely Less than half the time More than half the time Always

Do you have endometriosis and/or received treatments for endometriosis? Yes No

If yes, when did you receive treatments?

Have family members had endometriosis? Yes No If yes, which relatives?

Do you have breast/nipple discharge or fluid? Yes No

Have you tested for ovulation? Yes No

If yes, what method(s) did you use? Temperature Progesterone Urine Kits Endometrial Biopsy

Have you had a test for open tubes? Yes No

If yes, how was it tested? Laparoscopy HSG Other:

If yes, when/where was it tested? When? Where?

Have you had treatment for abnormal PAP? Yes No

If yes, what type and when? Cryo LEEP Cone Excision Year or Age

Have you had any prior pregnancies or miscarriages? Yes No (If yes, please add details below in order)

	Months/Weeks	Date/Year	C-section, vaginal or D&C	Complications
1.				
2.				
3.				
4.				
5.				

General Female Health Information (Please select all that apply)

Consitutional? Weight Gain Fatigue Weight Loss Fever Other None

If Other please describe:

Eyes? Rapid Worsening Vision Infection Blurred or Double Vision Other None

If Other please describe:

Ears, Nose, and Throat? Cold Sores/Fever Blisters Dizziness Ringing in Ears Hearing Loss Other None

If Other please describe:

Skin? Facial/Body Hair Growth Acne Skin Cancer Dry Skin Other None

If Other please describe:

Endocrine? Heart Racing Hair Loss Heat/Cold Intolerance Chronic Nausea Other None

If Other please describe:

Cardiovascular? Mitral valve disease Murmur Shortness of breath Blood clots Palpitations Other None

If Other please describe:

Respiratory? Blood in sputum x-ray Previous Abnormal Chest Chronic cough Other None

If Other please describe:

Gastrointestinal? Ulcers Nausea Cramping Diarrhea Constipation Jaundice Vomitting Bleeding Other None

If Other please describe:

Genital/Urinary? Painful urination Frequent Kidney Infections Stones Other None

If Other please describe:

Hemotalogic? Swollen lymph nodes Hemophilia Bleeding tendencies
Bleeding gums Other None

If Other please describe:

Neurologic? Seizures Paralysis
Stroke Other None

If Other please describe:

Musculoskeletal? Rheumatoid arthritis Osteoporosis Chronic myalgia
Muscle weakness Other None

If Other please describe:

Psychiatric? Chronic depression Anxiety disorder Crying spells
Current/prior treatment Other None

If Other please describe:

Female Medical History

Do you have any of the following medical conditions?

Asthma	Anemia	Eating Disorder	Thyroid Disease	Blood Clots Legs/Lungs
Colitis	Hypertension	Cannot Smell	Seizures	Irritable Bowel
Diabetes	Hypoglycemia	Kidney Disease	Cancer	Heart Attack
High Cholesterol	Stroke	Other		None

If other, please describe:

Have you had any past surgeries? Yes No (If yes, please provide details below in order)

	Name of Procedure	Date or Age	Findings or Complications
1.			
2.			
3.			
4.			
5.			
6.			

Have you ever had an allergic reaction to any medications? Yes No (If Yes, please specify below)

	Medication Name	Reaction or Symptoms associated with this medication
1.		
2.		
3.		

List all medications and doses currently taken: (Include vitamins, herbs and over-the-counter)

Female Social History

Do you CURRENTLY smoke cigarettes? Yes No

If yes, one pack lasts how many days? Days Years of age when started smoking?

Have you EVER smoked cigarettes in the past? Yes No If yes, packs smoked per day?

If yes, what ages did you start and stop? Age started smoking Age stopped smoking

Are you often exposed to smoke by others? Yes No

Do you use illicit street drugs? Yes No If yes, what drugs?

Have you ever had any of the following infections? "PID" Warts Herpes HIV
Gonorrhea Hepatitis Chlamydia None

Family Medical History

List conditions in siblings, parents or grandparents, such as diabetes, high blood pressure, heart disease, stroke, thyroid, cancer.

	Medical Condition	Relative who has this condition (maternal or paternal side)
1.		
2.		
3.		
4.		

Genetic History / Questionnaire

Question			
Are you OR the father-to-be from the following ethnic backgrounds? Italian, Greek, Middle Eastern, Spanish, Chinese, Asian Indian, Taiwanese, Filipino, Asian?	Yes	No	Not Sure
If yes, which ethnic backgrounds?			
Do you OR the father-to-be have a family member with thalassemia or other hemoglobin problem?	Yes	No	Not Sure
Are you OR the father-to-be from Jewish, French Canadian, or Cajun background?	Yes	No	Not Sure
Do you OR the father-to-be OR anyone in your families have a history of Tay-Sachs, Cystic Fibrosis, or Canavan?	Yes	No	Not Sure
Do you OR the father-to-be OR anyone in your families have a history of neural tube defect - spina bifida, open spine, anencephaly?	Yes	No	Not Sure
Do you OR the fahter-to-be or anyone in your families have hemophilia or another bleeding disorder?	Yes	No	Not Sure
Are you OR the father-to-be from African-American or Hispanic descent?	Yes	No	Not Sure
Do you OR the father-to-be OR anyone in your families have Sickle Cell Disease?	Yes	No	Not Sure
Do you OR the father-to-be OR anyone in your families have neuromuscular disease or muscular dystrophy?	Yes	No	Not Sure
Do you OR the father-to-be OR anyone in your families have Huntingtons disease?	Yes	No	Not Sure
Do you OR the father-to-be OR anyone in your families have autism, mental retardation or Fragile X?	Yes	No	Not Sure
Do you OR the father-to-be OR anyone in your families have a “genetic” disorder not listed above? (Marfans, Neurofibromatosis, etc)?	Yes	No	Not Sure
Do you OR the father-to-be OR anyone in your families have a birth defect not listed above? (blindness, deafness, mental retardation, cerebral palsy)?	Yes	No	Not Sure

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Male Partner's Medical History

Do you have any of the following medical conditions?

Asthma	Anemia	Eating Disorder	Thyroid Disease	Blood Clots Legs/Lungs
Colitis	Hypertension	Cannot Smell	Seizures	Irritable Bowel
Diabetes	Hypoglycemia	Kidney Disease	Cancer	Heart Attack
High Cholesterol	Stroke	Other		None

Any Family members with the above conditions? Yes No If yes, list:

Have you, the MALE had any surgical procedures? Yes No

If yes, please list any sugical procedures here:

Have you noticed a decrease in sex drive? Yes No

Is intercourse, urination or ejaculation painful? Yes No

Do you experience impotence? Yes No

If yes, how often do you experience impotence? Rarely Often Always Requires medication

Have you ever had a diagnoisis of prostatitis? Yes No If yes, when?

Have you had a vasectomy? Yes No If yes, when?

Have you had a vasectomy reversal? Yes No If yes, when?

Have you had a hernia repair? Yes No If yes, when?

Have you had surgery on your testicles, scrotum, prostate, or penis? Yes No

If yes, what procedure and at what age?

Have you fathered a pregnancy in THIS relationship? Yes No

Fathered a pregnancy in ANOTHER relationship? Yes No If yes, most recent year born?

Have you unsuccessfully attemped to conceive in ANOTHER relationship? Yes No

Have you had a prior SEMEN ANALYSIS? Yes No If yes, when & where?

If yes, what was the reported result? Normal Abnormal Not sure

Male Partner's Environmental Toxin Exposure

Do you currently smoke tobacco? Yes No

Do you use illicit street drugs? Yes No If yes, which?

Are you exposed to chemicals or toxins? Yes No If yes, which?

Male Partner's Medications and Allergies

List all medications currently taken (Include hormones, body-building supplements and over-the-counter)

Have you ever had an allergic reaction to any medications? Yes No (If yes, please specify below)

	Medication Name	Reaction or Symptoms associated with this medication
1.		
2.		

Patient/Partner Demographics, Insurance and Contact Information

	Female Information	Partner Information
Social Security #		
First Name		
Middle Initial		
Last Name		

Address Information

Address		
City		
State		
Zip Code		

Contact Information

Work Phone		
Mobile Phone		
Home Phone		
Email		

Emergency Contact Information

Name		
Phone		

Insurance Information 1

Policy Holder		
Insurance Company		
ID#		
Group#		
Insurance Phone		

Insurance Information 2

Policy Holder		
Insurance Company		
ID#		
Group#		
Insurance Phone		