Alabama Fertility

New Patient Medical History

MR #: _____ Initial Appointment Date: ____/____/____

Name: _____ Birth Date: ___/____/____

Address: _____ City: _____ State: _____ Zip: _____

Best Phone # to reach you: (___)_____ Second contact #: (____)_____

Email Address: _____

Occupation: _____ Marital status: ○S ○M ○W ○D Religion: _____

Race: _____ Referring physician: _____

Referring physician practice name: _____ City: _____ State: _____

Partner name (if applicable): _____ Birth Date: ___/____/____ Race: _____

Work phone: (_____)_____ Partner occupation: _____

Emergency contact: _____ Phone #: (____)_____

Reason for Visit (please check all that apply)

☐ Infertility (Duration: _____) ☐ Reversal of sterilization

☐ In Vitro Fertilization ☐ Endometriosis

☐ Repeated miscarriages ☐ Irregular periods

☐ Other (_____)

How did you hear about us? _____

Menstrual History

What age did your menstrual cycles begin? ____ years Are your cycles usually regular? _____

What is the average length of your menstrual cycle (from the 1st day of one period till the 1st day of the next)? ___

When was your last normal period? ___/____/____How painful are your periods? Mild○Moderate○Severe○

Do you bleed between periods? _____Do you bleed after intercourse?_____ Are your periods heavy? _____ How often do you have intercourse per week? _____ Is intercourse painful? __

_____ When was your most recent Pap smear? /____/____ Result: _____

Have you ever had an abnormal pap smear? _____

When was your most recent mammogram? ____/____/____ Result: _____

Past Medical History

Do you have any of the following: (circle) diabetes☐ hypertension☐ thyroid disease☐

Do you have any other medical problems? _____

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Have you ever undergone chemotherapy or radiation (if yes, please explain)? _____

_____

Have you ever been hospitalized?

Date	Reason
_____	_____
_____	_____
_____	_____
_____	_____

List all surgeries you have had:

Date	Reason
_____	_____
_____	_____
_____	_____
_____	_____

List any sexually transmitted disease you have had (such as, syphilis, gonorrhea, herpes, genital warts, PID):

_____

Alcohol use: Current: _____beverages/week

Cigarette use: Current: _____cigarettes/day

Past: _____cigarettes/day

Recreational drug use (please specify): Current: _____

Past recreational drug use: _____

Caffeinated beverages per day? _____

Do you exercise? _____

If yes, how many times per week? _____

Medications

Do you currently take a prenatal or multi-vitamin? _____

Please list all medications you are currently taking (prescription, over-the-counter, herbal supplements) and the indication:

Medication	Frequency	Indication
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What allergies do you have? _____

Contraceptive History

Please check all types of birth control methods you have used (past or currently):

Type	Dates	Type	Dates
☐ Birth control pills (_____)		☐ Condoms (_____)	
☐ IUD (_____)		☐ Other _____ (_____)	

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Obstetrical History

Please list all pregnancies (including ectopic, abortions, miscarriages, and deliveries):

#	Date	Type	Sex	Living Y/N	Complications

Family History

Are you adopted? _____

Please check the following in the appropriate box for the relative involved:

Problem	Mother	Father	Brother/Sister	Grandparent(s)	Children
Breast cancer					
Ovarian cancer					
Colon cancer					
Other cancer					
Thyroid disease					
Heart disease					
Diabetes					
High blood pressure					
Blood clots					
Irregular periods					
Infertility					
Uterine fibroids					
Endometriosis					
Birth defects					
Recurrent miscarriage					
Intellectual disability					
Other					

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Previous Infertility Evaluation and Treatment

Female: Please note the date and results of any of following tests you have had:

Test	Date	Results
Hysterosalpingogram (HSG)		
Laparoscopy		
Hysteroscopy		
Hormone tests (such as FSH, TSH, Prolactin, Progesterone levels)		

Medication	When	# cycles	Dose	Did you conceive?
Oral Medications **Clomiphene**				
Letrozole/Femara				
Gonadotropin injections				

Please note any fertility treatments you have had:

	When	# cycles	Where	Did you conceive?
Intra-uterine insemination				
In Vitro Fertilization				

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Male Partner

Age of spouse/partner: _____years Has he had a vasectomy?_____ Previous infertility history? Yes○ No○

Number of pregnancies with current spouse: _____ Number of pregnancies in prior relationship(s): _____

How many cigarettes does he smoke per day? _____ How many alcoholic beverages per day? _____

Please list **all** medications he currently takes: _____

Is he currently taking testosterone in any form? _____ Ever? _____ How long? _____

Does he have a family history notable for (please circle): Infertility☐ Miscarriage☐ Birth defects☐ Intellectual disability☐

Has he ever seen a urologist for infertility evaluation? _____ If yes, who? _____ When? _____

Has he had a semen analysis? _____ When: _____ Results: _____

Please remember to bring these completed forms with you to your visit to Alabama Fertility. We look forward to seeing you soon.

_____

MD signature