CENTER FOR FERTILITY AND REPRODUCTIVE ENDOCRINOLOGY
MAGEE-WOMENS HOSPITAL

FEMALE INTAKE FORM - REPRODUCTIVE

PATIENTS - PLEASE COMPLETE THE ENTIRE FROM. Today's Date:_____

Name: _____ _____
Last *First*

Age: _____ Occupation: _____ Referring MD: _____

Partner's Name: _____ _____
Last *First*

Occupation: _____

Reason for visit: _____

Trying to conceive? □ No □ Yes If so, how long without protection? Years_____ Months_____

Please answer the following questions. Do not write in shaded areas.

Comments

Menstrual History

Age you started to have periods			_____ years	
Are your periods regular?			□ Yes	□ No
If cycles Irregular, number cycles/year			_____ cycles	
On average, how many days between periods?			_____ days	
How long do your periods last?			_____ days	
Menstrual flow:		□ Normal	□ Light	□ Heavy
Pain with your periods?	□ None	□ Mild	□ Mod	□ Severe
Pain not associated with your periods?			□ Yes	□ No
Bleeding between periods?			□ Yes	□ No
Date of last menstrual period			_____	
Frequency of intercourse (per week)			_____	

Gynecological History

Gonorrhea	□ Yes	□ No	Chlamydia	□ Yes	□ No
Pelvic Infection	□ Yes	□ No	Herpes	□ Yes	□ No
Painful sex	□ Yes	□ No	Excessive hair	□ Yes	□ No
Breast discharge	□ Yes	□ No	Prior IUD use	□ Yes	□ No
Birth Control Pills	□ Yes	□ No	Mom took DES	□ Yes	□ No
Vaginal lubricants	□ Yes	□ No	Douche	□ Yes	□ No
Sexual abuse	□ Yes	□ No	Physical abuse	□ Yes	□ No
Abnormal Pap	□ Yes	□ No	Mammogram	□ Yes	□ No
Date last pap: _____			Acne	□ Yes	□ No

Obstetric History

Date *(mo/yr)*	Outcome (circle one)	Comments/Complications?
/	Miscar/ Nml deliv/ Cesar/ Tubal/ Abortion	
/	Miscar/ Nml deliv/ Cesar/ Tubal/ Abortion	
/	Miscar/ Nml deliv/ Cesar/ Tubal/ Abortion	
/	Miscar/ Nml deliv/ Cesar/ Tubal/ Abortion	

Prior Infertility Evaluation (if applicable)

		Year	Result	
Basal temp records	□ No	_____	□ Normal	□ Abnormal
Urine ovulation kits	□ No	_____	□ Normal	□ Abnormal
Endometrial biopsy	□ No	_____	□ Normal	□ Abnormal
Semen Analysis	□ No	_____	□ Normal	□ Abnormal
Hysterosalpingogram	□ No	_____	□ Normal	□ Abnormal
Postcoital	□ No	_____	□ Normal	□ Abnormal
Laparoscopy	□ No	_____	□ Normal	□ Abnormal
Hysteroscopy	□ No	_____	□ Normal	□ Abnormal
FSH blood test	□ No	_____	□ Normal	□ Abnormal

Patient Name:_____ Date:_____

Prior Infertility Treatments (if applicable)

			Year		
Clomid or Serophene	□ No	□ Yes	_____	#cycles	_____
FSH injectable meds.	□ No	□ Yes	_____	#cycles	_____
hCG injectable med.	□ No	□ Yes	_____	#cycles	_____
Intrauterine insemin.	□ No	□ Yes	_____	#cycles	_____
IVF or GIFT	□ No	□ Yes	_____	#cycles	_____

Take medications □ No □ Yes If yes, which ones: _____

Do you take folic acid or vitamins ? □ Yes □ No

Do you take herbal remedies? □ Yes □ No

Allergies □ Yes □ No If yes, describe: _____

What is your blood type ? □ Unknown □ Blood type _____

Past Surgeries □ Yes □ No If yes, state type, date, hospital:

Comments:

Social

Smoke	□ Yes	□ No	Alcohol weekly	□ Yes	□ No
Cocaine	□ Yes	□ No	Marijuana	□ Yes	□ No
IV drugs	□ Yes	□ No	Weight Change	□ Yes	□ No
Regular exercise	□ Yes	□ No	Caffeine	□ Yes	□ No

Ancestral Background *There are certain ancestral backgrounds that have an increased frequency of some genetic diseases. Please Indicate if either your mother or father are from any of the following backgrounds:*

□ African □ Caribbean □ Jewish □ Indian □ Asian

□ French-Canadian □ Latin-American □ Mediterranean □ Native American

Medical History (Review of Systems) *Please mark any current or serious past medical issues*

Abdominal Pain	□ Yes	□ No	Epilepsy	□ Yes	□ No
Anemia	□ Yes	□ No	Excessive thirst	□ Yes	□ No
Antibiotics	□ Yes	□ No	Fainting	□ Yes	□ No
Appendicitis	□ Yes	□ No	Fibroids	□ Yes	□ No
Arthritis	□ Yes	□ No	Exces,Constipation	□ Yes	□ No
Asthma	□ Yes	□ No	Severe headaches	□ Yes	□ No
Blood clots	□ Yes	□ No	Urinary Infections	□ Yes	□ No
Blood in stool	□ Yes	□ No	Heart disease	□ Yes	□ No
Blood transfusion	□ Yes	□ No	Heat/cold intolerance	□ Yes	□ No
Problem w/vision	□ Yes	□ No	Hepatitis, liver prob.	□ Yes	□ No
Breast Discharge	□ Yes	□ No	High blood pressure	□ Yes	□ No
Cancer	□ Yes	□ No	Hot flashes, sweats	□ Yes	□ No
Diabetes	□ Yes	□ No	Lack bladder control	□ Yes	□ No
Dizziness	□ Yes	□ No	Anxiety	□ Yes	□ No
Easy bruising	□ Yes	□ No	Kidney problems	□ Yes	□ No
Endometriosis	□ Yes	□ No	Mitral valve prolapse	□ Yes	□ No
Neck/back pain	□ Yes	□ No	Thrombophlebitis	□ Yes	□ No
Neurological prob.	□ Yes	□ No	Thyroid problems	□ Yes	□ No
Nose/gum bleeds	□ Yes	□ No	Tuberculosis	□ Yes	□ No
Palpitations	□ Yes	□ No	Shortness of breath	□ Yes	□ No
Stomach problems	□ Yes	□ No	Swollen joints	□ Yes	□ No
German measles	□ Yes	□ No	Chicken pox	□ Yes	□ No

Patient's Name: _____ Date: _____

REVIEW OF SYSTEMS

Physical Symptons

General:

□ Recent weight gain or loss
□ Anorexia/Bulimia
□ Lack of energy □ Fever/Chills
□ Loss of appetite □ Obesity
□ Mental disability □ Physical disability
□ Other _____
□ None

Head, Eyes, Ears, Nose, and Throat:

□ Dizziness □ Blurred vision
□ Difficulty keeping balanced
□ Headache
□ Hearing loss □ Ringing in ears
□ Loss of sense of smell
□ Loss of sense of taste
□ Loss of vision □ Nasal congestion
□ Sore throat
□ Cataracts □ Glaucoma □ Meniere's
□ Other _____
□ None

Respiratory:

□ Shortness of breath
□ Asthma □ Chronic bronchitis
□ Pneumonia □ Tuberculosis
□ Bloody cough □ Chronic cough
□ Strep throat □ Wheezing
□ Emphysema □ Lung cancer
□ Pneumonia □ Rheumatic fever
□ Other _____
□ None

Endocrine/Hormonal:

□ Diabetes □ Hair loss
□ Dry skin □ Excessive hunger/thirst
□ Rapid weight gain or loss
□ Temperature intolerance
□ (hot flashes or feeling cold)
□ Lack of sex drive
□ Leaking milk from breasts
□ Shakiness/tremors
□ Hyperthyroidism (increased)
□ Hypothyroidism (decreased)
□ Hyperparathyroidism
□ Lymphoma □ Pituitary tumor
□ Thyroid cancer □ Thyroid goiter
□ Other _____
□ None

Breasts:

□ Discharge clear? □ bloody? □ milky? □
□ Lumps □ Pain □ Cancer
□ Abnormal mammogram
□ Reduction
□ Augmentation/Breast implants
saline? □ silicone? □
□ Other _____ □ None

Neurological & Physchological

□ Changes in gait (walk) □ Change in speech
□ Depression □ Bipolar Disorder
□ Difficulty falling asleep
□ Frequent awakenings
□ Loss of balance □ Loss of memory
□ Loss of sensation
□ Panic attacks □ Anxiety Disorder
□ Snoring
□ Suicide attempts
□ Alzhelmer's Disease
□ Attention deficit disorder
□ Brain injury □ Brain tumor
□ Migraine headaches
□ Multiple Sclerosis
□ Obsessive-compulsive disorder
□ Parkinson's Disease
□ Stroke □ Seizures
□ Schizophrenia
□ Other _____
□ None

Gastrointestinal:

□ Nausea □ Stomach ulcers
□ Hepatitis □ Diarrhea
□ Blood in stools □ Change in stool color
□ Change in bowel habits
□ Chronic constipation □ Hemorrholds
□ Chronic vomiting □ Vomiting blood
□ Difficulty swallowing
□ Indigestion/Burning stomach
□ Gastric reflux
□ Diverticulitis/Diverticulosis
□ Gallbladder disease
□ Irritable Bowel Syndrome
□ Janudice □ Colitis(ulcerative or Crohn's)
□ Other _____
□ None

Musculoskeletal:

□ Unusual muscle weakness
□ Chronic back pain
□ Slipped disc/spine fracture
□ Decreased energy/stamina
□ Rheumatoid arthritis
□ Lupus Erythematosus
□ Myasthenia gravis
□ Fibromyalgia □ Hip fracture
□ Osteoarthritis □ Osteoporosis
□ Other _____
□ None

Gynecologic:

□ Cervical cancer □ Uterine cancer
□ Vulvar cancer
□ Polycystic ovaries
□ Pelvic Inflammatory Disease
□Other _____
□ None

Genito-Urinary:

□ Bladder Infections □ Bladder fistula
□ Chronic urinary tract infection
□ Kidney Infections □ Kidney stones
□ Kidney failure □ Kidney/Renal cancer
□ Polycysctic Kidney Disease
□ Vaginal Infections
□ Painful Urination □ Frequent urination
□ Urgency
□ Leaking urine with stress
□ Leak urine without stress
□ Blood in the urine
□ Burning with urination
□ Difficulty starting to urinate
□ Herpes
□ Other _____
□ None

Hematologic:

□ Bleeding tendencies
□ Bleeding problems
□ Blood transfusions (date/reasons_____)
□ Sickle Cell disease □ Thromboplilebitis
□ Easy bruising
□ Tender lymph nodes
□ Swollen glands/lymph nodes
□ Anemia
□ Blood clotting disorder/Blood clot
□ ITP/low platelets □ Leukemia
□ Other _____
□ None

Skin/Extremities:

□ Unexplained rash/inflammation
□ Moles changing in appearance
□ Itching
□ Acne □ Warts □ Burn injury
□ Excess hair growth
□ Change in hair texture
□ Eczema □ Pemphigus □ Psoriasis
□ Skin cancer □ Vitiligo
□ Other
□ None

Cardiovascular:

□ Papitations/Skipped beats
□ Chest pain □ Pounding in chest
□ Varicose veins □ Phlebitis/clots in vein
□ Angina □ Atrial fibrillation
□ Cardiovascular disease/arteriosclerosis
□ Congestive heart failure
□ Heart attack □ Murmurs
□ High blood pressure □ High cholesterol
□ Mitral valve prolapse (Need antibiotics
before dental procedures? □ Yes □ No
□ Pulmonary embolus
□ Other _____
□ None

Patient's Name: _____ Date: _____

Family History:	Living			Cause of Death/Age at Death
Mother	□ Yes	Age :	□ No	
Father	□ Yes	Age :	□ No	
Brother (s)	□ Yes	Age :	□ No	
	□ Yes	Age :	□ No	
	□ Yes	Age :	□ No	
Sister (s)	□ Yes	Age :	□ No	
	□ Yes	Age :	□ No	
	□ Yes	Age :	□ No	
Maternal Grandmother	□ Yes	Age :	□ No	
Maternal Grandfather	□ Yes	Age :	□ No	
Paternal Grandmother	□ Yes	Age :	□ No	
Paternal Grandfather	□ Yes	Age :	□ No	

What is your Ancestry?

□ African-American
□ American Indian/Native American
□ Ashkenazi Hewish
□ Asian-American
□ Cajun/French Canadian
□ Caucasian
□ Eastern European
□ Hispanic/Caribbean
□ Northern European
□ Southern European
□ Other (specify)

Disorders in Your Family		*Relationship to You*			**Physician Notes**
Breast cancer	□ Yes		□ No	□ Don't Know	*(for office use only)*
Ovarian cancer	□ Yes		□ No	□ Don't Know	
Uterine cancer	□ Yes		□ No	□ Don't Know	
Cervical cancer	□ Yes		□ No	□ Don't Know	
Colon cancer	□ Yes		□ No	□ Don't Know	
Other cancer_____	□ Yes		□ No	□ Don't Know	
Diabetes	□ Yes		□ No	□ Don't Know	
Thyroid or other endocrine problems	□ Yes		□ No	□ Don't Know	
Heart disease	□ Yes		□ No	□ Don't Know	
High blood pressure	□ Yes		□ No	□ Don't Know	
Stroke	□ Yes		□ No	□ Don't Know	
Blood clots	□ Yes		□ No	□ Don't Know	
Obesity	□ Yes		□ No	□ Don't Know	
Psychiatry problems	□ Yes		□ No	□ Don't Know	
Tuberculosis	□ Yes		□ No	□ Don't Know	
Endometriosis	□ Yes		□ No	□ Don't Know	
Menopause before age 40	□ Yes		□ No	□ Don't Know	
Neurologic (brain/spine)	□ Yes		□ No	□ Don't Know	
Bone/Skeletal Defects	□ Yes		□ No	□ Don't Know	
Polycystic kidney disease	□ Yes		□ No	□ Don't Know	
Heart defect from birth	□ Yes		□ No	□ Don't Know	
Deafness/Blindness	□ Yes		□ No	□ Don't Know	
Color blindness	□ Yes		□ No	□ Don't Know	
Mental Retardation	□ Yes		□ No	□ Don't Know	
□ None of the above	□ Other (Specify)		□ No	□ Don't Know	

EMOTIONAL STATUS

On a scale of 1-10 (10 being worst), estimate the level of stress you feel. _____

Have you in the past or do you currently suffer from depression? □ No □ Yes Please give details: _____

Do you see a counselor? □ No □ Yes --- For how long? _____ How often? _____

Do you see a phychiatrist? □ No □ Yes --- For how long? _____ How often? _____

List any antidepressant/antianxiety medications you are currently taking. _____

Describe any emotional, marital, or sexual problems _____

PATIENT'S SIGNATURE _____ Date: _____

I confirm that I have reviewed the above information.

PHYSICIAN'S SIGNATURE _____ Date: _____