LAS COLINAS OBSTETRICS-GYNECOLOGY & INFERTILITY

Date: _____ Name: _____ Date of Birth: _____

Age: _____ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow

Husband's or Partner's Name: _____ His Age: _____

Your Occupation: _____ His Occupation: _____

Home Phone: _____ Work Phone: _____

I. Medical and Surgical History

- Please list any medication you are taking: _____
- Please list any allergy: _____
- Please indicate any significant illness you have had:

☐ High blood pressure	☐ Seizure disorder	☐ Stroke
☐ Heart disease	☐ Mitral valve prolapse	☐ Rheumatic fever
☐ Bleeding problem	☐ Blood clots	☐ Ulcers
☐ Asthma	☐ Thyroid problems	☐ Kidney problems
☐ Hepatitis	☐ Mononucleosis	
☐ Other _____		

- Past surgeries:

	Date:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

- Do you smoke? _____ How many packs per day? _____
- Do you use alcohol? _____ How much per day? _____
- Do you use recreational drugs (cocaine, marijuana, amphetamine, ect.)? _____

II. Menstrual History

Your last menstrual period began on _____

- At what age did you have your first period? _____
- Have your periods been irregular over the last 12 months? ..... Yes No
  If yes, please describe: _____
- Do you have spotting or bleeding between periods? ..... Yes No
- How many days apart are your periods? _____
- How many days does your period last? _____
- Do you often pass blood clots during your periods? ..... Yes No
- Do you often have painful cramps before or during your periods? ..... Yes No
- Do you have pelvic or abdominal pain at any other times? ..... Yes No
- At what age did your mother underwent menopause? _____

III. Sexual History

Are you sexually active? ..... Yes No

- If yes, how often do you have intercourse? _____
- Do you often have pain with intercourse? ..... Yes No
- How many sexual partners have you had in the past 2 years? _____
- Have you ever been diagnosed with a sexually transmitted disease? ..... Yes No
  If yes please mark: ☐ herpes, ☐ Chlamydia, ☐ gonorrhea, ☐ venereal warts (condyloma)
- Have you ever had a tubal or pelvic infection? (not yeast infections) ..... Yes No
- Do you currently have vaginal discharge associated with itching and odor? ..... Yes No
- Please mark your current method of birth control: ☐ Not sexually active; ☐ Unprotected; ☐ Rhythm; ☐ Birth Control Pills; ☐ Diaphram/condom/sponge/foam; ☐ IUD; ☐ Norplant; ☐ Depo-Provera; ☐ Tubal ligation; ☐ Partner vasectomy; ☐ Hysterectomy
- Have you ever had an abnormal pap smear? ..... Yes No

IV. Obsterical History # of pregnancies:_____ # of children:_____ # miscarriages/abortions:_____

	Date of Delivery	Type of Delivery	Pregnancy Complication
1.			
2.			
3.			
4.			

V. Review of Systems

- How many hours per week do you exercise? _____
- What type of exercise? _____
- Do you have any significant weight gain or loss over last year?..... Yes No
  Please describe:_____
- Do you frequently feel tired, lack of energy, sleep, or depressed? (Please Circle)..... Yes No
  Please describe:_____
- Do you have any discharge from your breast:..... Yes No
- If yes, from which breast?_____ , amount_____ , color_____ .
- Do you have excessive facial or body hair?..... Yes No
- Do you shave your face? How often a week?_____
- Do you have a problem with acne?..... Yes No

VI. Blatter and Bowel Syptoms

- Do you have any problems with urination such as: frequency, pain, or sence of urgency? (Please Circle)..... Yes No
- Do you leak urine when you exercise of cough?..... Yes No
- Do you have to wake up to go to bathroom at night..... Yes No
- How many times a night?_____
- Has there been any change in your bowel habits (diarrhea, constipation, irritable stomach)?..... Yes No
- Do you have pain durring bowel movement?..... Yes No
- Do you notice any blood in the stool?..... Yes No

VII. Family Medical History

Has anyone in your immediate family (mother, father, sister, brother, aunts, uncles, ect.) ever had.....

- Birth Defects Who? _____ Yes No
- Genetic Diseases Who? _____ Yes No
- Cancer of Breast Who? _____ Yes No
- Cancer of Uterus or Overy Who? _____ Yes No
- Cancer of Colon Who? _____ Yes No
- Diabetes Who? _____ Yes No
- High Blood Pressure Who? _____ Yes No
- Heart Disease Who? _____ Yes No

VIII. Partner's Profile

- Has he fathered any children?_____ How many?_____ Age of youngest child?_____
- Does he have any significant illness (including childhood mumps)?..... Yes No
  Please specify:_____
- Does he take any medication?_____
- Has he ever had injury to the groin?..... Yes No
- Has he ever had male surgery (ie. prostate surgery, vasectomy)?..... Yes No
- Does he smoke?_____ Drink alcohol?_____
  Recreational drug? (marijuana, cocaine, amphetamine, ect.)_____
- Has he had prior exposure to radiation or chemical toxins?..... Yes No
  Please specify:_____