Las Colinas Obstetrics-Gynecology & Infertility

Physician/Provider: _____ Date: _____
Name: _____ Date of Birth: _____ Age: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow
Spouse/Partner's Name: _____ Age: _____
Your Occupation: _____ Work Phone: _____
Home Phone: _____ Cell Phone: _____
Spouse/Partner's Occupation: _____ Work Phone: _____

I. Medical and Surgical History

- Please list any medication you are taking: _____
  _____
- Please list any allergies: _____
  _____

Please indicate any significant illness you have had:

☐ High Blood Pressure	☐ Seizure Disorder	☐ Stroke	☐ Diabetes: Type I ___ Type II ___
☐ Heart Disease	☐ Mitral Valve Prolapse	☐ Rheumatic Fever	☐ Breast Cancer
☐ Bleeding Problem	☐ Blood Clots	☐ Ulcers	☐ Uterine or Ovarian Cancer
☐ Asthma	☐ Thyroid Problems	☐ Kidney Problems	☐ Colon Cancer
☐ Hepatitis	☐ Mononucleosis	☐ Other _____	

- **Past Surgeries:** Date:

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

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

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 do your periods last? _____
- Do you often pass 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 you mother begin menopause? _____

III. Sexual History

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

- If yes, how often do you have intercourse? _____
- Do you 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 infection)? ..... 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 ☐ Patch/Ring
- Have you ever had an abnormal pap smear? ..... Yes No

*IV. **Obstetrical History*** *# of pregnancies: _____ # of deliveries: _____ # of 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? _____		
• Have you had any significant weight gain or loss over the last year?	Yes	No
• Please describe: _____		
• Do you frequently feel tired, lack of energy or sleep, or depressed? (Please Circle)	Yes	No
• Please describe: _____		
• Do you have any discharge from your breast?	Yes	No
• If yes, from which breast? ___ Right ___ Left Amount _____ Color _____		
• Do you have excessive facial or body hair?	Yes	No
• Do you shave your face? ___ Yes ___ No If yes, how often a week? _____		
• Do you have a problem with acne?	Yes	No

*VI. **Bladder and Bowel Systems***

• Do you have any problems with urination such as: ___ Frequency ___ Pain ___ Sense of Urgency	Yes	No
• Do you leak urine when you exercise or cough?	Yes	No
• Do you wake up to go to the bathroom at night?	Yes	No
• If yes, how many times a night?_____		
• Has there been any change in your bowel habits? ___ Diarrhea ___ Constipation ___ Irritable Stomach	Yes	No
• Do you have pain during a bowel movement?	Yes	No
• Do you notice any blood in the stool?	Yes	No

*VII. **Family Medical History***

Has any immediate family member (parents, brothers, sisters, aunts, uncles, grandparents, cousins, etc.) ever had:

• Birth Defects	Yes	No	Who? _____
• Genetic Diseases	Yes	No	Who? _____
• Breast Cancer	Yes	No	Who? _____
• Uterine or Ovarian Cancer	Yes	No	Who? _____
• Colon Cancer	Yes	No	Who? _____
• Diabetes: Type I ___ Type II ___	Yes	No	Who? _____
• High Blood Pressure	Yes	No	Who? _____
• Heart Disease	Yes	No	Who? _____

*VIII. **Partner's Profile***

• Has he fathered any children? _____ How many? _____ Age of his youngest child? _____		
• Does he have any significant illness, including childhood mumps?	Yes	No
• Please specify: _____		
• Does he take any medication?	Yes	No
• Has he ever had an injury to the groin?	Yes	No
• Has he ever had any male surgery (prostate, vasectomy, etc.)?	Yes	No
• Does he smoke? _____ How many packs per day? _____		
• Does he use alcohol? _____ How many drinks per day? _____		
• Does he use recreational drugs (cocaine, marijuana, amphetamine, etc.)? _____		
• Has he had prior exposure to radiation or chemical toxins?	Yes	No
Please specify: _____		