Seth Levrant, MD PC

Partners in Reproductive Health

"A Partnership in Care"

Patient Name_____DOB:_____Age:____Date:_____

New Patient_____Established Patient_____Consultation_____Chart #_____

Primary Care Physician_____Gynecologist_____

Patient referred by_____Other physicians_____

FEMALE MEDICAL HISTORY AND INFORMATION

Reason for Visit: ☐ Infertility Evaluation ☐ Recurrent Pregnancy Loss ☐ Premature Ovarian Failure ☐ Other _____

What questions do want answered at this visit?_____

Chief Complaint or Problem(s)?_____

Pregnancy Summary

☐ Total Number of ALL Pregnancies: _____ □ Number of Miscarriages (less than 20 weeks): _____

☐ Number of Ectopic/Tubal Pregnancies: _____ □ Number of Elective Terminations (Abortions): _____

☐ Number of Full Term Deliveries: _____ Of these, how many were live births? ___ How many were stillborn? ___

☐ Number of Premature (less than 37 weeks) Deliveries: _____ Of these, how many were live births? ___ How many were stillborn? ___ ☐ Any Pregnancies with Birth Defects? ☐ Yes - explain _____ ☐ No

Date Pregnancy Ended or Delivered	Months to Conception	Treatments to Conceive	Delivery Type/D&C/ Complications	Wt	Sex	Current Partner?
1.					□ B □ G	□ Y □ N
2.					□ B □ G	□ Y □ N
3.					□ B □ G	□ Y □ N
4.					□ B □ G	□ Y □ N
5.					□ B □ G	□ Y □ N
6.					□ B □ G	□ Y □ N

Menstrual History

☐ Menstrual cycle pattern (check all that apply): ☐ Regular periods ☐ Irregular periods ☐ Spotting before periods ☐ Heavy periods ☐ Average or Moderate periods ☐ Light periods ☐ Bleeding between periods ☐ No periods

☐ Number of days between the start of one period to the start of the next period: _____days

☐ How many days of bleeding do you have? _____days

☐ Dates of the 1st day of your last 2 menstrual periods: _____/_____/_____; _____/_____/_____

☐ Age when you had your first period: _____years old

☐ Age when you first noticed: Breast development: ____years old Pubic hair: ____years old Underarm hair: ____years old

☐ How many periods do you have per year? _____

☐ Do you need medication to bring on a period? ☐ Yes - what type?_____ ☐ No

☐ If you do not have periods, at what age did you stop having them? _____ years old

☐ Do you have cramping or pelvic pain with your periods? ☐ Yes: __Always __Sometimes __Recently __In the past ☐ No

☐ Is the cramping or pelvic pain with your periods __Severe __Moderate __Mild __Interfere with daily activity __other times

Contraceptive History

☐ None ☐ Condoms - dates of use_____ ☐ Diaphragm - dates of use _____ ☐ IUD - dates of use_____

☐ Birth control pills - dates of use_____ - complications?_____☐ Never used birth control pills

☐ Injectable contraception (Depo-Provera®, Lunelle™, etc.) - dates of use_____ - complications?_____

☐ Skin patch - dates of use_____ - complications?_____ ☐ Foam or Jelly

☐ Tubal sterilization procedure (tubes tied) - date (month/year)_____/_____ ☐ Tubes untied - date (month/year)_____/_____

☐ Did your mother take DES when she was pregnant with you? ☐ Yes ☐ No ☐ Don't know

☐ At what age did your mother go through menopause: _____ ☐ Don't know ☐ not postmenopausal

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Sexual History Patient Name_____

☐ How many months have you been having intercourse without using any form of birth control?_____
☐ How many times do you have intercourse per week? _____times per week ☐ None ☐ Not applicable
☐ Have you used over-the-counter ovulation kits to time intercourse? ☐ Yes ☐ No
☐ Do you have pain with intercourse? ☐ Yes ☐ No
☐ Do you use lubricants (K-Y Jelly®, etc.) during intercourse? ☐ Yes - what types?_____ ☐ No
Have you had any of the following sexually transmitted diseases or pelvic infections? ☐ Yes (check all that apply) ☐ No
☐ Chlamydia - date_____ ☐ Gonorrhea - date_____ ☐ Herpes - date_____ Genital warts/HPV - date_____
☐ Syphilis - date_____ ☐ HIV/AIDS - date_____ ☐ Hepatitis - date_____ Other - date_____

Pap Smear History

☐ When was your last pap smear (month and year)?_____/_____ ☐ Normal ☐ Abnormal
☐ When was your last abnormal pap smear? _____ ☐ Not applicable

Have you undergone any procedures as a result of an abnormal pap smear?
☐ Yes (check all that apply) ☐ No
☐Colposcopy ☐ Cryosurgery (Freezing) ☐ Laser treatment ☐ Conization ☐ LEEP procedure

Breast Screening History

Have you ever had a mammogram? ☐ Yes - date_____ Result: ☐ normal ☐ abnormal - explain _____ ☐ No
Do you perform breast self exams? ☐ Yes ☐ No

Medical History

☐ Are you allergic to any medications? ☐ Yes ☐ No (Please list and describe reactions)
_____
_____
☐ Are you allergic to any foods (peanuts, eggs, etc.)? ☐ Yes ☐ No (If yes, please list and describe reactions)
_____
☐ List any medications you are currently taking, including over-the-counter medicines.
_____
_____
☐ Do you take any herbal medicines/vitamins or health food store supplements? ☐ Yes ☐ No (Please list)_____

☐ Do you have any medical problem(s)? ☐ Yes (Please list type, dates, and treatments.) ☐ No
(1)_____
(2)_____
(3)_____
(4)_____
(5)_____
☐ Did you have either of these childhood illnesses? ☐ Chickenpox (Varicella) ☐ German Measles (Rubella) ☐ Don't know
☐ Other childhood diseases:_____

Surgical History

☐ Have you had any surgeries? ☐ Yes (List all surgeries in chronologic order.) ☐ No

Year Reason and Type of Surgery
☐ _____ (1)_____
☐ _____ (2)_____
☐ _____ (3)_____
☐ _____ (4)_____
☐ _____ (5)_____
☐ _____ (6)_____
☐ Did you have any anesthesia problems? ☐ Yes (describe _____) ☐ No

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Social History Patient Name_____

- How many caffeinated beverages (coffee, tea, soda) do you drink per day?_____ □ None
- Do you smoke cigarettes? □ Yes □ No How many/day?_____ How many years?_____ □ Quit - when?_____
Second-hand Exposure □ Yes □ No
- Do you drink alcohol? □ Yes □ No
- □ Beer - # per week_____ □ Wine- # per week_____ □ Liquor - # per week_____
- Do you use marijuana, cocaine, or any other similar drug? □ Yes (describe_____) □ No
- Do you exercise? □ Yes □ No Regularly? □ Yes □ No
- How many hours of moderate exercise per week (i.e. walking, yoga) _____
- How many hours of vigorous exercise per week (i.e. running) _____
- Are you aware of any radiation exposures other than X-rays? □ Yes (describe_____) □ No
- Do you feel safe in your own home? □ Yes □ No (describe_____)
- Do you wear a seat belt regularly? □ Yes □ No
- Number of people in household____Current or most recent job_____
- School completed: High school_____College_____Graduate Degree_____Other_____

Physical Symptoms

General:
□ Recent weight gain or loss
□ Anorexia/Bulimia
□ Lack of energy
□ Fever/Chills
□ Other_____
□ None

Endocrine/Hormonal:
□ Diabetes □ Hair loss
□ Thyroid gland problems
□ Rapid weight gain or loss
□ Excessive hunger/thirst
□ Temperature intolerance–
hot flashes or feeling cold
□ Other_____
□ None

Gastrointestinal:
□ Nausea/Vomiting □ Ulcers
□ Hepatitis □ Diarrhea
□ Blood in your stools □ C o n s t i p a t i o n
□ Irritable Bowel Syndrome
□ Change in bowel habits
□ Colitis (ulcerative or Crohn's)
□ Other_____
□ None

Musculoskeletal:
□ Unusual muscle weakness
□ Decreased energy/stamina
□ Rheumatoid arthritis
□ Lupus Erythematosus
□ Myasthenia gravis
□ Other_____
□ None

Mental Health Problems:
□ Depression or Anxiety disorder
□ Schizophrenia
□ Other_____
□ **None**

Head, Eyes, Ears, Nose, and Throat:
□ Dizziness □ Loss of sense of smell
□ Headaches □ Chronic nasal congestion
□ Blurred vision □ Ringing ears
□ Hearing loss/deafness
□ Other_____
□ None

Breasts:
□ Discharge (clear?___ bloody?___
milky?___)
□ Lumps □ Pain □ Cancer
□ Abnormal mammogram
□ Reduction
□ Augmentation/Breast implants
(saline?___ silicone?___)
□ Other_____
□ None

Genito-Urinary:
□ Bladder infections
□ Kidney infections
□ Vaginal infections
□ Frequent urination □ Leaking urine
□ Blood in the urine
□ Herpes
□ Other_____
□ None

Hematologic:
□ Blood clotting disorder/Blood clot
□ Sickle Cell Anemia □ Thrombophlebitis
□ Easy bruising
□ Swollen glands/lymph nodes
□ Blood transfusions
(dates/reasons_____)
□ Other_____
□ None

Respiratory:
□ Shortness of breath
□ Asthma □ Bronchitis
□ Pneumonia □ Tuberculosis
□ Bloody cough
□ Other_____
□ None

Neurological Problems:
□ Weakness/Loss of balance
□ Seizures/Epilepsy
□ Headaches
□ Migraine headaches
□ Numbness
□ Memory loss
□ Other_____
□ None

Skin/Extremities:
□ Unexplained rash/inflammation
□ Acne
□ Skin cancer
□ Burn injury
□ Moles changing in appearance
□ Excess hair growth
□ Other_____
□ None

Cardiovascular:
□ Palpitations/Skipped beats
□ Chest pain □ Heart attack
□ Stroke □ Murmurs
□ High blood pressure
□ Rheumatic fever
□ Mitral valve prolapse (Need antibiotics before dental procedures?) Yes___ No___

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Patient Name_____

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 _____
  ☐Yes - age___ ☐No _____
- Sister(s) ☐Yes - age___ ☐No _____
  ☐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 _____

Disorders in Your Family **Relationship to You**

- Breast cancer ☐Yes _____ ☐No ☐Don't Know
- Ovarian 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 problems ☐Yes _____ ☐No ☐Don't Know
- Heart disease ☐Yes _____ ☐No ☐Don't Know
- Blood clots ☐Yes _____ ☐No ☐Don't Know
- Obesity ☐Yes _____ ☐No ☐Don't Know
- Psychiatric problems ☐Yes _____ ☐No ☐Don't Know
- Tuberculosis ☐Yes _____ ☐No ☐Don't Know
- Endometriosis ☐Yes _____ ☐No ☐Don't Know
- Infertility ☐Yes _____ ☐No ☐Don't Know
- Menopause before age 40 ☐Yes _____ - ☐No ☐Don't Know
- Birth defects ☐Yes _____ ☐No ☐Don't Know
- Cystic Fibrosis ☐Yes _____ ☐No ☐Don't Know
- Tay-Sachs disease ☐Yes _____ ☐No ☐Don't Know
- Canavan disease ☐Yes _____ ☐No ☐Don't Know
- Bloom syndrome ☐Yes _____ ☐No ☐Don't Know
- Gaucher disease ☐Yes _____ ☐No ☐Don't Know
- Niemann-Pick disease ☐Yes _____ ☐No ☐Don't Know
- Fanconi Anemia ☐Yes _____ ☐No ☐Don't Know
- Familial Dysautonia ☐Yes _____ ☐No ☐Don't Know
- Muscular Dystrophy ☐Yes _____ ☐No ☐Don't Know
- Neurologic (brain/spine) ☐Yes _____ ☐No ☐Don't Know
- Neural Tube Defects ☐Yes _____ ☐No ☐Don't Know
- Bone/Skeletal Defects ☐Yes _____ ☐No ☐Don't Know
- Dwarfism ☐Yes _____ ☐No ☐Don't Know
- Developmental delay ☐Yes _____ ☐No ☐Don't Know
- Learning problems ☐Yes _____ ☐No ☐Don't Know
- Polycystic kidney disease ☐Yes _____ ☐No ☐Don't Know
- Heart defect from birth ☐Yes _____ ☐No ☐Don't Know
- Down syndrome ☐Yes _____ ☐No ☐Don't Know
- Other chromosome defects ☐Yes _____ ☐No ☐Don't Know
- Marfan syndrome ☐Yes _____ ☐No ☐Don't Know
- Hemophilia ☐Yes _____ ☐No ☐Don't Know

What is your Ancestry?

☐African-American
☐Native A m e r i c a n
☐Ashkenazi Jewish
☐Asian-Chinese
☐Asian-Japanese
☐Asian-Korean
☐Asian-Indian
☐Asian-Filipino
☐Asian-Vietnamese
☐Asian-Other: _____
☐Caucasian-Northern European
☐Caucasian-Russian
☐Caucasian-Southern European
☐Hispanic – Mexican
☐Hispanic – South America
Country of Origin: _____
☐Hispanic – Central American
Country of Origin: _____
☐Hispanic – Spain
☐Middle Eastern-
Country of Origin_____
☐African-
Country of Origin:_____
☐Other_____

Disorders in Your Family **Relationship to You**

- Sickle Cell Anemia ☐Yes _____
  ☐No ☐Don't Know
- Thalassemia ☐Yes _____
  ☐No ☐Don't Know
- Galactosemia ☐Yes _____
  ☐No ☐Don't Know
- Deafness/Blindness ☐Yes _____
  ☐No ☐Don't Know
- Color Blindness ☐Yes _____
  ☐No ☐Don't Know
- Hemochromatosis ☐Yes _____
  ☐No ☐Don't Know
- High blood pressure ☐Yes _____
  ☐No ☐Don't Know
- Glaucoma ☐Yes _____
  ☐No ☐Don't Know
- Gallstones ☐Yes _____
  ☐No ☐Don't Know

Hepatitis ☐Yes _____
☐No ☐Don't Know

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Prior Fertility Testing and Treatments

Patient Name_____

☐ Have you had prior infertility testing or treatments elsewhere? □ Yes □ No Where? _____

Prior tests (check all that apply:)

☐ Day 3 FSH level Results _____ ☐ normal ☐abnormal
☐ AMH level Results _____ ☐ normal ☐abnormal
☐ Prolactin test Results_____ ☐ normal ☐abnormal
☐ Hysterosalpingogram(date) _____ ☐ normal ☐abnormal
☐ Hysteroscopy (date) _____ ☐ normal ☐abnormal
☐ Thyroid test. Results _____ ☐ normal ☐abnormal
☐ Semen Analysis Results _____ ☐ normal ☐abnormal
☐ Progesterone Results _____ ☐ normal ☐abnormal
☐ Sonohysterogram(date) _____ ☐ normal ☐abnormal
☐ Laparoscopy(date) _____ ☐ normal ☐abnormal

Prior Diagnosis? _____

Anovulation	Yes/ No	Congenital Adrenal Hyperplasia	Yes/ No	Diabetes	Yes/ No
Breast discharge	Yes/ No	Galactorrhea	Yes/ No	Delayed puberty	Yes/No
Dysmenorrhea	Yes/ No	Dyspareunia	Yes/ No	Endometrial polyp	Yes/No
Endometriosis	Yes/ No	Hirsutism	Yes/ No	Hyperprolactinemia	Yes/ No
Hyperthyroidism	Yes/ No	Hypothyroidism	Yes/ No	Hot Flashes	Yes/ No
Menopausal Symptoms	Yes/ No	Ovarian cysts	Yes/ No	Ovarian failure	Yes/ No
PCOS	Yes/ No	Pelvic pain	Yes/ No	Uterine anomaly	Yes/ No
Uterine fibroids	Yes/ No	Chemotherapy	Yes/ No	Genetic Carrier	Yes/ No

Prior Treatments (check all that apply)?	# cycles	Dates	Outcome
☐Clomiphene citrate with timed intercourse Dose of medication_____			☐pregnant ☐delivered ☐ectopic ☐miscarriage ☐ not pregnant
☐Clomiphene citrate with insemination Dose of medication_____			☐pregnant ☐delivered ☐ectopic ☐miscarriage ☐ not pregnant
☐Letrozole with timed intercourse Dose of medication_____			☐pregnant ☐delivered ☐ectopic ☐miscarriage ☐ not pregnant
☐Letrozole with insemination Dose of medication_____			☐pregnant ☐delivered ☐ectopic ☐miscarriage ☐ not pregnant
☐Gonadotropins with insemination Dose of medication_____			☐pregnant ☐delivered ☐ectopic ☐miscarriage ☐ not pregnant
☐Completed IVF cycles # eggs___# transferred___ # frozen___	1	_____	☐pregnant ☐delivered ☐ectopic ☐miscarriage ☐ not pregnant
# eggs___# transferred___ # frozen___	2	_____	☐pregnant ☐delivered ☐ectopic ☐miscarriage ☐ not pregnant
# eggs___# transferred___ # frozen___	3	_____	☐pregnant ☐delivered ☐ectopic ☐miscarriage ☐ not pregnant
# eggs___# transferred___ # frozen___	4	_____	☐pregnant ☐delivered ☐ectopic ☐miscarriage ☐ not pregnant
☐ Frozen Embryo transfers: # embryos transferred_____	1	_____	☐pregnant ☐delivered ☐ectopic ☐miscarriage ☐ not pregnant
# embryos transferred_____	2	_____	☐pregnant ☐delivered ☐ectopic ☐miscarriage ☐ not pregnant
# embryos transferred_____	3	_____	☐pregnant ☐delivered ☐ectopic ☐miscarriage ☐ not pregnant
# embryos transferred_____	4	_____	☐pregnant ☐delivered ☐ectopic ☐miscarriage ☐ not pregnant

EMOTIONAL STATUS

- On a scale of 1-10 (10 being the worst), estimate the level of stress you feel due to infertility and other pressures.__
- Do you see a counselor? ☐No ☐ Yes - For how long? _____ How often? _____
- List any antidepressant/antianxiety medications you are currently taking._____
- Describe any emotional, marital, or sexual problems caused by your infertility.

_____

PATIENT'S SIGNATURE_____ **DATE**_____

I confirm that I have reviewed the information above.

PHYSICIAN'S SIGNATURE_____ **DATE**_____

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Partners in Reproductive Health

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Male Partner Medical History and Information:

Name: _____ Age_____ DOB_____

Infertility History:

Conceived with another women	Yes/ No	If yes, ages of child(ren) _____
Conceived with current partner	Yes/ No	If yes, ages of child(ren) _____
Have you had a semen analysis	Yes/ No	Normal or Abnormal
Have you been evaluated by an urologist	Yes/ No	Findings_____

☐ Have you had prior infertility testing or treatments elsewhere? □ Yes □ No

Prior tests (check all that apply:)

☐ FSH & LH level Results ____ ☐ normal ☐abnormal ☐ Thyroid test. Results _____ ☐ normal ☐abnormal

☐ Prolactin test Results _____ ☐ normal ☐abnormal ☐ Testosterone Results _____ ☐ normal ☐abnormal

☐ Scrotol Ultrasound Results___ ☐ normal ☐abnormal ☐ Testicular biopsy Results _____ ☐ normal ☐abnormal

Prior Diagnosis? _____

Prior Treatments?_____

Medical History: ☐Allergies_____ ☐Cancer

☐Erectile dysfunction ☐Exposure to radiation ☐Occupational exposures ☐Genetic carrier

☐Chemotherapy ☐Testicular injury ☐Undescended testicle ☐Diabetes

☐Hypertension ☐Heart disease ☐Prostatic infections ☐Urinary infections

☐Multiple Sclerosis ☐Other Illness or Medical Problems_____

List your current medications:_____

☐ Have you had any of the following sexually transmitted diseases or pelvic infections?

☐ Chlamydia - date_____ □ Gonorrhea - date_____ □ Herpes - date_____ Genital warts/HPV - date_____

☐ Syphilis - date_____ □ HIV/AIDS - date_____ □ Hepatitis - date_____ Other - date_____

☐ Do you have scrotal or testicular pain? □ Yes □ No

☐ Did you have the mumps after puberty? □ Yes □ No

☐ Do you have retrograde ejaculation of sperm into the bladder? □ Yes □ No

☐ Have you had any fever in the last 3 months? □ Yes □ No

Surgical History: ☐Vasectomy_____ ☐Varicocele repair _____ ☐Vasectomy reversal_____

☐ Hernia surgery_____ ☐Bladder or penis surgery as a child_____

☐Other Surgeries _____

Social History:

☐ How many caffeinated beverages (coffee, tea, soda) do you drink per day?_____ □ None

☐ Do you smoke cigarettes? □ Yes □ No How many/day?_____ How many years?_____ □ Quit - when?_____

Second-hand Exp □ Yes □ No Smokeless tobacco □ Yes □ No Types: snuff/chew □ Quit - when?_____

☐ Do you drink alcohol? □ Yes □ No

☐ Beer - # per week_____ □ Wine- # per week_____ □ Liquor - # per week_____

☐ Do you use marijuana, cocaine, or any other similar drug? □ Yes (describe_____) □ No

☐ Do you exercise? □ Yes □ No Regularly? □ Yes □ No

☐ How many hours of moderate exercise per week (i.e. walking, yoga) _____

☐ How many hours of vigorous exercise per week (i.e. running) _____

☐ Are you aware of any radiation exposures other than X-rays? □ Yes (describe_____) □ No

☐ Do you use herbal medicines/vitamins or health food store supplements □ No □ Yes (describe_____)

☐ Do you use hot tubs regularly? □ Yes □ No

☐ Have any of your immediate family members had difficulty conceiving a child? □ Yes □ No If yes, please describe_____

_____

☐ Did your mother take DES during pregnancy to prevent miscarriage? □ Yes □ No □ Don't know

☐ Do you feel safe in your own home? □ Yes □ No (describe_____)

☐ Do you wear a seat belt regularly? □ Yes □ No

☐ Number of people in household____ Current or most recent job_____

☐Occupation_____ ☐Past Occupations_____

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Male Partner Name_____

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 _____
  ☐Yes - age___ ☐No _____
- Sister(s) ☐Yes - age___ ☐No _____
  ☐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 _____

Disorders in Your Family **Relationship to You**

- Breast cancer ☐Yes _____ ☐No ☐Don't Know
- Ovarian 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 problems ☐Yes _____ ☐No ☐Don't Know
- Heart disease ☐Yes _____ ☐No ☐Don't Know
- Blood clots ☐Yes _____ ☐No ☐Don't Know
- Obesity ☐Yes _____ ☐No ☐Don't Know
- Psychiatric problems ☐Yes _____ ☐No ☐Don't Know
- Tuberculosis ☐Yes _____ ☐No ☐Don't Know
- Endometriosis ☐Yes _____ ☐No ☐Don't Know
- Infertility ☐Yes _____ ☐No ☐Don't Know
- Menopause before age 40 ☐Yes _____ - ☐No ☐Don't Know
- Birth defects ☐Yes _____ ☐No ☐Don't Know
- Cystic Fibrosis ☐Yes _____ ☐No ☐Don't Know
- Tay-Sachs disease ☐Yes _____ ☐No ☐Don't Know
- Canavan disease ☐Yes _____ ☐No ☐Don't Know
- Bloom syndrome ☐Yes _____ ☐No ☐Don't Know
- Gaucher disease ☐Yes _____ ☐No ☐Don't Know
- Niemann-Pick disease ☐Yes _____ ☐No ☐Don't Know
- Fanconi Anemia ☐Yes _____ ☐No ☐Don't Know
- Familial Dysautonia ☐Yes _____ ☐No ☐Don't Know
- Muscular Dystrophy ☐Yes _____ ☐No ☐Don't Know
- Neurologic (brain/spine) ☐Yes _____ ☐No ☐Don't Know
- Neural Tube Defects ☐Yes _____ ☐No ☐Don't Know
- Bone/Skeletal Defects ☐Yes _____ ☐No ☐Don't Know
- Dwarfism ☐Yes _____ ☐No ☐Don't Know
- Developmental delay ☐Yes _____ ☐No ☐Don't Know
- Learning problems ☐Yes _____ ☐No ☐Don't Know
- Polycystic kidney disease ☐Yes _____ ☐No ☐Don't Know
- Heart defect from birth ☐Yes _____ ☐No ☐Don't Know
- Down syndrome ☐Yes _____ ☐No ☐Don't Know
- Other chromosome defects ☐Yes _____ ☐No ☐Don't Know

What is your Ancestry?

☐African-American
☐Native A m e r i c a n
☐Ashkenazi Jewish
☐Asian-Chinese
☐Asian-Japanese
☐Asian-Korean
☐Asian-Indian
☐Asian-Filipino
☐Asian-Vietnamese
☐Asian-Other: _____
☐Caucasian-Northern European
☐Caucasian-Russian
☐Caucasian-Southern European
☐Hispanic – Mexican
☐Hispanic – South America
Country of Origin: _____
☐Hispanic – Central American
Country of Origin: _____
☐Hispanic – Spain
☐Middle Eastern-
Country of Origin_____
☐African-
Country of Origin:_____
☐Other_____

Disorders in Your Family **Relationship to You**

- Sickle Cell Anemia ☐Yes _____
  ☐No ☐Don't Know
- Thalassemia ☐Yes _____
  ☐No ☐Don't Know
- Galactosemia ☐Yes _____
  ☐No ☐Don't Know
- Deafness/Blindness ☐Yes _____
  ☐No ☐Don't Know
- Color Blindness ☐Yes _____
  ☐No ☐Don't Know
- Hemochromatosis ☐Yes _____
  ☐No ☐Don't Know
- High blood pressure ☐Yes _____
  ☐No ☐Don't Know
- Glaucoma ☐Yes _____
  ☐No ☐Don't Know
- Gallstones ☐Yes _____
  ☐No ☐Don't Know

Hepatitis ☐Yes _____
☐No ☐Don't Know
Hemophilia ☐Yes _____
☐No ☐Don't Know
Marfan syndrome ☐Yes _____
☐No ☐Don't Know

PATIENT'S SIGNATURE_____ **DATE**_____
I confirm that I have reviewed the information above.

PHYSICIAN'S SIGNATURE_____ **DATE**_____

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Partners in Reproductive Health

"A Partnership in Care"

PHYSICIAN USE ONLY: PHYSICAL EXAMINATION Patient Name_____

Height: _____ Weight:_____ BMI: _____kg/m2_____BP:_____RR: _____Temp:_____

General Appearance ☐ Well developed ☐ Well nourished ☐ Well groomed ☐ No deformities

Skin ☐ Normal ☐ Abnormal Hair: fascial _____Chest ___Abdomen___Back ____Thighs_____

Neck/lymph nodes ☐ Normal ☐ Abnormal _____Thyroid ☐ Normal ☐ Abnormal

Lungs Auscultation ☐ Normal ☐ Abnormal _____Respiratory effort☐ Normal ☐ Abnormal

Heart /CVD: Auscultation ☐ Normal ☐ Abnormal _____Peripheral vascular ☐ Normal ☐ Abnormal

GI: Abdomen/Hernia ☐ Normal ☐ Abnormal _____Liver/Spleen ☐ Normal ☐ Abnormal

Neurological/Psychiatric ☐ Normal ☐ Abnormal Oriented x 3 Yes/ No Mood/Affect ☐ Normal ☐ Abnormal

Breasts ☐ Normal ☐ Abnormal _____Axilla lymph nodes☐ Normal ☐ Abnormal

Ext. Genitalia / Urethral meatus/Urethra/ Bladder/Vagina / Cervix ☐ Normal ☐ Abnormal _____

Adnexa ☐ Normal ☐ Abnormal Anus/perineum ☐ Normal ☐ Abnormal

Uterine size: _____Position:_____☐ Normal ☐ Abnormal_____

FEMALE DIAGNOSES:

1) _____ICD 10 _____
2) _____ICD 10 _____
3) _____ICD 10 _____
4) _____ICD 10 _____
5) _____ICD 10 _____
6) _____ICD 10 _____

MALE DIAGNOSES:

1) _____ICD 10_____
2) _____ICD 10_____

INFO/ADVICE/Counseling

☐ Explained female reproductive physiology

☐ Procreative counseling

☐ genetic carrier screening counseling

LMP:_____Today is cycle day:_____

☐ Start PNV/Folate

GENERAL: PNP CBC CMP 25OH-Vitamin D3 Varicella Rubella Blood type ☐ CoQ10 / Vit D

REI: Day 3 FSH/LH/E2 Random FSH/LH/E2 AMH Pelvic Sono with AFC ☐ Weight Loss

ENDO: TSH PRL HgA1C Fasting Insulin Fasting Glucose 3 hour GTT Lipid Profile ☐ Stop Smoking

ANDRO: Total and Free Testosterone 17-OHP DHEAS 8am Cortisol ☐PCOS/Metformin

STD: Chlamydia GC HIV I/II Hepatitis C AB Hepatitis B sAg CMV IgG / IgM RPR ☐ Fibroids

GENETIC: Karyotype- female Sickle cell Screen Carrier Screening: expanded panel ☐Genetic testing

ANATOMIC: HSG Sonohysterogram Pelvic Sono Trial Transfer ☐Endometriosis

IMMUNE: LAC ACA (IgM/IgG) anti-β2GP1 (IgM/IgG) Anti-thyroid ATB ☐ DOR / RPL

MALE: Semen analysis Retrograde analysis SA Refer to Urology Sperm back up cryo ☐Male Infertility

MALE ENDO: FSH LH PRL TSH Total and free Testosterone ☐Meds' Preg Categ

MALE STD: HIV I/II RPR Hepatitis B sAg Hepatitis C AB CMV IgG IgM Blood type ☐Clomid/Letrozole

MALE GENETIC: Karyotype- male Y-chromosome microdeletions CF mutation analysis ☐Gonadotropins

(Need) Medical Records from: _____ F/U Appt:_____☐ IUI

Notes/Summary_____☐ IVF ICSI PGT

_____☐ Donor Sperm

_____☐ Donor Egg

_____☐ bASA/Heparin

_____☐ Lovenox

_____☐ LSC / HSC

Physician Signature_____Date_____Referral LTR dictated_____Page8

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