



Texas Tech Physicians
of LUBBOCK
THE CENTER FOR FERTILITY
AND REPRODUCTIVE SURGERY

NEW PATIENT CONSULTATION

Date Forms Were Completed: _____

PLEASE FILL OUT ALL INFORMATION BELOW. THANK YOU.

Name of Physician who is sending you for consultation:

Physician's Name: _____

Physician's Address: _____

City _____ State _____ Zip code _____

Physician's phone number: _____

Your Name: _____ Date of Birth: _____ Age: _____

Occupation: _____

Partner/Spouse's Name _____ Date of Birth: _____ Age: _____

Occupation: _____

Religious preference: _____

Reason for visit: _____

I- Past Medical History: (Please list any health problems such as high blood pressure, diabetes, asthma or any other conditions requiring medical treatment)

1. _____

2. _____

3. _____

II Past Surgical History:

Date: _____ Type of Surgery _____

Date: _____ Type of Surgery _____

Date: _____ Type of Surgery _____

III-Medications: (Please list all current prescription and over counter medications)

1. _____

2. _____

3. _____

4. _____

IV-Allergies to Medications (or Foods or others):

1. _____ Reaction that occurs: _____

2. _____ Reaction that occurs: _____

V-Social History:

Years of marriage (if applicable): _____
Years with current partner: _____
Do you smoke? _____ If yes, how many cigarettes per day? _____ How many years? _____
Do you drink alcohol? _____ If yes, how many alcoholic beverages per week? _____
Do you use drugs? _____ If yes, what kind? _____ How often? _____

V-Obstetrical History:

Total number of pregnancies in your lifetime: _____

Please include all miscarriages, abortions, stillborn, and ectopic

<u>Date of Pregnancy</u> <u>miscarriage/ectopic</u>	<u>Weeks of Gestation:</u>	<u>Vaginal birth or</u> <u>C-Section</u>	<u>Male/</u> <u>Female</u>	<u>Weight</u>
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____

V-Gynecologic History:

a- Cervical Factors:

Date of last pap smear? _____ Was it normal? _____
History of cryotherapy (freezing of cervix), LEEP, LETZ or cone biopsy? _____
Have you had previous one of those infections? Circle one or more:
Chlamydia Gonorrhea Trichomonas HPV/warts Herpes

b- Ovulatory Factors:

Age when you had your first period? _____
Are your menstrual cycles regular or irregular? _____
Menstrual cycles occur at intervals of _____ days (Example: How many days from the first day of one menstrual cycle to the first day of the next menstrual cycle?).
The bleeding lasts for _____ days.
Are your periods ever so heavy that you must change a pad or tampon hourly? _____

c- Pelvic & uterus and tubal factors:

When is your menstrual cycle most uncomfortable? (Please check one)
____ Day before bleeding starts
____ First few days of bleeding
____ My periods are never uncomfortable

Do your periods require use of over-the-counter pain medications? _____
If yes, what do you usually take? _____
Do you ever have pelvic discomfort with intercourse? _____
Do you ever use a heating pad or heating patches on your period? _____

Do you ever reduce your activities during your period due to discomfort? _____
Do you ever miss work or school because of menstrual discomfort? _____

Have you ever been diagnosed with the following? (Please check all that apply)

- _____ Fibroids
- _____ Pelvic adhesions or scar tissue
- _____ Ectopic (tubal) pregnancy
- _____ Endometriosis
- _____ Uterine polyps
- _____ Ovarian cysts
- _____ Abnormal shape of uterus
- _____ Polycystic ovary syndrome (PCOS)
- _____ Blocked fallopian tubes

Have you ever had a tubal dye test (Hysterosalpingogram) to determine if your fallopian tubes are open? _____ If yes, when? _____ Where? _____

Have you had a tubal ligation? (tubes tied) _____ if yes when? _____
Where? _____ More info: _____

Previous form of contraception used and when? _____

d- Central Factors:

Please check all of the following that you are currently experiencing:

- _____ Thyroid problem
- _____ Breast discharge
- _____ Difficulty losing weight
- _____ Difficulty gaining weight
- _____ Frequent headaches
- _____ Changes in vision not corrected by glasses or contact lenses
- _____ I do not exercise regularly
- _____ I do not eat a well-balanced diet
- _____ I am under a significant amount of stress

VI-Previous Fertility Treatment: (Please check all that apply)

- | | | |
|------------------|---------------------------------|---------------------------|
| _____ Clomid | If yes, number of cycles: _____ | Pregnancy yes or no _____ |
| _____ Femara | If yes, number of cycles: _____ | Pregnancy yes or no _____ |
| _____ injections | If yes, number of cycles: _____ | Pregnancy yes or no _____ |
| _____ IUI | If yes, number of cycles: _____ | Pregnancy yes or no _____ |
| _____ IVF | If yes, number of cycles: _____ | Pregnancy yes or no _____ |

If have done IVF try to answer to describe the following (if possible):

Number of eggs retrieved: _____ Numbers of eggs fertilized: _____ ICSI _____
Dose of Medication: _____ Number of embryos placed back: _____
Quality of eggs or embryos: _____ Any frozen embryos: _____

VII-Review of Systems:

Please check all of the following that you are currently experiencing:

- Problems with your heart (Cardiovascular)
- Problems with your lungs (Pulmonary)
- Problems with constipation or diarrhea (Gastrointestinal)
- Numbness or tingling in your hands or feet (Neurological)
- Unexplained bruising or bleeding from your gums (Hematology/Oncology)
- Problems with urination (Genitourinary)
- Painful periods (Genitourinary)
- Irregular periods (Genitourinary)

VIII-Family History:

Please indicate if any of your immediate relatives have: (parents, grandparents or siblings-Only for female family not spouse- except for birth defects include both your and spouse family)

Diagnosis	Mother	Father	Brother	Sister	Grandparent
Diabetes Mellitus					
High blood pressure					
Heart attack or Stroke					
Breast Cancer					
Colon Cancer					
Uterine Cancer					
Ovarian Cancer					
Bleeding or Clotting Disorder					
Birth Defects					
Congenital Defects in Male or Female family					

IX-Male Factors:

Husband or Partner's Name: _____ Age _____ Children from previous partners _____

Medical Problems: _____

Past Surgeries: _____

Current Medications: _____

Allergies to Medications: _____

Please check all that apply:

- Pain with intercourse
- Inability to have intercourse due to erectile problems
- History of genital injury or surgery
- Loss of libido (sex drive)
- Smokes or uses tobacco
- Drinks more than two alcoholic beverages per day
- Exposure to extremes of heat, radiation or harmful chemicals

History of previous semen analysis: _____

If yes, when? _____ Where? _____

Remainder For Office/Physician's Use:

Physical Examination:

Height: _____ Weight: _____ BMI: _____ LMP _____
Temp: _____ Blood pressure: _____ Pulse: _____ Respirations: _____

General:

Nutrition:

Hair Distribution:

Hair Texture:

HEENT:

Neck:

Heart:

Lungs:

Abdomen:

Extremities:

Pelvic: (Vulva, Vagina, Cervix, Uterus, Adnexa)

Rect:

Urine:

Ultrasound:

Impression:

Plan:

Total Face-To-Face Time for Consultation: _____ Minutes