NEW PATIENT HISTORY FORM

Female Name________________________________ **Age**_________

Male Name _________________________________ **Age**_________

Female History

Are you allergic to any medications? ______________________________

(If yes, what reaction did you have?) ______________________________

How many times have you been pregnant? ______

How many deliveries have you had? ______

Date: __________ Vaginal delivery: Yes ☐ No ☐
Date: __________ Vaginal delivery: Yes ☐ No ☐
Date: __________ Vaginal delivery: Yes ☐ No ☐
Date: __________ Vaginal delivery: Yes ☐ No ☐
Were there any complication? Yes ☐ No ☐ If yes please explain______________
____

How many miscarriages have you had? ______ Dates _______ ____________

How many ectopic pregnancies? ________ Dates _______ ____________

What was the first day of your last period? _____________

How many days does your period last? ________________

Please rate your period pain from 1 (Minimal) to 10 (Severe) _______What medications do you take for the cramping? ____

Do you have any chronic medical conditions Yes ☐ No ☐ If yes please explain
____

Have you ever had major surgery? Yes ☐ No ☐ If yes please list what was done and when.
____

Is there a family history of breast, uterine or ovarian cancer? Yes ☐ No ☐
If yes please explain ____

Is there a family history of serious medical conditions Yes ☐ No ☐? If yes please explain
____

Do you smoke Yes ☐ No ☐?

Have you had previous fertility testing or treatment Yes☐No☐?
If yes please explain____

____

If you have records of testing or previous fertility procedures please bring these to your appointment.

Male History

Have you ever initiated any pregnancies? Yes☐No☐.
If yes, How many?_____.
Were they with your present partner? Yes☐No☐

Are you allergic to any medication? Yes☐No☐. If yes please list the medication and what reaction you had____

Do you have any chronic medical conditions? Yes☐No☐. If yes please explain

____

Have ever had major surgery? Yes☐No☐. If yes please explain __________________

____

Is there a family history of any serious medical conditions? Yes☐ No☐ If yes please explain____

Do you smoke Yes☐ No☐?

Have you ever had a semen analysis Yes☐ No☐. If yes, were you told the result was normal? Yes ☐ No☐. If no please explain____________________________________