Advanced Reproductive Medicine
UNIVERSITY OF COLORADO

PLEASE FILL IN AS COMPLETELY AS POSSIBLE:

Gynecology History Form **Date of visit:** ____________________

Name: ________________________________ Age: ______ Birth date: _______________

Address: ____
Street *City* *State* *Zip Code*

Home telephone: (_____) _____-__________ E-mail address_______________________

Work telephone: ____________________________Cell phone: ___________________

Your occupation: ___________________________Your employer: ________________________

Marital status: Married Single Separated Divorced Other

If applicable:

Your partner's name___________________________Partner's date of birth: ________________

Partner's occupation: ______________________ Partner's employer: ____________________

Partner's work telephone: ___________________ Partner's cell phone_____________________

Partner's email address___________________________

Physician who referred you: ____

Referring physician address: ____
Street *City* *State* *Zip Code*

Referring physician telephone: ______________________ Fax: ____________________________

Reason for your clinic visit: ____

Trying to conceive since: ____________________________
Month *Year*

Allergies to medications:

____

____

Describe as thoroughly as possible the background of your present problem(s). Include all symptoms you feel may be helpful, how long you have experienced them, and indicate whether they have become worse, lessened, or stayed the same in severity over time. Please try to organize your problems by priority. List your most pressing problem as #1, your next more pressing as #2 and so on.

____

____

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MENSTRUAL HISTORY:

At what age did you begin to menstruate? ____________
What were the dates of your last two menstrual periods? ________________ and ________________
Have you ever gone more than 3 months without having a period? YES NO
If yes, how long? _____ months _____ years
List approximate dates when this occurred: ______________________

Are your cycles: REGULAR IRREGULAR
If irregular, please describe: ______________________

What is the average length of your menstrual cycle? ______________________
(Interval from first day of bleeding until day before bleeding of the next cycle.)
Has this changed since puberty? YES NO
If yes, please explain: ______________________

How many days does your period last? ______ Is the flow: LIGHT MEDIUM HEAVY
Does this vary? YES NO
If yes, please explain: ______________________

Can you tell you are about to have a period before you start bleeding (breast tenderness, fullness, etc)? YES NO

Do you have a clear vaginal discharge around the time of ovulation? YES NO

Do you have pain **during** your periods? YES NO
If yes, please explain: ______________________

Do you have pain **between** periods? YES NO
If yes, please explain: ______________________

Do you bleed between periods? YES NO
If yes, please describe frequency and amount of blood loss: ______________________

____

Frequency of intercourse: _____ times per week _____ times per month _____ N/A
Changes in libido (interest in sex)? YES NO N/A
Do you bleed during or after intercourse? YES NO N/A
Any pain during or after intercourse: YES NO N/A
Do you have any noticeable discharge? YES NO N/A

If yes, describe your discharge (noting color, consistency, presence of odor, itching, etc.: ____________________
____

Have you had regular gynecologic exams? YES NO
Date of last exam: ______________________________
Date and result of last Pap smear: ______________________________

Have you had regular breast examinations? YES NO
Date of last exam: ______________________________
Date and findings of last abnormal exam: ______________________________
Date and findings of last mammogram: ______________________________

Have you ever had a milky discharge from one or both breasts? YES NO
If yes, when: ______________________________

Have you had a history of: [*If yes, please give date(s)*]
Chlamydia: ______________________________
Gonorrhea: ______________________________
Pelvic (tubal) infection: ______________________________

List all **gynecologic** surgical procedures you have had, the approximate date, duration of your hospitalization, and the name of the hospital where you had your surgeries performed.

Surgery	***Date***	***Stay***	***Hospital***	***City, State***

OBSTETRICAL HISTORY: *(If not applicable, please continue onto the next section.)*

	Number	**Date(s)**	**Months to conceive**	**Sex/Weight**	**Vaginal/C-section**
Full term deliveries (36+ weeks)					
Premature deliveries (<36 weeks)					

	Number	**Date(s)**
Miscarriages		
Induced abortions		
Ectopic pregnancies		
Stillbirths		
Newborn deaths		

Were there any complications during or after your pregnancies (infection, excessive bleeding, need for a transfusion)? YES NO

If yes, state which delivery and describe the complication(s): ______________________________

____

____

Were any of your children born with congenital defects? YES NO

If yes, state which delivery and describe the congenital defects: ______________________________

____

____

Dates of pregnancies with your present partner: ______________________________

Number of living children from this relationship: ______________________________

Did you have any pregnancies/children from a previous partner? YES NO

*If yes, list the dates of the pregnancies:*______________________________

Living children? ______________________________

If applicable, dates of pregnancies through artificial insemination (donor sperm only): ______________

____

*Living children?*______________________________

CONTRACEPTION: *(If not applicable, please continue onto next section.)*

Please check any of the following methods of contraception you are currently using and/or have used in the past. Fill in the dates of usage.

	Method		**Dates of usage:**
_____	Birth Control Pills	Type: ______________	______________
_____	IUD	Type: ______________	______________
_____	Diaphragm		______________
_____	Condom		______________
_____	Jellies/Foam		______________
_____	Withdrawal		______________
_____	Sterilization	___ Male ___ Female	______________
_____	Other	______________	______________

GENERAL MEDICAL HISTORY:

List current medication(s), including prenatal vitamins or supplements. State the name of the medication, indication for its use, and how long you have taken it. Include prescription and over-the-counter medications, herbs, and vitamins.

Medication	**Began**	**Used through**	**Dosage**	**Indication(s)**

List all serious medical illnesses and **non-gynecologic** surgeries/procedures with date(s). If hospitalized, list where.

____
____
____
____
____
____

Describe your general health: _____ Excellent _____Good _____Fair _____Poor

Childhood illnesses: _____ Routine (chicken pox, measles, mumps, etc.) _____ Unusual
*If unusual, please describe:*____

Have you ever been in a serious accident? YES NO
*If yes, please describe:*____
____
____

Have you ever had a blood transfusion? YES NO
If yes, approximate date(s): ____

Do you drink alcohol? DAILY WEEKLY MONTHLY NEVER

Do you smoke cigarettes? YES NO
*If yes, how many cigarettes per day?*____
If you smoked in the past and have since quit, please give the approximate dates of smoking: ______________
____

Do you exercise regularly? YES NO

If you exercise regularly, describe the frequency:

Every day 5-6 days/week 2-4 days/week 1-2 days per week

If you exercise regularly, describe the type of exercise:

Cardio Weight training Yoga Team sports Other________________

If you exercise regularly, describe the length of time you exercise daily:

Up to 20 minutes 20-45 minutes 45-60 minutes More than 60 minutes

Drug usage in the past year:

Drug	Extent of exposure
Marijuana	______
Cocaine	______
Depressants	______
Stimulants	______
Other: ______	______
______	______

Have you had any difficulty or recent change in your habits of sleep, diet, or exercise? YES NO

If yes, please describe: ______

______

ETHNICITY (circle all that apply)

Caucasian

Caucasian Hispanic (Latina)

Black Non-Hispanic

Black Hispanic (Latina)

Mainland Asian

Asian Pacific Islander

FAMILY HISTORY:

Are you adopted YES NO

	Living	Age and cause of death
Mother	Y N	______
Age at menopause		______
Father	Y N	______
Brother(s)	Y N	______
	Y N	______
Sister(s)	Y N	______
	Y N	______

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DISORDERS IN FAMILY:
Have any members of your family (parents, children, brothers, sisters, grandparents, uncles, aunts, or cousins) had any of the following?

Disorder			**Relationship to you**
Cancer	YES	NO	______________
Diabetes	YES	NO	______________
Thyroid disorders	YES	NO	______________
Blood clotting disorder	YES	NO	______________
Seizures	YES	NO	______________
Obesity	YES	NO	______________
Psychiatric disorders	YES	NO	______________
Substance Abuse	YES	NO	______________
Infertility	YES	NO	______________
Multiple miscarriages	YES	NO	______________
Baby born with birth defects	YES	NO	______________
Chromosome abnormalities	YES	NO	______________
Kidney disease	YES	NO	______________
Depression	YES	NO	______________
Brain or spine abnormalities *(hydrocephalus, spina bifida)*	YES	NO	______________
Hearing problems/deafness	YES	NO	______________
Cleft lip and/or cleft palate	YES	NO	______________
Down syndrome	YES	NO	______________
Muscular dystrophy	YES	NO	______________
Epilepsy *(convulsions/seizures)*	YES	NO	______________
Mental retardation	YES	NO	______________
Endometriosis	YES	NO	______________

REVIEW OF SYSTEMS:

Check any of the following disorders **you** currently have or have a history of:

Central Nervous System
( ) Seizures
( ) Migraine headaches
( ) Other: ______________________________

EENT
( ) Eye disorders
( ) Double or blurry vision
( ) Problem with sense of smell
( ) Other: ______________________________

Cardiovascular
( ) Chest pain
( ) Palpitations
( ) Diagnosed with rheumatic fever
( ) Heart valve disease
( ) High blood pressure
( ) Mitral valve prolapse
( ) Given prophylactic antibiotics
( ) Other: ______________________________

Respiratory
( ) Shortness of breath
( ) Asthma *(date of last attack: _________)*
( ) Bronchitis
( ) Pneumonia
( ) Cough producing blood
( ) Tuberculosis
( ) Other: ________________________

Gastrointestinal
( ) Nausea/vomiting
( ) Blood in stool
( ) Ulcers
( ) Hepatitis
( ) Constipation
( ) Spastic colon
( ) Other: ________________________

Genito-urinary
( ) Bladder infections *(cystitis)*
( ) Kidney infection
( ) Vaginal infections
( ) Frequent urination
( ) Other: ________________________

Musculo-skeletal
( ) Unusual muscle weakness
( ) Decreased energy/stamina
( ) Rheumatoid arthritis
( ) Lupus erythematosus
( ) Other: ________________________

Hematologic
( ) Unusual muscle weakness
( ) Sickle cell anemia or trait
( ) Thrombophlebitis
( ) Other: ________________________

Endocrine

( ) Diabetes
( ) Thyroid disease
( ) Excessive growth or hair on various parts of the body
( ) Hair loss
( ) Unexplained rash
( ) Rapid weight gain
( ) Rapid weight loss
( ) Excessive hunger/thirst
( ) Other: ________________________

Skin/Extremities

( ) Unexplained rash
( ) Acne
( ) Skin cancer
( ) Injuries
( ) Dermatitis
( ) Other: ________________________

Mental Health

( ) Depression, Bipolar Disorder or other Mood Disorder
( ) Anxiety Disorders (panic attacks, general anxiety, phobias, obsessive-compulsive disorder)
( ) Psychiatric Hospitalizations or suicide attempts
( ) Eating Disorders
( ) Alcohol or other substance abuse problems
( ) Learning disabilities/ADHD
( ) Medications for depression or anxiety (please specify): ______________________________________