Name____
Date of birth/Age____
Date of last period____
Referred by____
Reason for visit____
Current OBGYN____
Height ________
Weight________

OB History

Number of pregnancies:

Delivery Date	Outcome	Delivery type	Baby weight	With current partner Yes or No

GYN History

Periods since age of _____, occur every _________days and last ____days
Painful period _____yes _____no
Last pap smear_____________
Abnormal pap smears _____yes ______no _____if yes – when? _________
History of pelvic inflammatory disease _____yes _____no
History of sexually transmitted diseases ____yes _____no
Pelvic pain ____yes ____no
Contraception history ____none ______or list below:
____
____
____

Past Medical History: (diabetes, high blood pressure…)
____
____

Past Surgical History:
____
____

Acupuncture: YES NO

If yes, please provide name and number of acupuncturist:

Medications (including supplements):

____

____

Allergies:

____

Social History

Smoking _______none or __________packs per day

Alcohol _______none or __________drinks per week

Drugs _______none or______________________________________

Occupation____

Family History: (diabetes, cancer, heart disease…)

____

____

Ethnic background:

____

____

Infertility History

Duration(years/months): _______________________________________

Intercourse (times per week): ___________________________________

Painful intercourse: _______yes __________no______________________

Use of lubricant: _________yes __________no______________________

Sexual problems: ________yes __________no________________________

If yes, please specify: ____

Previous infertility evaluation: _________yes __________no

Labs done in the past: ____

Hysterosalpingogram (HSG) done in the past (when?) _________________

____

Previous infertility treatment: _________yes __________no

If yes, specify briefly

____

____

____

____

___________Partner information___________

Name____
Date of birth/Age_______________________________________
Occupation____
Height ____________
Weight____________

Past medical History: (diabetes, high blood pressure…)
____
____

Past surgical History:
____
____
____

Medications (including supplements):
____
____

Allergies:
____
____

Social History
Smoking _______none or __________packs per day
Alcohol _______none or __________drinks per week
Drugs _______none or____
Children with previous partner _______yes _________no______________

Family History: (diabetes, cancer, heart disease…)
____
____
____

Ethnic background:
____
____

Semen analysis (If applicable):

Done in the past: _________________yes _________ no ______________

If yes, list when and the results:
____
____