AWH
Associates in Womens Health, LLC

Account No. _____

PATIENT INFORMATION:

Name:_____ Age:_____ Date of birth:_____
Occupation: _____Partner's name:_____
Who referred you to our care:_____

Is this your FIRST visit to discuss infertility? YES_____ NO_____
If NO, please list name of provider previously seen:_____

Do you experience any of the following: (please circle as many as apply)

Amenorrhea (no periods)
Polycystic ovaries (PCOS)
Irregular periods
Hirsutism (excessive facial/body hair)
Pelvic pain
Dyspareunia (pain with sex)
Menorrhagia (heavy periods)
Endometriosis

PREGNANCY HISTORY: (please include ALL pregnancies)

Year of delivery or loss	How many months to get pregnant?	How long did the pregnancy last?	Same partner for all pregnancies?	Any complica-tions?
_____	_____	_____	_____	_____

1._____

2._____

3._____

4._____

5._____

OVULATION ASSESSMENT:

Do you have regular, predictable, spontaneous periods? YES NO
Age at your first period:_____ How many days does your period last?_____
How many days from the first day of one period to the first day of the next?_____
Do you ever have spotting in between periods?_____
If you do not have periods, when did they stop?_____
Are you periods heavy, either now or in the past?_____
Do you have premenstrual symptoms? YES NO
Do you have pain or cramps with your periods? YES (___mild ___moderate ___severe) NO
Do you have pelvic pain between your periods? YES NO
What medicine or action helps decrease the pain?_____
What have you used for birth control?_____ When did you stop?_____
Have you ever taken medicine to start your period? YES (When?_____ What?_____) NO

Do you have or have you ever had? (Please circle as many as apply)

Blood test for: Progesterone FSH thyroid glucose insulin Hgb A1C prolactin

Nipple discharge Hot flashes Night sweats Hair loss Acne Unwanted hair growth

What is your weekly exercise? _____

What is your weight? Currently_____ Ideally_____ One year ago_____ 5 years ago_____

FERTILITY WORK-UP:

Have you had a hysterosalpingogram (HSG) or other test to see if fallopian tubes are open? YES NO

When?_____ Where?_____

Results:_____

Have you had an ultrasound to assess pelvis (uterus/ovaries)? YES NO

When?_____ Where?_____

Results:_____

Has your partner had a child with a different person? YES NO

Has your partner had a semen analysis to assess sperm counts/motility? YES NO

When?_____ Where?_____

Results:_____

Pertinent Partner Medical History: (please list details) _____

_____

Have you had surgery done on your uterus? YES NO

When:_____ Where?_____

Results:_____

PAST MEDICAL HISTORY: (please circle any conditions that you have or have had)

High blood pressure	Heart disease	Stroke
Lung disease/asthma	Liver disease	Depression/anxiety
Bowel disease	Kidney disease	Diabetes
Bleeding disorder	HIV infection	Anemia
Thyroid disorder	Cancer	Neurological disorder/seizures

Surgeries or hospitalizations: (please give dates)_____

_____

_____

Date of your last pap smear: _____ Was it normal? YES NO

Have you ever had an abnormal pap smear? YES NO

Have you had surgery on your cervix (LEEP/cone/cryo)? YES NO

Current medications: (Please include dosage, frequency and over-the-counter products)

_____

_____

_____

Food/medication/latex Allergies:_____

_____

Habits: Do you use tobacco? YES (____cig/day ____ total # of years) NO
Are you a former smoker? YES When did you quit? _____ NO
Do you drink alcohol? YES (# drinks/week _____) NO
Illicit drug use? YES (Type? _____ How often?_____) NO

FAMILY HISTORY: (Please list medical related problems for the following)
Mother:_____
Father:_____
Brothers/sisters:_____

_____ _____
Patient's Signature Date