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Southwest Fertility Center

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Intake History Summary

Name: _____ Age: _____ Date: _____

Reason for this office visit: _____

Allergies: _____

Past operations/dates (Include hospitals): _____

Have you ever had: (Indicate by circling)

- | | | |
|---|------------------------------------|---|
| Anemia | Varicose Veins/Blood Clots | Cancer |
| Blood Transfusions | Hepatitis | Gallbladder Disease |
| Diabetes | Jaundice | Indigestion, Ulcer, Stomach trouble |
| Rheumatic Fever | Kidney or Bladder Disease | Rectal Bleeding, Constipation, Diarrhea |
| Skin Disease | Loss of Urine with Cough or Sneeze | Chlamydia |
| Eye/Eye Disease, Injury, Impaired Sight | DES Exposure | Genital Warts (HPV) |
| Trouble w/ Nose, Sinus, Mouth, Throat | Emotional Difficulties | Gonorrhea/Chlamydia/ Syphilis |
| Tuberculosis/Valley Fever | Nervous Breakdown | HIV/AIDS |
| Bruise Easily | Sought Psychiatric Help | Mononucleosis |
| Chest Pain/Palpitations | Epilepsy | Swelling of Hands, Feet or Ankles |
| Heart Disease/Heart Murmur | Migraine Headaches | Other: _____ |
| High/Low Blood Pressure | Night Sweats | |
| Pneumonia | Polio/Meningitis | |

Significant Sexual History and/or Difficulties: _____

Ever used Marijuana, Heroin, LSD, Other Drugs: _____

Cigarettes _____ Packs per day / Alcoholic Beverages: Never _____ Moderate _____ Daily _____

Obstetric History

- Number of Pregnancies _____
- Number of & ages living children _____
- Largest child at birth _____
- Smallest child at birth _____
- Miscarriages _____
- Abortions _____
- Stillborn _____
- Other complications _____
- Most recent pap smear _____
- Abnormal pap smear _____

Menstrual / Contraception History

- Age of Menstrual onset _____
- Is your cycle regular _____
- How long are your cycles _____
- How long are your periods _____
- How heavy is your flow _____
- Menstrual pain or cramping _____
- Bleeding after intercourse _____
- Pain with intercourse _____
- Contraception _____
- Last Monthly period _____

Has any relative ever had: (Please indicate relative)

- | | |
|----------------------|---------------------------|
| Stroke _____ | High Blood Pressure _____ |
| Tuberculosis _____ | Diabetes _____ |
| Mental Illness _____ | Suicide _____ |
| Heart Attack _____ | Heart Trouble _____ |
| Breast Cancer _____ | Endometrial Cancer _____ |
| Ovarian Cancer _____ | Colon/Rectal Cancer _____ |
| Cancer (Other) _____ | Cancer (Other) _____ |

Physician use only:

