MEDICAL AND REPRODUCTIVE HISTORY

Today's date_____/_____/_____ Date of appointment_____/_____/_____

PATIENT:

(Legal) Last name:_____ **(Legal)** First name:_____ Middle initial _____

Age: _____Date of Birth: _____/_____/_____ Soc. Security #: _____-_____-_____

Marital Status: _____single _____married _____ divorced _____domestic partner

MAILING ADDRESS:

Street:_____ City: _____

State/Providence: _____ Zip/Postal Code: _____ Country: _____

	OK to leave message?		Best # to reach you:
Home Phone Number: (_____)_____-_____	☐ Yes	☐ No	☐
Work Phone Number: (_____)_____-_____	☐ Yes	☐ No	☐
Cell Phone Number: (_____)_____-_____	☐ Yes	☐ No	☐

Email Address: _____

How did you hear about SRM?

- ☐ Family/Friend
- ☐ Internet
- ☐ Radio
- ☐ Medical office/physician referral
  - o Name of office/physician: _____
- ☐ Other _____

Would you like medical notes sent to your other healthcare providers

- ☐ Yes
- ☐ No

If yes, please indicate which provider(s) you would like us to send medical notes to:

Provider Name	Address	Please indicate provider type: Primary care	OB/Gyn	Other

REPRODUCTIVE HISTORY

PREGNANCY HISTORY: List all pregnancies, specifying under outcome whether liveborn, stillborn, ectopic, miscarriage or elective termination (abortion).

Pregnancy #	Preg. Ended (mo./yr.)	Preg. Length (weeks, months)	Outcome	FATHER (check one)	
				Present partner	Previous partner

REPRODUCTIVE HEALTH HISTORY

MENSTRUAL HISTORY:

Age when you had your first menstrual period: _____ years old

The first day of your most recent menstrual period: _____ / _____ / _____

Menstrual cycle pattern without hormones or oral contraceptive pills (OCP's)-- (check all that apply):

☐ Regular periods ☐ Irregular periods ☐ No periods
☐ Spotting between periods ☐ Heavy periods ☐ Light periods

How many days from the first day of one period to the first day of the next? _____days

How many days of bleeding do you usually have? _____days

Do you need medication to bring on a period? ☐Yes ☐No If yes, what type? _____

Do you have cramping or pelvic pain with your periods? (check one)

☐ Always ☐ Sometimes ☐ Recently ☐ In the past ☐ No

Degree of pain (1 to 10, with 10 being most severe): _____

Over the past few years, is the pain: ☐ getting better ☐ getting worse ☐ staying the same

If you do not have periods, at what age did you stop having them? _____ years old

When was your last Pap smear? _____ / _____ Was it normal? ☐ Yes ☐ No

Have you ever had an abnormal Pap smear? ☐Yes ☐No If "Yes," date and treatment:_____

Have you ever had a mammogram? ☐Yes ☐No If yes, when was the last one? _____/_____

Was your mammogram normal? ☐Yes ☐No

CONTRACEPTIVE METHOD HISTORY:

Type	Years Used
☐ Birth Control Pill / Patch	
☐ Depo-Provera, Lunelle	
☐ Nuva Ring	
☐ Norplant/Implanon	
☐ IUD	

SEXUAL HISTORY:

Have you ever had any sexually transmitted infections? (please check all that apply)

☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ Other
☐ Syphilis ☐ Genital Warts ☐ Trichomonas _____
☐ HIV ☐ HPV ☐ Hepatitis

Have you ever had pelvic inflammatory disease? ☐Yes ☐No
If yes, when?_____ Were you hospitalized?_____

GENERAL MEDICAL HISTORY

Have you and/or a partner (if applicable) traveled to a country, territory, or city where there has been active Zika virus transmission in the last 6 months? If so, please specify place(s) and dates. _____

Are you and/or a partner (if applicable) planning travel to a country, territory, or city where there has been active Zika virus transmission? If so, please specify place(s) and dates. _____

Are you currently being treated or being seen for any medical condition(s)? ☐Yes ☐No
If yes, please describe: _____

_____

REVIEW OF SYSTEMS:

Check any of the following that you are presently having or have had in the past:

Eye problems ☐	Gall bladder problems ☐	Excessive thirst ☐
Stuffy nose, hay fever ☐	Liver disease ☐	Temperature intolerance ☐
Frequent nose bleeds ☐	Frequent urination at night ☐	Headaches ☐
Fast or irregular heartbeat ☐	Vaginal discharge,itching,pain ☐	Shaking, tremor ☐
Heart murmur ☐	Pelvic pain ☐	Anxiety ☐
Mitral valve prolapse ☐	Sexual problems ☐	Depression ☐
Dizziness, fainting ☐	Endometriosis ☐	Bulimia or anorexia ☐
Shortness of breath ☐	Ovarian tumor ☐	Anemia ☐
Lung disease ☐	Dark skin on neck, armpits ☐	Easy bleeding or bruising ☐
Asthma ☐	Acne or pimples ☐	Poor circulation ☐
Tuberculosis ☐	Enlarged or painful breasts ☐	Blood transfusion ☐

Heartburn, indigestion ☐	Discharge from nipples ☐	Fatigue ☐
Gas, cramps, pain ☐	Breast lumps ☐	Low energy ☐
Blood in stool or black stool ☐	Breast disease ☐	Past history of IV drug use ☐
Nausea, vomiting ☐	Hot flashes ☐	Rubella (German Measles) ☐
Constipation ☐	Excessive face or body hair ☐	Other ☐
Diarrhea ☐	Hair thinning or loss ☐	☐
Hernia ☐	Fever, sweats, chills ☐	☐

Please explain any positive responses:

_____

_____

SURGICAL HISTORY:

Please list any major surgeries or hospitalizations in the table below. Include elective termination (abortion), ectopic pregnancy, tubal surgery or any other surgeries:

	Mo. / Year	Procedure	Reason
1			
2			
3			

ALLERGIES:

Latex? ☐Yes ☐No If yes, specify reaction: _____

Iodine? ☐Yes ☐No If yes, specify reaction: _____

Medications? ☐Yes ☐No Which meds, specify reaction:_____

_____

MEDICATIONS INCLUDING: VITAMINS / HERBS / OVER THE COUNTER MEDICATION (OTC'S)

Please list all medications or treatments you are currently taking:

Medication	Dosage	Frequency	Reason

SOCIAL HISTORY

Current Occupation: _____

Have you or do you use any of the following?

	Never	Not in the last 3 months	Yes	List amount, type and frequency (how often-per day / per week)
Tobacco	☐	☐	☐	
Marijuana	☐	☐	☐	
Alcohol	☐	☐	☐	
Social drugs	☐	☐	☐	
Exercise	☐	☐	☐	

EMOTIONAL STATUS:
On a scale of 1 to 10, (10 being the highest) what do you estimate your average level of stress to be? _____

In the past month, have there been times when you felt down, depressed, or hopeless? ____ Yes ____ No

FAMILY AND GENETIC HEALTH HISTORY

Are there any known genetic diseases or conditions that run in your family? _____Yes _____No

If yes, which one(s) and whom?_____

Are you adopted? _____Yes _____No

Personal and Family History

Are you of the following ethnic backgrounds? *Please check all that apply.*

_____ Asian (Chinese, Japanese, Filipino, Indian)

_____ Mediterranean

_____ Middle Eastern

_____ Ashkenazi Jewish

_____ African

_____ Hispanic or Caribbean

_____ French Canadian or Cajun

_____ Caucasian

Have you had a blood test to see if you were a genetic carrier for:

Condition		Result
α (Alpha) Thalassemia	**Yes No**	
ß (Beta) Thalassemia	**Yes No**	
Sickle Cell Anemia	**Yes No**	
Tay Sach's Disease	**Yes No**	
Cystic Fibrosis	**Yes No**	
Spinal Muscular Atrophy	**Yes No**	

If you are of Eastern European Jewish ancestry (Ashkenazi), have you had blood tests to see if you were a genetic carrier for:

Condition		Result
Canavan Disease	**Yes No**	
Familial Dysautonomia	**Yes No**	
Fanconi Anemia	**Yes No**	
Neimann-Pick Disease	**Yes No**	
Mucolipodisis Type IV	**Yes No**	
Bloom Syndrome	**Yes No**	
Gaucher Disease	**Yes No**	

Please indicate which of the following conditions may be found in your family:

MEDICAL PROBLEM	Yourself	PARENTS		SIBLINGS		MATERNAL GRANDPARENTS		PATERNAL GRANDPARENTS		YOUR	OTHER
		Mother	Father	Sisters	Brothers	GM	GF	GM	GF	Children	Relatives
Autoimmune disorder, such as lupus or rheumatoid arthritis											
Birth defects requiring surgery (cleft lip, etc)											
Bleeding disorders (hemophilia, etc.)											
Blindness											
Bone disorders											
Cancer before age 50 (specify)											
Chromosome Problems (Down syndrome, Klinefelter syndrome)											
Clotting disorders (Factor V Leiden, etc.)											
Deafness											
Diabetes (Insulin dependent)											
Endocrine Disorders (adrenal gland, parathyroid, thyroid disorders, Adrenal Hyperplasia)											
Epilepsy (seizures)											
Heart defects (“hole in the heart”, etc)											
Heart Disease											
High Blood Pressure											
High Cholesterol											
Hydrocephaly (“water on the brain”)											
Kidney Disease											
Limb defects (missing or extra fingers, toes, shorten arms or legs)											

MEDICAL PROBLEM	Yourself	PARENTS		SIBLINGS		MATERNAL GRANDPARENTS		PATERNAL GRANDPARENTS		YOUR	OTHER
		Mother	Father	Sisters	Brothers	GM	GF	GM	GF	Children	Relatives
Marfan Syndrome											
Mental Illness (schizophrenia, bipolar, etc)											
Mental retardation, autism or learning disabilities											
Muscular Dystrophy											
Neurofibromatosis											
Neurologic or neurodegenerative diseases (Alzheimer, Huntington, etc)											
Neuromuscular diseases (muscular dystrophies, etc.)											
Phenylketonuria (PKU)											
Polycystic Kidney disease											
Skin Diseases (eczema, melanoma)											
Stillbirth or children who have died as infants											
Stroke											
Thalassemia (Cooley’s anemia)											
Unusual genitals in boys or girls											
Urinary Tract abnormalities											
Women who have had multiple miscarriage											
Other serious health issues											

Please explain any positive answers:_____

_____