REPRODUCTIVE ENDOCRINOLOGY
+ INFERTILITY CLINIC
Texas Tech Physicians

NEW PATIENT CONSULTATION

PLEASE FILL OUT ALL INFORMATION BELOW. THANK YOU!

Your Name: _____Date of Birth: _____Age:_____
Occupation: _____
Phone Number where we can leave a voicemail: _____
Partner/Spouse's Name _____Date of Birth: _____Age:_____
Occupation: _____
Phone Number where we can leave a voicemail: _____
Name of Physician who is sending you for consultation (if applicable):
Physician's Name: _____
Physician's Address: _____
City_____ State_____ Zip code_____
Physician's phone number: _____
Pharmacy of choice: _____
Reason for visit: _____

Past Medical History: (Please list any health problems such as high blood pressure, diabetes, thyroid disorder, asthma or any other conditions requiring medical treatment)
1._____
2._____
3._____
4._____

Past Surgical History:
Date: _____Type of Surgery _____
Date: _____Type of Surgery _____
Date: _____Type of Surgery _____
Date: _____Type of Surgery _____

Medications: (Please list all current prescription medications and dose taken)
1._____
2._____
3._____
4._____

Over-the–counter (Nonprescription) Medications, Vitamins or Herbs:
1._____
2._____

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Allergies to Medications (or Foods):
1._____Reaction that occurs: _____
2._____Reaction that occurs: _____
3._____Reaction that occurs: _____

Social History:
Years with current partner: _____
Do you smoke? _____ If yes, how many packs per day? _____ How many years? ____
Do you drink alcohol? _____ If yes, how many alcoholic beverages per week? _____
Do you use drugs? _____If yes, what kind? _____How often? _____

Obstetrical History:
Total number of pregnancies in your lifetime: _____

Date of Delivery	How many weeks Pregnant?	Vaginal birth or C-Section	Birthweight and Gender
1._____	_____	_____	_____ _____
2._____	_____	_____	_____ _____
3._____	_____	_____	_____ _____
4._____	_____	_____	_____ _____
5._____	_____	_____	_____ _____

Gynecologic History:
Date of last Pap smear? _____ Was it normal? _____
History of cryotherapy (freezing of cervix), LEEP, LETZ or cone biopsy? _____
Last Menstrual Period (LMP):_____
Age when you had your first period? _____
Are your menstrual cycles regular or irregular? _____
Menstrual cycles occur at intervals of _____days (Example: How many days from the first day of one menstrual cycle to the first day of the next menstrual cycle?).
The bleeding lasts for _____days.
Are your periods ever so heavy that you must change a pad or tampon hourly? _____

When is your menstrual cycle the **most** uncomfortable? (Please check one)
☐ Day before bleeding starts
☐ First day of bleeding
☐ Middle of period (cycle days 2 to 4)
☐ My periods are never uncomfortable

Do your periods require use of over-the-counter pain medications? _____
If yes, what do you usually take? _____
Do you ever have pelvic discomfort with intercourse? _____

Do you ever use a heating pad or heating patches on your period? _____
Do you ever reduce your activities during your period due to discomfort? _____
Do you ever miss work or school because of menstrual discomfort? _____

Have you ever been diagnosed with the following? (Please check all that apply)
☐ Fibroids
☐ Pelvic adhesions or scar tissue
☐ Ectopic (tubal) pregnancy
☐ Endometriosis
☐ Uterine polyps
☐ Ovarian cysts
☐ Abnormal shape of uterus
☐ Polycystic ovary syndrome (PCOS)
☐ Blocked fallopian tubes

Have you ever had a tubal dye test (called an "HSG" or Hysterosalpingogram) to determine if your fallopian tubes are open? _____
If yes, when? _____ where?_____

***If an HSG has been done previously, please send a copy of the report to our office prior to your New Patient appointment.

Please check all of the following that you are currently experiencing:
☐ Thyroid problem
☐ Breast discharge
☐ Difficulty losing weight
☐ Difficulty gaining weight
☐ Frequent headaches
☐ Changes in vision not corrected by glasses or contact lenses
☐ I do not exercise regularly
☐ I do not eat a well-balanced diet
☐ I am under a significant amount of stress

<u>Previous Fertility Treatment</u>: (Please check all that apply)
☐ Clomid if yes, number of cycles: _____
☐ Femara if yes, number of cycles: _____
☐ IUI if yes, number of cycles: _____
☐ IVF if yes, number of cycles: _____

Review of Systems:
Please check all of the following that you are currently experiencing:

☐ Problems with your heart (Cardiovascular)
☐ Problems with your lungs (Pulmonary)
☐ Problems with constipation (Gastrointestinal)
☐ Problems with diarrhea (Gastrointestinal)
☐ Numbness or tingling in your hands or feet (Neurological)
☐ Unexplained bruising or bleeding from your gums (Hematology/Oncology)
☐ Problems with urination (Genitourinary)
☐ Painful periods (Genitourinary)
☐ Irregular periods (Genitourinary)

Family History:
Please check if any of your close relatives (parents, grandparents or siblings) have the following health problems:

Diagnosis	Mother	Father	Brother	Sister	Grandparent
Diabetes Mellitus	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐
Uterine Cancer	☐	☐	☐	☐	☐
Ovarian Cancer	☐	☐	☐	☐	☐
Bleeding or Clotting Disorder	☐	☐	☐	☐	☐
Birth Defects	☐	☐	☐	☐	☐
Cystic Fibrosis	☐	☐	☐	☐	☐
Genetic Disorder	☐	☐	☐	☐	☐

Male Factors:

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Husband or Partner's Name: _____Age_____
Medical Problems: _____
Past Surgeries: _____
Current Medications: _____
Allergies to Medications: _____
Please check all that apply:
_☐_Pain with intercourse
_☐_Inability to have intercourse due to erectile problems
_☐_History of genital injury or surgery
_☐_Loss of libido (sex drive)
_☐_Smokes or uses tobacco
_☐_Drinks more than two alcoholic beverages per day
_☐_Exposure to extremes of heat, radiation or harmful chemicals

History of previous semen analysis: _____
If yes, date performed? _____Where? _____
Were results normal? _____
***If a semen analysis has been done previously, please send a copy of the report to our office prior to your New Patient appointment.

Thank you so much for completing this questionnaire.
We look forward to meeting you!

Revised 10/09/2018