OREGON HEALTH & SCIENCE UNIVERSITY

FERTILITY CONSULTANTS
Center for Health & Healing
3303 SW Bond Avenue, 10th Floor
Portland, OR 97239-4501

PATIENT CHART INFORMATION ◆ Please complete & bring to your first appointment.

Patient ***LEGAL*** Name: _____

Referring Physician: Address: _____

_____ _____

Phone (Incl. Area Code): HOME: _____; WORK: _____; CELL: _____

E-mail address: _____

► IF YOU ARE NOT CERTAIN OF AN ANSWER PUT A QUESTION MARK ◄

Main reason for seeking medical attention: ☐ Consultation ☐ Second Opinion ☐ Problem

☐ Well woman care (desire GYN health check-up & Pap smear)

Describe in detail the reason or problem that brings you to our office:

_____

_____

_____

SOCIAL HISTORY

Age: _____ Birth Date: _____ Height: _____ Weight: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Domestic Partnership

Married more than once? ☐ No ☐ Yes, & dates married: _____

Length of time that you have lived in the Portland area: _____ ☐ Months ☐ Years

EDUCATION: ____ years of High School ____ years of College ____ years of Graduate School

OCCUPATION: _____ RELIGION: _____

Do you smoke? ☐ No ☐ Yes, & the number of ☐ cigarettes ☐ packs per day is ____

Do you use alcohol? ☐ No ☐ Yes, & the amount that I consume is _____ drinks ☐ daily ☐ weekly ☐ monthly

Do you use any street drugs or marijuana, etc.? ☐ Yes ☐ No

HUSBAND/PARTNER'S Name: _____ Age: ____ Birth Date: _____

HUSBAND/PARTNER'S Education: ____ years of High School ____ years of College ____ years of Graduate School

HUSBAND/PARTNER'S Current Health Status: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

HUSBAND/PARTNER'S Height: _____, Weight: _____ & Occupation: _____

LIFESTYLE HISTORY

Do you exercise? ☐ No ☐ Yes, & the kind of exercise that I do is:

_____How often? _____

Caffeine intake? Amount per day _____

Hobbies, Sports, Activities: _____

MENSTRUAL HISTORY

Age of first menses? ____ Date of last menses? _____ Cycle length: _____ Flow days: _____

Any abnormalities, changes or spotting? _____

Painful menses? ☐ Yes No ☐ Date of last Pap smear: _____ Abnormal Pap smears? ☐ Yes No ☐

Painful intercourse? ☐ Yes No ☐ Pelvic pain? ☐ Yes No ☐ Incontinence? ☐ Yes No ☐

Lubricants? ☐ Yes No ☐ Douching? ☐ Yes No ☐ Any sexually transmitted diseases? _____

OBSTETRIC HISTORY

► Number of pregnancies: ____
► Number of babies born alive: ____
► Number of stillbirths: ____
► Number of Premature babies (less than 5½-lbs. or earlier than 37-wks.) born alive: ____
► Number of Cesarean Sections: ____
► 3 or more first-trimester Miscarriages ☐ **No** ☐ **Yes**
► Number of Therapeutic abortions: ____
► Any serious physical complications with any pregnancy, labor or delivery? ☐ **No** ☐ **Yes (please explain):**

► How many living children do you have? ____

Name: **Birth Date:** **Male/Female:**

_____

_____

_____

_____

_____

► Were any of your children born with congenital or developmental problems? ☐ **No** ☐ **Yes, & (please comment):**

► Did you ever have any serious problems during pregnancy, labor & delivery, or the postpartum period (up to the fourth week following discharge from the hospital), e.g., severe nausea & vomiting during pregnancy, depression during or after pregnancy? ☐ **No** ☐ **Yes**

GENERAL HEALTH √mark any of the following symptoms that you have NOW or that have been present during the PAST 6-MONTHS		
☐ Any eye problem, injury, impaired sight, dryness	☐ Any ear disease, injury, impaired hearing	☐ Chronic or frequent cough
☐ Bloody sputum	☐ Shortness of breath	☐ Rapid or irregular breathing
☐ Swelling of hands, feet, ankles	☐ Acne	☐ Recent weight loss/gain
☐ Nausea or vomiting	☐ Difficulty in swallowing	☐ Heartburn or indigestion
☐ Diarrhea	☐ Constipation	☐ Blood or mucus in stool
☐ Black or tarry stool	☐ Abdominal cramps or pain	☐ Back pain
☐ Joint pain or stiffness	☐ Leg cramps or limp	☐ Severe headaches (migraines)
☐ Loss of consciousness, fainting or seizures	☐ Nightmares or insomnia	☐ Worry, tension or nervousness
☐ Depression	☐ Marriage problems	☐ Unusual growth or loss of hair
☐ Hot flashes	☐ Abnormal thirst	☐ Tremor or numbness in hands or feet
☐ Salt craving	☐ Excessive tiredness or weakness	☐ Breast discharge or change in size (aside from breast-feeding)
☐ Bladder or kidney infection/stones	☐ Blood in urine	☐ Skin sores, rash or itching; lumps in breast or groin
☐ Loss of appetite	☐ Problems with anger	☐ Loss of sexual interest
☐ Disinterest or displeasure with daily activities	☐ Thoughts of suicide or death	☐

Have you ever been hospitalized for any medical/surgical illness? ☐ No ☐ Yes, and diagnosis and year:

Have you ever been hospitalized for any psychiatric illness? ☐ No ☐ Yes, and diagnosis and year:

Do *YOU* or your *PARTNER* have the following ancestry?	**YOU**		**PARTNER**		***FOR CLINIC USE:***	
	No	**Yes**	**No**	**Yes**	**IF YES**	**IF POSITIVE**
Southeast Asia, Taiwan, China, Philippines	☐	☐	☐	☐	CBC with MCV	Test Partner
Italy, Greece, or the Middle East	☐	☐	☐	☐	CBC with MCV	
Eastern European (Ashkenazi) Jewish	☐	☐	☐	☐	Ashkenazi Jewish Panel	
French Canadian	☐	☐	☐	☐	Tay-Sachs biochem.	
Cajun	☐	☐	☐	☐	Tay-Sachs biochem.	
African American	☐	☐	☐	☐	Hgb electrophoresis	

FOR CLINIC USE: ☐ Offer Cystic Fibrosis testing

Has a *parent, sibling, grandparent, aunt, uncle, first-cousin* in either of your families had:	**YOUR Family**		**PARTNER'S Family**		***FOR CLINIC USE:***
	No	**Yes**	**No**	**Yes**	**IF YES**
Down syndrome	☐	☐	☐	☐	Translocation? Offer consult.
Any chromosome abnormalities	☐	☐	☐	☐	
Neural tube defects, e.g., open spine, spina bifida, anencephaly	☐	☐	☐	☐	Folate 4 mg qd
Hemophilia	☐	☐	☐	☐	If maternal side, offer consult.
Cystic Fibrosis	☐	☐	☐	☐	CF testing
Sickle Cell Anemia	☐	☐	☐	☐	Hgb electrophoresis
Thalassemia (Mediterranean anemia)	☐	☐	☐	☐	
Tay-Sachs disease	☐	☐	☐	☐	Tay-Sachs testing
Mental Retardation	☐	☐	☐	☐	Offer consult
Fragile X syndrome *(X-linked disorder – screening based on maternal history/condition)*	☐	☐	☐	☐	Fragile X testing
Muscular Dystrophy *(X-linked disorder – screening based on maternal history/condition)*	☐	☐	☐	☐	Offer consult
Neurofibromatosis	☐	☐	☐	☐	
Huntington disease	☐	☐	☐	☐	
Phenylketonuria (PKU) or any other metabolic condition requiring special foods or other treatment	☐	☐	☐	☐	
Deafness or hearing loss beginning in childhood	☐	☐	☐	☐	
Known genetic disorder	☐	☐	☐	☐	
Kidney defect	☐	☐	☐	☐	If syndromic, e.g., associated with other malformation or mental retardation, offer consult.
Heart defect (from birth)	☐	☐	☐	☐	
Cleft lip and/or cleft palate	☐	☐	☐	☐	
Limb birth defects (extra/missing digits, malformed arms, legs, hands, feet)	☐	☐	☐	☐	
Any other birth defects (missing kidney, water on the brain)	☐	☐	☐	☐	

FOR CLINIC USE:

Patient offered Genetics consult? ☐ No ☐ Yes Patient declined: _____
(Patient's Signature)

FAMILY HISTORY				
	Living		Deceased	
Family Member	Age	Health	Age at Death	Cause
Father				
Mother				
Brother or Sister: 1.				
2.				
3.				
4.				
5.				
Son or Daughter: 1.				
2.				
3.				
4.				
5.				

DO YOU HAVE ANY BLOOD RELATIVES WHO HAVE HAD:					
	√	Who?		√	Who?
Diabetes	☐		Glaucoma	☐	
Tuberculosis	☐		Alcoholism	☐	
Cancer	☐		Emotional disorders	☐	
High blood pressure	☐		Depression	☐	
Other	☐				

MEDICATIONS	Never	Not in past year	Occasionally	Frequently	Daily
Antibiotics	☐	☐	☐	☐	☐
Cortisone or steroids	☐	☐	☐	☐	☐
Blood pressure pills	☐	☐	☐	☐	☐
Thyroid	☐	☐	☐	☐	☐
Heart medicine	☐	☐	☐	☐	☐
Diuretic (water) pills	☐	☐	☐	☐	☐
Tranquilizer or nerve pills	☐	☐	☐	☐	☐
Appetite suppressant or pep pill	☐	☐	☐	☐	☐
Hormone pill or shots	☐	☐	☐	☐	☐
Sleeping pill	☐	☐	☐	☐	☐
Asthma medicine	☐	☐	☐	☐	☐
Arthritis medicine	☐	☐	☐	☐	☐
Antidepressant	☐	☐	☐	☐	☐
Infertility drugs	☐	☐	☐	☐	☐
Pain medication	☐	☐	☐	☐	☐
Other:		☐	☐	☐	☐

LIST ALL CURRENTLY USED PRESCRIPTIONS & OVER-THE-COUNTER MEDICATIONS & THEIR DOSAGES	
Yourself	**Husband/Partner**

Are you now in ☐ poor health or ☐ suffering from any chronic pain?

(None) (Moderate) (Severe)

PAIN SCALE (circle): 0 1 2 3 4 5 6 7 8 9 10

Average weight in the past year? _____ Weight at age 18? _____ Maximum weight (non-pregnant)? _____

Do you have any allergies (side-effects) to drugs, vaccines, or other agents (e.g., aspirin or pain medication, penicillin, sulfa, Novocain, birth control pills, Other: _____)? ☐ No If yes, please describe:

_____

_____

_____

ABUSE ASSESSMENT SCREEN	Yes	No
Have you ever been emotionally or physically abused by your partner or someone important to you?	☐	☐
Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone? ► If "**yes**", by whom? ☐ Husband ☐ Ex-husband ☐ Partner ☐ Stranger ☐ Other ☐ Multiple ► Number of times?	☐	☐
Within the past year, has anyone forced you to have sexual activities? ► If "**yes**", by whom? ☐ Husband ☐ Ex-husband ☐ Partner ☐ Stranger ☐ Other ☐ Multiple ► Number of times?	☐	☐
Are you afraid of your husband or anyone else that you have √marked above?	☐	☐
Would you like a referral for counseling?	☐	☐

THANK YOU FOR YOUR ASSISTANCE