OREGON HEALTH & SCIENCE UNIVERSITY
OHSU

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:_____ Date of Birth_____

Address: _____

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

Are you ok with UFC leaving a detailed voice message at your : Home?_____ Cell?_____ Work?_____

E-mail address: _____

Referring Physician:_____; OB/GYN:_____; Primary Care Provider:_____

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

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

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

SOCIAL HISTORY

Age:_____Height:_____Weight:_____Marital Status: ☐ Single ☐ Married ☐ Divorced
☐ Domestic Partnership ☐ Separated

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

EDUCATION: ____years of High School ____years of College ____years of Graduate School

OCCUPATION:_____ RELIGION:_____

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

Marijuana? ☐ No ☐ Yes, How much?_____

Do you use any street drugs, etc.? ☐ No ☐ Yes; If so, please list:_____

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

SPOUSE/PARTNER'S Name: Age:_____Birth Date:_____

SPOUSE/PARTNER'S Education: years of High School_____years of College ____years of Graduate School

SPOUSE/PARTNER'S Height: _ _ Weight: _____ Occupation: _____

Do your SPOUSE/PARTNER smoke Tobacco? ☐ No ☐ Yes, the number of ☐ cigarettes ☐ packs per day is ___

Does your SPOUSE/PARTNER use Marijuana? ☐ No ☐ Yes, How much?__

Do your SPOUSE/PARTNER use any street drugs, etc.? ☐ No ☐ Yes; If so, please list:_____

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: _____

MALE MEDICAL HISTORY (If Applicable)

Have you previously conceived with another woman? ☐ Yes: How many times?_____ ☐ No: Birth Control Used?_____

Have you had a semen analysis? ☐ Yes No ☐ , Have you had a vasectomy? ☐ Yes (date_____) ☐ No

Do you have difficulty with erections? ☐ Yes No ☐ , Are you able to ejaculate inside your partner's vagina? ☐ Yes No ☐

Are you exposed to any radiation or harmful chemicals in the workplace? ☐ Yes No ☐

Have you had chemotherapy or radiation for cancer? ☐ Yes No ☐

What is yourAncestry?

- ☐ African-American
- ☐ American Indian/Native American
- ☐ Ashkenazi Jewish
- ☐ Asian-American
- ☐ Cajun/French Canadian
- ☐ Caucasian
- ☐ Eastern European
- ☐ Hispanic/Caribbean
- ☐ Northern European
- ☐ Southern European
- ☐ Other (specify_____)

Specific to Male Partner
List any current medical problem(s):_____
_____
_____

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 ☐

Have you had any of the following sexually transmitted diseases or pelvic infections? Yes ☐ (check all that apply) No ☐

☐ Chlamydia- date_____ ☐ Gonorrhea- date_____ ☐ Herpes- date_____ ☐ Syphilis- date_____

☐ Genital warts/HPV- date_____ ☐ HIV/AIDS- date_____ ☐ Hepatitis- date_____ ☐ Other- date_____

OBSTETRIC HISTORY

Total number of ALL pregnancies:_____Number of miscarriages (less than 20 weeks): _____

Number of ectopic/tubal pregnancies:_____Number of elective terminations (abortions):_____

Number of full term deliveries:_____Of these, how many were live births?_____How many were stillborn? _____

Number of premature (less than 37 weeks) deliveries:_____Of these, how many were live births?_____How many were stillborn? _____

Any Pregnancies with birth defects? ☐ Yes- explain_____No ☐

Date Pregnancy Ended or Delivered	Months to Conception	Treatments to Conceive	Delivery Type/D&C/ Complications	Current Partner?
1. _____	_____	_____	-	□ Yes No □
2. _____	_____	_____	-	□ Yes No □
3. _____	_____	_____	-	□ Yes No □
4. _____	_____	_____	-	□ Yes No □
5. _____	_____	_____	-	□ Yes No □
6. _____	_____	_____	-	□ Yes No □

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	☐

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:

Surgical History:

Have you had any surgeries? □ No □ Yes, please list all in chronological order:

	Year	**Reason and Type of Surgery**
1.		
2.		
3.		
4.		
5.		
6.		
7.		

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

LIST ALL CURRENTLY USED PRESCRIPTIONS & OVER-THE-COUNTER MEDICATIONS & THEIR DOSAGES (Including Vitamins, Herbs, and Supplements)	
Yourself	**Husband/Partner**

FAMILY HISTORY

Family History

	Living		Cause of Death/Age at Death
• Mother	☐Yes - age___	☐No	_____
• Father	☐Yes - age___	☐No	_____
• Brother(s)	☐Yes - age___	☐No	_____
	☐Yes - age___	☐No	_____
• Sister(s)	☐Yes - age___	☐No	_____
	☐Yes - age___	☐No	_____
• Maternal Grandmother	☐Yes - age___	☐No	_____
• Maternal Grandfather	☐Yes - age___	☐No	_____
• Paternal Grandmother	☐Yes - age___	☐No	_____
• Paternal Grandfather	☐Yes - age___	☐No	_____

What is yourAncestry?

- ☐ African-American
- ☐ American Indian/Native American
- ☐ Ashkenazi Jewish
- ☐ Asian-American
- ☐ Cajun/French Canadian
- ☐ Caucasian
- ☐ Eastern European
- ☐ Hispanic/Caribbean
- ☐ Northern European
- ☐ Southern European
- ☐ Other (specify_____)

MEDICAL OR GENETIC DISORDERS in YOU/YOUR FAMILY

Self or Relationship to You

• Baby with birth defects	◻ Yes_____	◻ No	◻ Don't Know
• Birth defects	◻ Yes_____	◻ No	◻ Don't Know
• Blood clots	◻ Yes_____	◻ No	◻ Don't Know
• Bone/Skeletal defects	◻ Yes_____	◻ No	◻ Don't Know
• Canavan disease	◻ Yes_____	◻ No	◻ Don't Know
• Cancer	◻ Yes_____	◻ No	◻ Don't Know
• Breast cancer	◻ Yes_____	◻ No	◻ Don't Know
• Colon cancer	◻ Yes_____	◻ No	◻ Don't Know
• Ovarian cancer	◻ Yes_____	◻ No	◻ Don't Know
• Cystic Fibrosis	◻ Yes_____	◻ No	◻ Don't Know
• Deafness/Blindness	◻ Yes_____	◻ No	◻ Don't Know
• Developmental delay	◻ Yes_____	◻ No	◻ Don't Know
• Diabetes	◻ Yes_____	◻ No	◻ Don't Know
• Down syndrome	◻ Yes_____	◻ No	◻ Don't Know
• Other chromosome defects	◻ Yes_____	◻ No	◻ Don't Know
• Dwarfism	◻ Yes_____	◻ No	◻ Don't Know
• Endometriosis	◻ Yes_____	◻ No	◻ Don't Know
• Epilepsy/ Seizure disorder	◻ Yes_____	◻ No	◻ Don't Know
• Familial dysautonia	◻ Yes_____	◻ No	◻ Don't Know
• Fanconi Anemia	◻ Yes_____	◻ No	◻ Don't Know
• Fragile X	◻ Yes_____	◻ No	◻ Don't Know
• Galactosemia	◻ Yes_____	◻ No	◻ Don't Know
• Gaucher disease	◻ Yes_____	◻ No	◻ Don't Know
• Glaucoma	◻ Yes_____	◻ No	◻ Don't Know
• Heart defect from birth	◻ Yes_____	◻ No	◻ Don't Know
• Heart disease	◻ Yes_____	◻ No	◻ Don't Know
• Hemochromatosis	◻ Yes_____	◻ No	◻ Don't Know
• Hemophilia	◻ Yes_____	◻ No	◻ Don't Know
• High blood pressure	◻ Yes_____	◻ No	◻ Don't Know
• High cholesterol	◻ Yes_____	◻ No	◻ Don't Know
• Huntington Chorea	◻ Yes_____	◻ No	◻ Don't Know
• Infertility	◻ Yes_____	◻ No	◻ Don't Know
• Inherited disorder	◻ Yes_____	◻ No	◻ Don't Know
• Learning problems	◻ Yes_____	◻ No	◻ Don't Know
• Marfan syndrome	◻ Yes_____	◻ No	◻ Don't Know
• Menopause before age 40	◻ Yes_____	◻ No	◻ Don't Know
• Miscarriages (2 or more)	◻ Yes_____	◻ No	◻ Don't Know
• Muscular dystrophy	◻ Yes_____	◻ No	◻ Don't Know
• Myotonic dystrophy	◻ Yes_____	◻ No	◻ Don't Know
• Neural tube defects	◻ Yes_____	◻ No	◻ Don't Know
• Nerofibromatosis	◻ Yes_____	◻ No	◻ Don't Know
• Neurologic (brain/spine)	◻ Yes_____	◻ No	◻ Don't Know
• Niemann-Pick disease	◻ Yes_____	◻ No	◻ Don't Know
• Polycystic kidney disease	◻ Yes_____	◻ No	◻ Don't Know
• Psychiatric problems	◻ Yes_____	◻ No	◻ Don't Know
• Renal disease	◻ Yes_____	◻ No	◻ Don't Know
• Sickle cell anemia	◻ Yes_____	◻ No	◻ Don't Know
• Spinal muscular atrophy	◻ Yes_____	◻ No	◻ Don't Know
• Tay-Sachs disease	◻ Yes_____	◻ No	◻ Don't Know
• Thalassemia	◻ Yes_____	◻ No	◻ Don't Know
• Thyroid problems	◻ Yes_____	◻ No	◻ Don't Know

☐ None of the above ☐ Other_____

EMOTIONAL STATUS

- On a scale of 1-10 (10 being the worst), estimate the level of stress you feel due to infertility and other pressures.

  _____

- Do you see a counselor? □ Yes □ No
- Describe any emotional, marital, or sexual problems caused by your infertility.

  _____
  _____
  _____
  _____
  _____
  _____

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