HEALTH HISTORY QUESTIONNAIRE

The information requested on the attached form will help us provide you with more effective medical care. Your answers will be treated confidentially, as are all aspects of your medical care.

Please print legibly using a ballpoint pen. These forms will become a part of your permanent medical record.

Answer each question to the best of your ability by filling in the information or by marking the appropriate space. Don’t worry if you are uncertain of the answer to some of the questions. You will have a chance to review them with the doctor.

PLEASE BRING THE COMPLETED QUESTIONNAIRE WITH YOU TO YOUR INITIAL APPOINTMENT.

Thank you.
Date: ______________

Name: _______________________________ DOB: ______________ Age: _____ Sex: ___

Address: _______________________________ Home phone: _____-______________

____________________________________ Work phone: _____-______________

Your occupation: _________________________ Your employer _______________________

Married: Y / N

Name of Spouse/Partner: ____________________ Occupation: _______________________

Spouse/Partner employer: ____________________ Work phone: _____-______________

REASON FOR YOUR VISIT

Infertility

Pelvic Pain

Blocked Fallopian tubes

Pre-menstrual Tension

Desire Reversal of Previous Tubal Sterilization

Excess Facial or Body Hair

Abnormal Menstrual Periods

Menopause management

Lack of Menstrual Periods

Other Gynecologic problem (describe)

Endometriosis

None of the Above (describe)

Please describe your present problem. Include all symptoms, how long you have experienced them and their patterns. Also indicate whether they have changed in severity over time:
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

PREVIOUS EVALUATION FOR PRESENT PROBLEM

Year | Doctor’s Name | Tests & Results | Treatments / Medications
--- | --- | --- | ---

_____________________________________________________________________________________
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1
MENSTRUAL HISTORY

Age at onset: _________ What were the dates of your last two periods: ____________________________

Are your cycles regular: Y / N Periods come every _______ days. # of days periods last: ____________

Amount of bleeding and change during the period: _______________________________________________

Painful periods (describe)? _________________________________________________________________

Can you tell, by the way you feel in the week to ten days before bleeding, that your period is drawing near? Y / N

If yes, what symptoms do you usually experience?

- Breasts larger, or tender
- Mood changes (nervous, irritable, depressed), explain ________________________________
- Abdominal discomfort, bloating
- Weight gain, swelling
- Headache
- Other ________________________________

Bleeding between periods Y / N / sometimes

Pain between periods Y / N / sometimes If yes, explain ________________________________________

________________________________________________________________________________________

Do you have “ovulation pains” between periods? Y / N / Sometimes

Do you have increased vaginal discharge between periods? Y / N / Sometimes

Did your periods change since puberty? If yes, please explain _________________________________

________________________________________________________________________________________

What was the longest time (days) you have gone without a period, other than during pregnancy? ____________

What was the shortest time (days) between periods? _______________________________

Have you ever received treatment to bring on or to regulate your periods? Y / N If yes, explain: ______________________

________________________________________________________________________________________

FOR POSTMENOPAUSAL WOMEN

Age at menopause _______________

Cause of menopause:

- Spontaneous
- Surgical
- Radiation
- Drugs

Symptoms:

- None
- Hot flashes
- Mood swings
- Back pain
- Vaginal dryness
- Painful intercourse
- Other, Explain _____________________________________________________________

________________________________________________________________________________________

Are you currently taking estrogen and / or other hormone preparation? Y / N

If yes, please describe what hormone, what dosage and for how long ______________________________

Have you changed your hormone therapy for any reason since menopause? Y / N If yes, please describe:

________________________________________________________________________________________
GYNECOLOGIC HISTORY

Prior examinations:

Regular GYN exams?  Y / N
Date of last exam ________ Reason: ________________  Doctor: ____________  Place: ________
Date of last PAP smear __________  Result __________________
History of abnormal PAP Y / N  Dates ________________  Treatments __________________________
Regular breast exams  Y / N
Last breast exam ____________________
History of abnormal breast exam Y / N  Dates ___________  Treatments __________________________
Last mammogram ________________  Results ________________

Have you had a history of (if yes, please give dates and type of treatments)

Milky breast discharge ____________________________
Chlamydia ______________________________________
Pelvic infection __________________________________
Other gynecologic problem __________________________________________
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Prior gynecologic surgical procedure (please list them in chronological order)

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<thead>
<tr>
<th>Date</th>
<th>Procedure</th>
<th>Reason for surgery</th>
<th>Hospital / Doctor</th>
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Birth control history

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<tr>
<th>Method</th>
<th>Dates</th>
<th>Problems</th>
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<td>IUD</td>
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<td>Pills</td>
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<td>Diaphragm</td>
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<td>Foam</td>
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<td>Condoms</td>
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<td>Ligation of tubes</td>
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<td>Norplant</td>
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<td>Depo-Provera</td>
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<td>Other</td>
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</table>
PREGNANCY HISTORY
List all the pregnancies you have had, in chronological order, including miscarriages, abortions, tubal pregnancies, stillbirths, premature and normal births:

<table>
<thead>
<tr>
<th>Dates</th>
<th>Outcome</th>
<th>Complications</th>
<th>Months to Conceive</th>
<th>Is current partner the father? (Y/N)</th>
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Did you have infertility treatment to achieve any of the above pregnancies? If yes, describe the dates and the type of treatments you had ________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

Fertility medications taken in the past:

- **Clomid**
  - How many cycles? ______
  - Maximum dose ______

- **Pergonal**
  - How many cycles? ______
  - Maximum dose ______

- **Metrodin**
  - How many cycles? ______
  - Maximum dose ______

- **Humegon**
  - How many cycles? ______
  - Maximum dose ______

- **Fertinex**
  - How many cycles? ______
  - Maximum dose ______

- **Other**
  - Describe name, dose, # of cycles ________________________________

If you ever used Lupron describe when and for how long ____________________________________________

_____________________________________________________________________________________________

Did you ever have inseminations? Y / N

If yes, explain when, how many times and indicate what, if any, fertility medications were used:

_____________________________________________________________________________________________

_____________________________________________________________________________________________

Did you ever have IVF or other cycles using assisted reproductive technologies? Y / N

If yes, list all cycles:

<table>
<thead>
<tr>
<th>Dates</th>
<th>Place</th>
<th>Medications, dosages, length of therapy</th>
<th>Outcome</th>
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</thead>
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<td>1.</td>
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Lawrence Amesse, MD, PA

Have you ever received donor sperm or donor egg? Y / N
If yes, please list cycles, type of treatments and whether anonymous or directed donor was used: __________

________________________________________


PAST INFERTILITY EVALUATION

Check all that apply

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Dates</th>
<th>Results</th>
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<tbody>
<tr>
<td>Partner semen analysis</td>
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<td>Temperature charts</td>
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<td>Postcoital test</td>
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<td>Endometrial biopsy</td>
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<td>X-ray of tubes (HSG)</td>
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<td>Sonohysterogram</td>
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<td>Hysteroscopy</td>
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<td>Laparoscopy</td>
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<td>Chromosomal studies</td>
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<td>Hormonal tests (list all below)</td>
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<td>Other tests / comments</td>
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________________________________________


GENERAL HEALTH

List current and past non-gynecologic medical problems:

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<thead>
<tr>
<th>Date</th>
<th>Illness</th>
<th>Treatments</th>
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5
List all non-gynecologic surgeries you had:

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<th>Illness</th>
<th>Surgery</th>
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List allergies and the type of allergic reactions you have:

_______________________________________________

_____________________________________________________________________________________________

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Medications you are currently on and medications you have taken regularly in the past:

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

Serious accidents? ___________________________________________________________________________ Blood transfusions? ____________________________________________________________________

Alcohol consumption (amount) __________________________________________________________________ Number of cigarettes per day __________________________________________________________________

Drugs used (for how long) _____________________________________________________________________ Caffeine (how much) __________________________________________________________________

FAMILY HISTORY
List below the ages of your immediate living relatives, or their age at death if deceased, and their medical problems, if any, including gynecologic problems and age at menopause.

Mother _____________________________________________________________________________________

Father _____________________________________________________________________________________

Brother(s) _________________________________________________________________________________

Sister(s) __________________________________________________________________________________

Grand parents ______________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

HUSBAND / PARTNER HISTORY
Date of birth: ______________ Present age: ___________ Duration of present relationship: ___________

Has partner initiated pregnancy in previous relationship? If yes, please give dates and outcome of pregnancy: ______________________________________________________________

Has partner had a previous relationship where pregnancy did not occur even though no contraception was used? If yes, how long a period was involved? _____________________________________________________________

Medical problem? If yes, please list and give specifics _____________________________________________________________

___________________________________________________________________________________________

History of reproductive system problem or surgery? _____________________________________________________________
Lawrence Amesse, MD, PA

Any history of serious accidents? ________________________________

History of blood transfusion? ________________________________

History of transmissible disease? ________________________________

Current medication and medications taken regularly in the past ________________________________

Alcohol consumption (amount)? __________________________ Number of cigarettes per day __________

Any drugs used (for how long) __________________________ Caffeine (how much) __________________________

Exposed to:

- High temperature / Jacuzzi
- Radiation
- Toxic substances
- Hazardous chemicals

Exposure specifies:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

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ADDITIONAL PATIENT COMMENTS

Please add any pertinent medical information not previously mentioned:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

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________________________________________________________________________

________________________________________________________________________

Who referred you to our office? ________________________________

If an other physician please indicate name and address below:

Referring physician: ________________________________

Address: ________________________________

Office phone ______-__________

Patient’s signature __________________________ Date __________________________