James W. Douglas, M.D.
Board Certified
Reproductive Endocrinology
Obstetrics Gynecology

NEW PATIENT MEDICAL HISTORY FORM

Medical Information: FEMALE EVALUATION

Name _____ Age_____

Height____ Weight ____ Allergies_____

Current Medications_____

Occupation_____

Smoke ☐ Yes ☐ No _____/PPD Alcohol ☐ Yes ☐ No _____/WK

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Other

Duration of marriage _____years

Last pap smear _____ History of abnormal pap? ☐ Yes ☐ No

Cryosurgery on cervix? ☐ Yes ☐ No

Age of first menses? _____ Date of last menses? (First day) _____

Usual menses interval _____ Usual duration of bleeding _____

Cramps? ☐ Yes ☐ No Severity of cramping? ☐ minimal ☐ moderate ☐ severe

Are cramps always present? ☐ Yes ☐ No

Usual frequency of sexual intercourse _____ Lubricant used? ☐ Yes ☐ No Specify _____

Duration of infertility _____ Do you know your blood type? ☐ Yes ☐ No Specify _____

Have you ever been evaluated or treated for infertility before? ☐ Yes ☐ No
If yes, who was your physician? _____ Diagnosis?_____

What drugs have you taken for infertility? Mark all that apply:

☐ Clomiphene (Clomid, Serophene) ☐ HMG (Menopur, Bravelle, Gonal-F, Follistim, Repronex)

☐ Glucophage (metformin) ☐ Femara (letrozole)

☐ HCG (Pregnyl, Profasi, Novarel, Ovidrel) ☐ Parlodel (bromocriptine)

I was referred by: ☐ physician ☐ friend ☐ insurance ☐ internet
☐ other _____

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Which of the following tests have you had performed? Give the results, if known, for all that apply:

☐ Serum Progesterone Results_____

☐ Hormonal assays (FSH, LH, Prolactin, DHEA, Testosterone, Thyroid) Results_____

☐ HSG Results_____

☐ Post-coital test (Sims- Huhner) Results_____

☐ Sperm penetration test (Hamster Test) Results_____

☐ Ultrasound Results_____

☐ Laparoscopy Results_____

☐ Hysteroscopy Results_____

PAST MEDICAL HISTORY

Have you ever had any pelvic surgery or infertility surgery? ☐ Yes ☐ No
If yes, specify _____

Have you ever had any tubal or ovarian infections? ☐ Yes ☐ No

Have you ever been diagnosed with a sexually transmitted disease? ☐ Yes ☐ No

Have you ever had hepatitis? ☐ Yes ☐ No

Have you ever undergone artificial insemination or in-vitro fertilization? ☐ Yes ☐ No

Is your partner being evaluated for infertility? ☐ Yes ☐ No

Is your partner taking any medication or seeing a physician regularly? ☐ Yes ☐ No
If yes, specify_____

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NEW PATIENT MEDICAL HISTORY FORM

Medical Information: MALE EVALUATION

Name_____ Age_____

Height____ Weight ____ Allergies_____

Smoke ☐ Yes ☐ No _____/PPD

Alcohol ☐ Yes ☐ No _____/WK

Occupation_____

Are you currently taking Testosterone?_____

MALE PAST MEDICAL HISTORY

Current Medications_____

I have had the following conditions or procedures to my penis, testicles or pelvic area

☐ Surgery _____ ☐ Infection_____

☐ Injury _____ ☐ Other _____

Which of the following tests have you had performed? Give the results, if known, for all that apply:

☐ Semen Analysis Results_____

☐ Other Results_____

Referring ObGyn PHYSICIAN INFORMATION

Name: _____

Address: _____

City, State: _____

Phone: _____