



John L. Couvaras, M.D.

INITIAL VISIT

Please fill out the following information and return it to our office prior to your initial consultation.

DATE: _____

PATIENT S NAME: _____

PARTNER S NAME: _____

ADDRESS: _____ APT.#: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE (day): _____ TELEPHONE (evening): _____

REFERRING DOCTOR: _____ PRIMARY CARE DR. (If applicable): _____

REFERRED BY:(if other than the above doctor): _____

PATIENT S AGE: _____ date of birth: _____ ethnic origin: _____

PARTNER S AGE: _____ date of birth: _____ ethnic origin: _____

OCCUPATION (patient): _____

OCCUPATION (partner): _____

MARITAL STATUS: _____ length of marriage: _____

CHILDREN (ages/sex): _____

MENSTRUAL HISTORY

Last Menstrual Period: _____ Previous Menstrual Period: _____

Age at time of first menstrual period: _____ Are your periods regular or irregular? _____

How many days do you bleed? _____

How many long is your menstrual cycle? (from the start of one cycle to the start of the next): _____

Do you have cramps? _____ If yes, are they: Mild: _____ Moderate: _____ Severe: _____

Do you take pain medication for cramps? Yes _____ No _____ If yes, specify: _____

Do you bleed or spot in between periods? Yes _____ No _____ If yes, specify: _____

If you have ever been on oral contraceptives (birth control pills), were your periods regular after you stopped taking them? Yes _____ No _____ If yes, date/length of use: _____

How many times per week do you and your partner have sexual intercourse? _____

How many times do you have intercourse around ovulation? _____

Is sexual intercourse painful or difficult for you? Painful _____ Difficult _____ Neither _____

How long have you been trying to get pregnant? _____

PAST OBSTETRICAL HISTORY

Table with 8 columns: Year, Live Birth, Miscarriage, Elective Abortion, Infertility Treatment, Time to Conception, Current partner is the father. Rows for 1st through 8th pregnancy.

OBSTETRICAL HISTORY CONTINUED

Were there any complication during or after any of your pregnancies?----- Yes ___ No ___

If yes, explain: _____

Did your mother or father have any difficulty with conception or pregnancy?----- Yes ___ No ___

If yes, explain: _____

Did your mother take Diethylstilbestrol (DES) when she was pregnant with you?----- Yes ___ No ___

PAST MEDICAL HISTORY

Weight: _____ Height: _____ Blood type (if known): _____

Have you ever been treated for cancer?----- Yes ___ No ___

If yes, explain therapy: _____

Have you ever received X-rays to the pelvic area for therapy or treatment of the diagnosis?----- Yes ___ No ___

Do you have or have you ever had any of the following?(check all that apply):

- | | | |
|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Ovarian Cysts |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Parasitic Infection |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Pelvic Infection |
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Breast Discharge (milky) | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Poor Sense of Smell |
| <input type="checkbox"/> Breast Soreness | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Breast Tenderness | <input type="checkbox"/> Herpes | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Cancer, Specify: _____ | <input type="checkbox"/> Hirsutism (Excessive hair growth) | <input type="checkbox"/> Seizures |
| _____ | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Immunization: German Measles | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chronic Headaches | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Vaginitis (Trichomoniasis,
Yeast) # of episodes: _____ |
| <input type="checkbox"/> Color Blindness | <input type="checkbox"/> Measles: German | <input type="checkbox"/> Visual Disturbances |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Measles: Regular | <input type="checkbox"/> Any Allergies? List: _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Neurological Problems | _____ |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Nongonococcal Urethritis | _____ |

PAST SURGICAL HISTORY

Please give chronological order starting with the most recent surgery

If any of the following categories do not allow enough space, please list any further procedures and information on the back of this page.

Procedure	Month and Year of Surgery
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____

MEDICATIONS

(List all medications you are currently taking)

Name of Medication	Dosage	Frequency of Use	Reason for Use
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____

ALLERGIES

(list all medications, iodine, and/or shellfish)

SOCIAL HISTORY

(Occupation - Hobbies - Habits)

Smoking History (circle) Never smoked/used to smoke/still smoke _____ Packs per day: _____ How many years? _____

Recreational drugs: _____ Alcohol intake: _____

PAST CONTRACEPTION

What form of contraception method do you use now or have used in the past? Check all that apply:

_____ Pills (name): _____ IUI(name): _____ Other: _____
_____ Diaphragm _____ Withdrawl _____ Foams/Jellies _____ Condoms _____ Rhythm _____ None

For each method of contraceptive used, specify length of use and reason for discontinuation:

Method	Length of Use	Reason for Discontinuation
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

PSYCHIATRIC HISTORY/EMOTIONAL PROBLEMS

DIET AND EXERCISE

Do you follow any particular food diet or have any special dietary habits? If yes, explain:

List the forms and frequency of regular, vigorous exercise (swimming, cycling, running, etc.) and age you began:

PREVIOUS EVALUATION FOR INFERTILITY OR GYNECOLOGICAL PROBLEMS

Have you ever been treated for infertility before?----- Yes___ No___

If yes, who was your physician?_____

What diagnosis was determined as the cause of your infertility?_____

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

- | | |
|---|---|
| <input type="checkbox"/> Clomiphene citrate (Serophene, Clomid) | <input type="checkbox"/> hCG (Profasi, A.P.L.) |
| <input type="checkbox"/> hMG (Pergonal, Humegon, Repronex) | <input type="checkbox"/> Bromocriptine (Parlodel) |
| <input type="checkbox"/> estrogen | <input type="checkbox"/> danazol (Danocrine) |
| <input type="checkbox"/> progesterone | <input type="checkbox"/> urofollitropin (Follistim, Metrodin) |
| <input type="checkbox"/> prednisone (or cortisone-like drugs) | <input type="checkbox"/> None |
| <input type="checkbox"/> antibiotics | <input type="checkbox"/> Any others?, Specify:_____ |
| <input type="checkbox"/> GnRh or LHRH (Factrel) | _____ |

Which of the following tests have you had performed? Check all that apply and the results if known:

- | | | |
|--|------------|---------------|
| <input type="checkbox"/> BBT----- | Date:_____ | Results:_____ |
| <input type="checkbox"/> Postcoital Test----- | Date:_____ | Results:_____ |
| <input type="checkbox"/> Hormonal Assays (FSH, LH, prolactin, estrogen, DHEA-S, progesterone, testosterone)- | Date:_____ | Results:_____ |
| <input type="checkbox"/> Endometrial Biopsy----- | Date:_____ | Results:_____ |
| <input type="checkbox"/> Hysterosalpingogram----- | Date:_____ | Results:_____ |
| <input type="checkbox"/> Ultrasound----- | Date:_____ | Results:_____ |
| <input type="checkbox"/> Antibodies----- | Date:_____ | Results:_____ |
| <input type="checkbox"/> Laparoscopy, Hysteroscopy----- | Date:_____ | Results:_____ |
| <input type="checkbox"/> Mycoplasma/Chlamydia Cultures----- | Date:_____ | Results:_____ |
| <input type="checkbox"/> Thyroid tests----- | Date:_____ | Results:_____ |
| <input type="checkbox"/> Other? Specify:_____ | Date:_____ | Results:_____ |

Have you ever had surgery for Tubal Reversal?----- Yes___ No___

If yes, specify dates:_____

Have you ever had surgery for removal of adhesions?----- Yes___ No___

Have you ever had a cervical conization, cryo, or cautery?----- Yes___ No___

Have you ever had any other surgery? (D&C, Ovarian, Appendectomy, Thyroid)----- Yes___ No___

If yes, please specify:_____

Have you ever undergone Artificial Insemination or In Vitro Fertilization?----- Yes___ No___

If yes, using partner or donor sperm?_____

Is your partner seeing a doctor for evaluation of infertility?----- Yes___ No___

If yes, specify physician s name and location:_____

Does the doctor feel that your partner has an infertility problem?----- Yes___ No___

If yes, what is the diagnosis and how is he being treated?_____

Has he ever fathered a child with another woman?----- Yes___ No___

If yes, when:_____

If there is any other information you feel would help us in your diagnosis or treatment, please enter below:
