**Southwest Fertility Center**
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## Intake History Summary

Name: _____ Age: _____ Date: _____

Reason for this office visit: _____

Allergies: _____

Past operations/dates (Include hospitals): _____
_____

### Have you ever had: (Indicate by circling)

Anemia
Blood Transfusions
Diabetes
Rheumatic Fever
Skin Disease
Eye/Eye Disease, Injury, Impaired Sight
Trouble w/ Nose, Sinus, Mouth, Throat
Tuberculosis/Valley Fever
Bruise Easily
Chest Pain/Palpitations
Heart Disease/Heart Murmur
High/Low Blood Pressure
Pneumonia
Varicose Veins/Blood Clots
Hepatitis
Jaundice
Kidney or Bladder Disease
Loss of Urine with Cough or Sneeze
DES Exposure
Emotional Difficulties
Nervous Breakdown
Sought Psychiatric Help
Epilepsy
Migraine Headaches
Night Sweats
Polio/Meningitis
Cancer
Gallbladder Disease
Indigestion, Ulcer, Stomach trouble
Rectal Bleeding, Constipation, Diarrhea
Chlamydia
Genital Warts (HPV)
Gonorrhea/Chlamydia/ Syphilis
HIV/AIDS
Mononucleosis
Swelling of Hands, Feet or Ankles
Other: _____

Significant Sexual History and/or Difficulties: _____

Ever used Marijuana, Heroin, LSD, Other Drugs: _____

Cigarettes _____ Packs per day / Alcoholic Beverages: Never _____Moderate _____ Daily _____

### Obstetric History

Number of Pregnancies _____
Number of & ages living children _____
Largest child at birth _____
Smallest child at birth _____
Miscarriages _____
Abortions _____
Stillborn _____
Other complications _____
Most recent pap smear _____
Abnormal pap smear _____

### Menstrual / Contraception History

Age of Menstrual onset _____
Is your cycle regular _____
How long are your cycles _____
How long are your periods _____
How heavy is your flow _____
Menstrual pain or cramping _____
Bleeding after intercourse _____
Pain with intercourse _____
Contraception _____
Last Monthly period _____

Has any relative ever had: (Please indicate relative)

Stroke _____
Tuberculosis _____
Mental Illness _____
Heart Attack _____
Breast Cancer _____
Ovarian Cancer _____
Cancer (Other) _____
High Blood Pressure _____
Diabetes _____
Suicide _____
Heart Trouble _____
Endometrial Cancer _____
Colon/Rectal Cancer _____
Cancer (Other) _____

Physician use only:
_____
_____
_____
_____
_____
_____
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