|  |
| --- |
| Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Preferred email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| DOB \_\_\_\_\_\_\_\_ | Age \_\_\_\_\_\_\_\_ | Height \_\_\_\_\_\_\_\_ | Weight \_\_\_\_\_\_\_\_ |   |
| Primary Ob/Gyn doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Primary care doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |

Past Medical History

*Please circle the appropriate response*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Abnormal Bleeding | yes | no | Blood clots in the legs | yes | no |
| Thyroid problems | yes | no | Diabetes currently | yes | no |
| Cancer | yes | no | Diabetes while pregnant | yes | no |
| Systemic Lupus  | yes | no | Age at onset of diabetes | \_\_\_\_\_\_\_\_\_\_ |
| Kidney disease | yes | no | Diabetes control | good | poor |
| Hepatitis | yes | no | Polycystic ovarian syndrome (PCOS) | yes | no |
|  Do you have to take antibiotics before dental work | yes | no |
| Problems with anesthesia | yes | no |
| Hypertension (high blood pressure) | yes | no |
|  AIDS/HIV | yes | no |
|  |  |  | High cholesterol or triglycerides | yes | no |

|  |  |  |
| --- | --- | --- |
| Past Surgical HistoryPlease list all surgeries andapproximate dates (year) | Past HospitalizationsPlease list all hospitalizations andapproximate dates (year) | Comorbiditiesoffice use only |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |
| --- |
| Psychiatric History |

*Please circle all the appropriate responses*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Anxiety disorder | yes | no | Postpartum depression | Yes | no |
| Bipolar I disorder | yes | no | Anorexia nervosa | Yes | no |
| Bipolar II disorder | yes | no | Bulimia nervosa | Yes | no |
| Borderline personality disorder | yes | no | Binge eating disorder | Yes | no |
| Depression | yes | no | Eating disorder, NOS | Yes | no |
|  |  |  |  |  |  |

|  |
| --- |
| Review of Systems |

|  |  |
| --- | --- |
| *Check all that applies:* |  |
| **General** | **Musculoskeletal** | **Breasts** | **Respiratory** |
| * Weight gain/loss
 | * Muscle weakness
 | * Discharge (clear? bloody? milky? )
 | * Shortness of breath
 |
| * Anorexia/bulimia
 | * Decreased energy/stamina
 | * Lumps
* Pain
 | * Asthma
 |
| * Lack of energy
 | * Rheumatoid arthritis
 | * Rash
 | * Wheezing
 |
| * Fever/Chills
 | * Lupus erythematosus
 | * Abnormal mammogram
 | * Bloody cough
 |
| * Other
 | * Other
 | * Pain
 | * Other
 |
|  |  | * Other
 |  |
|  | **Mental Health Problems** |  | **Neurological Problems** |
| **Endocrine/Hormonal** | * Depression Anxiety
 |  **Genito-Urinary** | * Weakness/loss of balance
 |
| * Diabetes
 | * Schizophrenia
 | * Bladder infections
 | * Seizures/Epilepsy
 |
| * Hair loss
 | * Other
 | * Kidney infections
 | * Headaches
 |
| * Thyroid gland problems
 |  | * Vaginal infections
 | * Migraine headaches
 |
| * Excessive thirst or hunger
 | **Head, Eyes, Nose, & Throat** | * Frequent urination
 | * Numbness
 |
| * Temperature intolerance –
 | * Dizziness
 | * Leaking urine
 | * Memory loss
 |
| * Hot flashes or feeling cold
 | * Headaches
 | * Blood in the urine
 | * Other
 |
| * Other
 | * Blurred vision
 | * Other
 |  |
|  | * Hearing loss/deafness
 |  | **Skin/Extremities** |
| **Gastrointestinal** | * Loss of sense of smell
 | **Hematologic** | * Unexplained rash
 |
| * Nausea/vomiting
 | * Chronic nasal congestion
 | * Blood clotting disorder/blood clot
 | * Acne
 |
| * Ulcers
 | * Other
 | * Sickle cell anemia
 | * Skin cancer
 |
| * Diarrhea
 |  | * Easy bruising
 | * Excess hair growth
 |
| * Constipation
 | **Cardiovascular** | * Swollen glands/lymph nodes
 | * Moles changing appearance
 |
| * Irritable Bowel Syndrome
 | * Palpitations Murmurs
 | * Blood transfusions (dates/reasons )
 | * Other
 |
| * Change in bowel habits
 | * Chest pain
* Stroke
 | * Other
 |  |
| * Other
 | * Heart attack
 |  |  |
|  | * Mitral valve prolapse
 |  |  |
|  | * Other
 |  |  |

Epworth Sleepiness Scale

*Please place a check in the appropriate box given each situation ranking your chance of dozing or sleeping*

 **0 1 2 3**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **NEVER**  | **SLIGHT** | **MODERATE** | **HIGH** |
| Sitting and reading |  |  |  |  |
| Watching TV |  |  |  |  |
| Sitting inactive in a public space |  |  |  |  |
| Being a passenger in a motor vehicle for an hour or more |  |  |  |  |
| Lying down in the afternoon |  |  |  |  |
| Sitting and talking to someone |  |  |  |  |
| Sitting quietly after lunch (no alcohol) |  |  |  |  |
| Stopped for a few minutes in traffic while driving |  |  |  |  |

Medications

*List all daily medications including over-the-counter
medications and vitamins, herbs or supplements, and contraceptives*

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Dosage** | **Frequency** | **Reason** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Allergies

*List any known allergies or sensitivities*

|  |  |
| --- | --- |
| **Medication Allergy** | **Reaction** |
|  |  |
|  |  |
|  |  |
|  |  |

*List any allergies and sensitive to the following:*

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  | **Reaction** |
| Latex | yes | no |  |
| Dye | yes | no |  |
| Iodine | yes | no |  |
| Tape | yes | no |  |

Social History

Marital status□ Single □ Married/Partnered □ Divorced/Separated □ Widowed

Ethnic background

Education

Number of people living in your home Who?

What type of work do you do?

What type of hobbies or activities do you do?

Are you currently sexually active □ yes □ no if yes, current number of partners \_\_\_\_\_\_\_\_\_\_\_

 Is your partner(s) □ male □ female □ both

 If no, have you been sexually active previously □ yes □ no: If yes, were your partners □ male □ female □ both

How would you describe your sexual orientation: □ heterosexual □ homosexual □ bisexual □ transgender □ other

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Do you currently smoke? | yes | no |  | Do you drink alcohol? | yes | no |
| Have you ever smoked more than 100 cigarettes? | yes | no |  |  Drinks per day | \_\_\_\_\_\_\_\_\_ |
|  How often | \_\_\_\_\_\_\_\_\_ |
|  Age started | \_\_\_\_\_\_\_\_\_ |  | Do you use controlled substances? | yes | no |
|  Age last smoked | \_\_\_\_\_\_\_\_\_ |
|  Average cigarettes per day | \_\_\_\_\_\_\_\_\_ |  | How often | \_\_\_\_\_\_\_\_\_ |
|  Total years smoking | \_\_\_\_\_\_\_\_\_ |  |   |  |  |

Menstrual History

Age of first period \_\_\_\_\_\_\_\_ Dates of Last two menstrual periods \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Menstrual cycle pattern (check all that apply) 🞏Regular periods 🞏 Irregular periods 🞏Spotting before periods

🞏 No periods 🞏 Heavy periods 🞏 Light periods 🞏 Bleeding between periods

If you have Irregular periods please complete questions 1-7:

1. How many days from start of one period to start of the next period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. How many days of bleeding do you have? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_days
3. If you have irregular periods:
4. How long have your periods been irregular \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_months/years
5. What is the typical time between your periods? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_weeks/months
6. What is the longest period of time between two periods \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_weeks/months
7. What is the shortest period of time between two periods \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ weeks/months

*Pelvic pain/cramps with your period:* 🞏 none 🞏 during period 🞏 before period 🞏after period 🞏at mid cycle

🞏 during intercourse 🞏with bowel movement 🞏with urination

🞏 cause you to miss work 🞏 cause you to miss usual activities

*Pelvic pain/cramps are*: 🞏 mild 🞏 moderate 🞏 severe

🞏 worsening 🞏 improving 🞏no change 🞏 in midline 🞏on right side 🞏 on left side

**Do you have or have you had? (Check all that apply)**

🞏 Hot flashes 🞏 Increased facial or body hair 🞏Breast discharge 🞏Increased acne

**Please explain a “Yes” answer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Family Medical History

|  |
| --- |
| *Please indicate if you have a family history of the following:* |
|  | **Parent(s)** | **Sibling(s)** | **Other Relatives***cousins, aunts, grandparents, etc.* | **No Family History** | **Don’t Know** |
| *Mother* | *Father* | *Brother* | *Sister* |
| Diabetes |  |  |  |  |  |  |  |
| Heart Disease |  |  |  |  |  |  |  |
| Hypertension |  |  |  |  |  |  |  |
| Gallstones |  |  |  |  |  |  |  |
| Obesity |  |  |  |  |  |  |  |
| Sleep Apnea |  |  |  |  |  |  |  |
| Asthma |  |  |  |  |  |  |  |
| Cancer *(specify type)* |  |  |  |  |  |  |  |
| Depression |  |  |  |  |  |  |  |
| High Cholesterol |  |  |  |  |  |  |  |
| Osteoporosis |  |  |  |  |  |  |  |
| Stroke |  |  |  |  |  |  |  |
| PCOS |  |  |  |  |  |  |  |
| Chemical dependency |  |  |  |  |  |  |  |
| Bipolar disorder |  |  |  |  |  |  |  |

|  |
| --- |
| **PCOS History** |

For how many years have you had the diagnosis of PCOS? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

What symptoms do you experience?

🞏 Irregular menstrual cycles 🞏 Abnormal dark hair growth 🞏 Acne/skin problems 🞏 Balding

🞏 Polycystic appearing ovaries on ultrasound 🞏 Weight gain/Trouble losing weight

What medical conditions do you have related to PCOS?

🞏 Diabetes or insulin problems 🞏 high blood pressure 🞏 heart disease

What is most concerning to you about PCOS? (please rank the areas, 1 being the most concerning, use 0 if not concerning)

\_\_\_Irregular menses \_\_\_ Infertility \_\_\_ Weight loss \_\_\_Abnormal hair growth

\_\_\_Risk of cancer \_\_\_Acne/skin problems \_\_\_Balding

\_\_\_Medical conditions associated with PCOS (Diabetes /heart disease)

If you experience dark hair growth, please list the areas: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What hair removal techniques do you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you perform hair removal? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What treatments have you taken/done for hair removal? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please rate you hair pattern for these 9 areas (If you have no dark hair growth in an area(s) leave blank):



Infertility History

Do you have a history of infertility? Yes No

How long have you had infertility \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ months/years

Have you done infertility treatment? Yes No

If yes, What medications have you taken? 🞏 metformin, highest dose \_\_\_\_\_\_\_\_\_\_ 🞏 Clomid, highest dose \_\_\_\_\_\_\_\_\_\_🞏Letrozole or Femara, highest dose \_\_\_\_\_\_\_\_\_ 🞏 Gonadotropin injections

What treatment cycles have you done?

🞏 Ultrasound monitored cycles 🞏 intrauterine insemination (IUI) 🞏 in vitro fertilization

Number of cycles completed \_\_\_\_\_\_\_ Ultrasound monitored \_\_\_\_\_\_\_\_ IUI \_\_\_\_\_\_\_\_\_\_\_ IVF

Weight Loss History

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Age you first became overweight | \_\_\_\_\_\_\_\_\_ |  | Weight comfortably maintained  | \_\_\_\_\_\_\_\_\_ |
| Highest adult weight | \_\_\_\_\_\_\_\_\_ | Lowest adult weight | \_\_\_\_\_\_\_\_\_ |
| *Please circle all that apply*Grew up: overweight normal weight active in sports under wt. average wt.Weight gain after: pregnancy marriage divorce separation quit smoking  moved desk job injury gradual  |
|  |  |  |  |  |

List any weight loss programs that you have completed without supervision (i.e. South Beach or Adkins diet)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any weight loss programs that you have completed with supervision (i.e. Weight Watchers or Jenny Craig) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any medications you have taken for weight loss \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exercise History

*Please place a check in the appropriate box*

**Frequency of exercise:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **I don’t do this** | **1x/week** | **2-3x/week** | **4-5x/week** | **6+x/week** |
| Walking |  |  |  |  |  |
| Stretching |  |  |  |  |  |
| Weight Lifting |  |  |  |  |  |
| Aerobic |  |  |  |  |  |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |

**Average time spend exercising:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **I don’t do this** | **< 15 min.** | **15-29 min.** | **30-44 min.** | **45-59 min.** | **60+ min.** |
| Walking |  |  |  |  |  |  |
| Stretching |  |  |  |  |  |  |
| Weight Lifting |  |  |  |  |  |  |
| Aerobic |  |  |  |  |  |  |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |  |

**Physical limitations preventing exercise:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Hip pain | yes | no | Back pain | yes | no |
| Knee pain | yes | no | Fatigue | yes | no |
| Ankle pain | yes | no | Diaphoresis | yes | no |
| Foot pain | yes | no | Shortness of breath | yes | no |

Nutrition History

|  |  |
| --- | --- |
|  |  |
| How many meals do you eat daily | \_\_\_\_\_\_\_\_\_\_ |
| Do you snack between meals | yes | no |
| Do you drink soda | yes | no |
|  Diet | yes | no |
|  Regular | yes | no |
| How many sodas do you drink daily | \_\_\_\_\_\_\_\_\_\_ |

**Food Preferences**

|  |
| --- |
|  |
| Candy | yes | no | Fast food | yes | no |
| Cookies | yes | no | Seafood | yes | no |
| Fried food | yes | no | Cakes or pies | yes | no |
| Pizza | yes | no | Vegetables | yes | no |
| Chocolate | yes | no | Steak or red meat | yes | no |
| Chips and snacks | yes | no | Dairy products | yes | no |
|  |
| **Food allergies** **Eating Behaviors**

|  |
| --- |
|  |
| Chaotic eating patterns/ no eating regular meals | yes | no | Excessive snacking on starchy foods – pretzels, chips | yes | no |
| Drinking sweetened beverages – pop, kool-aid, etc. | yes | no | Excessive sweets | yes | no |
| Emotional/ stress eating | yes | no | Large portion sizes | yes | no |

**Other contributing factors**

|  |
| --- |
|  |
| Decrease in activity after job change | yes | no | Smoking cessation | yes | no |
| Decreased activity after an injury | yes | no | Weight gain with pregnancy | yes | no |
| Genetics | yes | no | Yo-yo dieting | yes | no |
| Medications | yes | no |  |  |  |

 |