DOXOLOGY
HEALTH & FERTILITY

Name:
DOB:
MRN:

Reason for visit: _____

General Medical History

- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart disease
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ Gallstones
- ☐ Colitis
- ☐ Ulcers
- ☐ Recurrent Urinary Infection
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Diabetes/Prediabetes
- ☐ Thyroid disease
- ☐ Skin disease
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Cancer _____
- ☐ Anemia
- ☐ Blood Transfusion
- ☐ Varicose Veins
- ☐ Blood clot in the legs or lungs
- ☐ Bleeding disorder
- ☐ Migraines
- ☐ Seizure
- ☐ Stroke
- ☐ Autoimmune disease
- ☐ Drug dependency
- ☐ Alcohol dependency
- ☐ Depression
- ☐ Attempted Suicide
- ☐ Anxiety
- ☐ Other _____ _____

Menstrual History

Age at first period: _____ First day of last menstrual period: _____ Cycle length _____
Duration _____ Irregular periods? _____
How often do you change your pad/tampon/cup on heavy days? _____ For how many days? _____
CIRCLE which symptoms you have with your period: cramping, pelvic pain, headaches, mood swings, PMS, leg pain, back pain, nausea, vomiting, pain with bowel movements, painful urination.
CIRCLE which symptoms you have between your periods: abnormal bleeding, cramping, pelvic pain

Date of Last PAP: _____ Mammogram: _____ Colonoscopy: _____ Bone density: _____

Gynecologic History

- ☐ Abnormal PAP
- ☐ Colposcopy
- ☐ Cone/LEEP/Cryo
- ☐ Recurrent Yeast Infection
- ☐ Trichomonas
- ☐ Bacterial Vaginosis
- ☐ Genital Lesions
- ☐ Genital Herpes
- ☐ Genital Warts
- ☐ Gonorrhea
- ☐ Chlamydia
- ☐ Syphilis
- ☐ Pelvic Inflammatory Disease (PID)
- ☐ HIV
- ☐ Ovarian Cysts
- ☐ Uterine Fibroids
- ☐ Polycystic Ovarian Syndrome
- ☐ Fibrocystic Breast
- ☐ Breast biopsy or surgery
- ☐ Breast cancer
- ☐ Ovarian cancer
- ☐ Uterine cancer
- ☐ Colon cancer
- ☐ Infertility
- ☐ Painful intercourse
- ☐ Lack of sexual desire
- ☐ Endometriosis
- ☐ D&C
- ☐ Laparoscopy
- ☐ Hysterectomy
- ☐ Bladder surgery
- ☐ Urinary leakage

Did your mother take Diethylstilbestrol (DES) when pregnant with you? Y N Unknown
Have you ever been pregnant: Y N (please list below)
Full term _____ Preterm _____ Ectopic _____ Terminations _____ Miscarriages _____
Any pregnancy complications (circle)? Gestational diabetes/preeclampsia/high blood pressure

Are you attempting pregnancy: Y N Unknown
Are you avoiding pregnancy: Y N Method to avoid pregnancy?_____

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Surgeries

Date/Year	Surgery	Surgeon/Location	Location

Have you ever had surgery or anesthesia complications? (Please describe)

_____

Allergies: _____

Current Medications and Dosages:

_____

_____

Family History:

Has anyone in your family every had:

- ☐ Breast cancer
- ☐ Ovarian Cancer
- ☐ Uterine cancer
- ☐ Colon cancer
- ☐ Heart disease
- ☐ Diabetes
- ☐ Autoimmune disease
- ☐ Blood clots
- ☐ Depression

Social History (please circle)

Marital status (circle): Single, Engaged, Married, Separated, Divorced
Sexually active (circle): Y N
Do you have sex with (circle): Men Women Both
Have you ever smoked (circle)? Y N If yes, for how many years? _____
Do you smoke now (circle)? Y N How many packs per day? _____
Do you drink alcohol (circle)? Y N If yes, please circle: beer wine liquor
How many times a week do you drink alcohol? _____ How many drinks at a time? _____
How many times a week do you exercise? _____ What kind of exercise? _____
Occupation: _____
Children (list names, ages): _____
Who do you live with? _____
Do you feel safe at home? _____