Lawrence Amesse, MD, PA

HEALTH HISTORY QUESTIONNAIRE

The information requested on the attached form will help us provide you with more effective medical care. Your answers will be treated confidentially, as are all aspects of your medical care.

Please print legibly using a ballpoint pen. These forms will become a part of your permanent medical record.

Answer each question to the best of your ability by filling in the information or by marking the appropriate space. Don't worry if you are uncertain of the answer to some of the questions. You will have a chance to review them with the doctor.

PLEASE BRING THE COMPLETED QUESTIONNAIRE WITH YOU TO YOUR INITIAL APPOINTMENT.

Thank you.

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Date: _____________

Name: ____________________________________ DOB: _____________ Age: _____ Sex: ____

Address: __________________________________ Home phone: _____-_______________

__________________________________ Work phone: _____-_______________

____

Your occupation: ___________________________ Your employer ____________________

Married: Y / N

Name of Spouse/Partner:_____________________ Occupation: ____________________

Spouse/Partner employer:____________________ Work phone: ____-_______________

REASON FOR YOUR VISIT

Infertility

Blocked Fallopian tubes

Desire Reversal of Previous Tubal Sterilization

Abnormal Menstrual Periods

Lack of Menstrual Periods

Endometriosis

Pelvic Pain

Pre-menstrual Tension

Excess Facial or Body Hair

Menopause management

Other Gynecologic problem (describe)

None of the Above (describe)

Please describe your present problem. Include all symptoms, how long you have experienced them and their patterns. Also indicate whether they have changed in severity over time:

____

____

____

____

PREVIOUS EVALUATION FOR PRESENT PROBLEM

Year	Doctor's Name	Tests & Results	Treatments / Medications

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MENSTRUAL HISTORY

Age at onset: _________ What were the dates of your last two periods: ____________________________________

Are your cycles regular: Y / N Periods come every _________ days. # of days periods last: _______________

Amount of bleeding and change during the period: ____

Painful periods (describe)? ____

Can you tell, by the way you feel in the week to ten days before bleeding, that your period is drawing near? Y / N

If yes, what symptoms do you usually experience?

- Breasts larger, or tender
- Mood changes (nervous, irritable, depressed), explain __________________________________
- Abdominal discomfort, bloating
- Weight gain, swelling
- Headache
- Other ____

Bleeding between periods Y / N / sometimes

Pain between periods Y / N / sometimes If yes, explain ____

____

____

Do you have "ovulation pains" between periods? Y / N / Sometimes

Do you have increased vaginal discharge between periods? Y / N / Sometimes

Did your periods change since puberty? If yes, please explain ____

____

What was the longest time (days) you have gone without a period, other then during pregnancy? ________________

What was the shortest time (days) between periods? __________________________

Have you ever received treatment to bring on or to regulate your periods? Y / N If yes, explain: _______________

____

FOR POSTMENOPAUSAL WOMEN

Age at menopause ________________

Cause of menopause:

Spontaneous	Radiation
Surgical	Drugs

Symptoms:

None	Back pain
Hot flashes	Vaginal dryness
Mood swings	Painful intercourse

Other, Explain ____

____

Are you currently taking estrogen and / or other hormone preparation? Y / N

If yes, please describe what hormone, what dosage and for how long ____

Have you changed your hormone therapy for any reason since menopause? Y / N If yes, please describe:

____

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GYNECOLOGIC HISTORY

Prior examinations:

Regular GYN exams? Y / N

Date of last exam _________ Reason: ___________________ Doctor: _____________ Place: _________

Date of last PAP smear ____________ Result _____________________

History of abnormal PAP Y / N Dates ________________ Treatments ___________________________

Regular breast exams Y / N

Last breast exam _________________

History of abnormal breast exam Y / N Dates ___________ Treatments _________________________

Last mammogram _________________ Results _________________

Have you had a history of (if yes, please give dates and type of treatments)

Milky breast discharge ____

Chlamydia ____

Pelvic infection ____

Other gynecologic problem ____

____

____

____

Prior gynecologic surgical procedure (please list them in chronological order)

Date Procedure Reason for surgery Hospital / Doctor

____

____

____

____

____

____

Birth control history

Method Dates Problems

IUD ____

Pills ____

Diaphragm ____

Foam ____

Condoms ____

Ligation of tubes ____

Norplant ____

Depo-Provera ____

Other ____

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PREGNANCY HISTORY

List all the pregnancies you have had, in chronological order, including miscarriages, abortions, tubal pregnancies, stillbirths, premature and normal births:

Dates	Outcome	Complications	Months to Conceive	Is current partner the father? (Y/N)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

Did you have infertility treatment to achieve any of the above pregnancies? If yes, describe the dates and the type of treatments you had ____

____

____

____

Fertility medications taken in the past:

Clomid	How many cycles? __________	Maximum dose __________
Pergonal	How many cycles? __________	Maximum dose __________
Metrodin	How many cycles? __________	Maximum dose __________
Humegon	How many cycles? __________	Maximum dose __________
Fertinex	How many cycles? __________	Maximum dose __________
Other		

Describe name, dose, # of cycles ____

If you ever used Lupron describe when and for how long ____

____

Did you ever have inseminations? Y / N

If yes, explain when, how many times and indicate what, if any, fertility medications were used:

____

____

____

Did you ever have IVF or other cycles using assisted reproductive technologies? Y / N

If yes, list all cycles:

	Dates	Place	Medications, dosages, length of therapy	Outcome
1.				
2.				
3.				
4.				
5.				
6.				

Have you ever received donor sperm or donor egg? Y / N

If yes, please list cycles, type of treatments and whether anonymous or directed donor was used: ____________

____

____

____

PAST INFERTILITY EVALUATION

Check all that apply	Dates	Results
Partner semen analysis	____________________	__________________________________
Temperature charts	____________________	__________________________________
Postcoital test	____________________	__________________________________
Endometrial biopsy	____________________	__________________________________
X-ray of tubes (HSG)	____________________	__________________________________
Sonohysterogram	____________________	__________________________________
Hysteroscopy	____________________	__________________________________
Laparoscopy	____________________	__________________________________
Chromosomal studies	____________________	__________________________________
Hormonal tests (list all below)	____________________	__________________________________
Other tests / comments	____________________	__________________________________

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GENERAL HEALTH

List current and past non-gynecologic medical problems:

Date	Illness	Treatments

____

____

____

____

____

____

____

____

____

List all non-gynecologic surgeries you had:

Date Illness Surgery

____

____

____

____

____

List allergies and the type of allergic reactions you have: ____

____

____

Medications you are currently on and medications you have taken regularly in the past: ______________________

____

____

Serious accidents? ____ Blood transfusions? ________________

Alcohol consumption (amount) _________________________ Number of cigarettes per day ____________________

Drugs used (for how long) _____________________________ Caffeine (how much) ___________________________

FAMILY HISTORY

List below the ages of your immediate living relatives, or their age at death if deceased, and their medical problems, if any, including gynecologic problems and age at menopause.

Mother ____

Father ____

Brother(s)____

Sister(s) ____

Grand parents ____

____

____

HUSBAND / PARTNER HISTORY

Date of birth: ________________ Present age: _____________ Duration of present relationship: _______________

Has partner initiated pregnancy in previous relationship? If yes, please give dates and outcome of pregnancy: ____

____

Has partner had a previous relationship where pregnancy did not occur even though no contraception was used?

If yes, how long a period was involved? ____

Medical problem? If yes, please list and give specifics ____

____

____

History of reproductive system problem or surgery? ____

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Any history of serious accidents? ____

History of blood transfusion? ____

History of transmissible disease? ____

Current medication and medications taken regularly in the past ____

____

Alcohol consumption (amount)? ______________________________ Number of cigarettes per day ______________

Any drugs used (for how long) _______________________________ Caffeine (how much) _____________________

Exposed to:

High temperature / Jacuzzi
Radiation
Toxic substances
Hazardous chemicals

Exposure specifies:

____

____

____

____

ADDITIONAL PATIENT COMMENTS

Please add any pertinent medical information not previously mentioned:

____

____

____

____

____

____

Who referred you to our office?____

If an other physician please indicate name and address below:

Referring physician: ____________________________________

Address: ____

____

Office phone ____-___________

Patient's signature ________________________________Date ________________________________