Texas Tech Physicians
of LUBBOCK
THE CENTER FOR FERTILITY
AND REPRODUCTIVE SURGERY

NEW PATIENT CONSULTATION

Date Forms Were Completed:_____
PLEASE FILL OUT ALL INFORMATION BELOW. THANK YOU.

Name of Physician who is sending you for consultation:
Physician's Name:_____
Physician's Address:_____
City_____ State_____ Zip code_____
Physician's phone number:_____

Your Name:_____Date of Birth:_____Age:_____
Occupation:_____
Partner/Spouse's Name_____Date of Birth:_____Age:_____
Occupation:_____
Religious preference:_____

Reason for visit:_____
_____

I- Past Medical History: (Please list any health problems such as high blood pressure, diabetes, asthma or any other conditions requiring medical treatment)
1._____
2._____
3._____

II Past Surgical History:
Date:_____Type of Surgery_____
Date:_____Type of Surgery_____
Date:_____Type of Surgery_____

III-Medications: (Please list all current prescription and over counter medications)
1._____
2._____
3._____
4._____

IV-Allergies to Medications (or Foods or others):
1._____Reaction that occurs:_____
2._____Reaction that occurs:_____

V-Social History:

Years of marriage (if applicable):_____
Years with current partner:_____
Do you smoke?_____ If yes, how many cigarettes per day?_____How many years?____
Do you drink alcohol?_____ If yes, how many alcoholic beverages per week?_____
Do you use drugs?_____If yes, what kind?_____How often?_____

V-Obstetrical History:

Total number of pregnancies in your lifetime:_____
Please include all miscarriages, abortions, stillborn, and ectopic

Date of Pregnancy miscarriage/ectopic	Weeks of Gestation:	Vaginal birth or C-Section	Male/ Female	Weight
1._____	_____	_____	_____	_____
2._____	_____	_____	_____	_____
3._____	_____	_____	_____	_____
4._____	_____	_____	_____	_____
5._____	_____	_____	_____	_____

V-Gynecologic History:

a- Cervical Factors:
Date of last pap smear?_____ Was it normal?_____
History of cryotherapy (freezing of cervix), LEEP, LETZ or cone biopsy?_____
Have you had previous one of those infections? Circle one or more:
Chlamydia Gonorrhea Trichomonas HPV/warts Herpes

b- Ovulatory Factors:
Age when you had your first period?_____
Are your menstrual cycles regular or irregular?_____
Menstrual cycles occur at intervals of _____days (Example: How many days from the first day of one menstrual cycle to the first day of the next menstrual cycle?).
The bleeding lasts for _____days.
Are your periods ever so heavy that you must change a pad or tampon hourly?_____

c- Pelvic& uterus and tubal factors:
When is your menstrual cycle most uncomfortable? (Please check one)
_____Day before bleeding starts
_____First few days of bleeding
_____My periods are never uncomfortable

Do your periods require use of over-the-counter pain medications?_____
If yes, what do you usually take?_____
Do you ever have pelvic discomfort with intercourse?_____
Do you ever use a heating pad or heating patches on your period?_____

Do you ever reduce your activities during your period due to discomfort?_____
Do you ever miss work or school because of menstrual discomfort?_____
Have you ever bee diagnosed with the following? (Please check all that apply)
_____Fibroids
_____Pelvic adhesions or scar tissue
_____Ectopic (tubal) pregnancy
_____Endometriosis
_____Uterine polyps
_____Ovarian cysts
_____Abnormal shape of uterus
_____Polycystic ovary syndrome (PCOS)
_____Blocked fallopian tubes

Have you ever had a tubal dye test (Hysterosalpingogram) to determine if your fallopian tubes are open? _____ If yes, when? _____ Where?_____

Have you had a tubal ligation? (tubes tied)_____ if yes when?_____
Where?_____More info:_____

Previous form of contraception used and when?_____

d- Central Factors:
Please check all of the following that you are currently experiencing:
_____Thyroid problem
_____Breast discharge
_____Difficulty losing weight
_____Difficulty gaining weight
_____Frequent headaches
_____Changes in vision not corrected by glasses or contact lenses
_____I do not exercise regularly
_____I do not eat a well-balanced diet
_____I am under a significant amount of stress

VI-Previous Fertility Treatment: (Please check all that apply)
_____Clomid If yes, number of cycles:_____ Pregnancy yes or no_____
_____Femara If yes, number of cycles:_____ Pregnancy yes or no_____
_____injections If yes, number of cycles:_____ Pregnancy yes or no_____
_____IUI If yes, number of cycles:_____ Pregnancy yes or no_____
_____IVF If yes, number of cycles:_____ Pregnancy yes or no_____

If have done IVF try to answer to describe the following (if possible):
Number of eggs retrieved:_____ Numbers of eggs fertilized:_____ICSI_____
Dose of Medication:_____ Number of embryos placed back:_____
Quality of eggs or embryos:_____ Any frozen embryos:_____

VII-Review of Systems:

Please check all of the following that you are currently experiencing:

_____Problems with your heart (Cardiovascular)
_____Problems with your lungs (Pulmonary)
_____Problems with constipation or diarrhea (Gastrointestinal)
_____Numbness or tingling in your hands or feet (Neurological)
_____Unexplained bruising or bleeding from your gums (Hematology/Oncology)
_____Problems with urination (Genitourinary)
_____Painful periods (Genitourinary)
_____Irregular periods (Genitourinary)

VIII-Family History:

Please indicate if any of your immediate relativeshave: (parents, grandparents or siblings-Only for female family not spouse- except for birth defects include both your and spouse family)

Diagnosis	Mother	Father	Brother	Sister	Grandparent
Diabetes Mellitus					
High blood pressure					
Heart attack or Stroke					
Breast Cancer					
Colon Cancer					
Uterine Cancer					
Ovarian Cancer					
Bleeding or Clotting Disorder					
Birth Defects					
Congenital Defects in Male or Female family					

IX-Male Factors:

Husband or Partner's Name:_____Age____Children from previous partners_____
Medical Problems:_____
Past Surgeries:_____
Current Medications:_____
Allergies to Medications:_____
Please check all that apply:

_____Pain with intercourse
_____Inability to have intercourse due to erectile problems
_____History of genital injury or surgery
_____Loss of libido (sex drive)
_____Smokes or uses tobacco
_____Drinks more than two alcoholic beverages per day
_____Exposure to extremes of heat, radiation or harmful chemicals

History of previous semen analysis:_____
If yes, when?_____Where?_____

Remainder For Office/Physician's Use:

Physical Examination:

Height:_____ Weight:_____ BMI:_____ LMP_____
Temp:_____ Blood pressure:_____ Pulse:_____ Respirations:_____

General:
Nutrition:
Hair Distribution:
Hair Texture:
HEENT:
Neck:
Heart:
Lungs:
Abdomen:
Extremities:
Pelvic: (Vulva, Vagina, Cervix, Uterus, Adnexa)
Rect:
Urine:

Ultrasound:

Impression:

Plan:

Total Face-To-Face Time for Consultation: _____Minutes