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

# NEW PATIENT CONSULTATION

PLEASE FILL OUT ALL INFORMATION BELOW. THANK YOU!

Your Name:_____Date of Birth:_____Age:_____
Occupation:_____

Partner/Spouse's Name__ _____Date of Birth:_____Age:_____
Occupation:_____

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

Reason for visit:_____

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

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

**Medications:** (Please list all current prescription medications and dose taken)
1._____
2._____
3._____
4._____

**Over-the–counter (Nonprescription) Medications, Vitamins or Herbs**:
1._____
2._____

**Allergies to Medications (or Foods):**

1._____Reaction that occurs:_____
2._____Reaction that occurs:_____
3._____Reaction that occurs:_____

**Social History:**

Years of marriage (if applicable):_____
Years with current partner:_____
Do you smoke?_____ If yes, how many packs 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?_____

**Obstetrical History:**

Total number of pregnancies in your lifetime:_____

| Date of Delivery | How many weeks pregnant? | Vaginal birth or C-Section | Birthweight (Male / Female) |
|---|---|---|---|
| 1._____ | _____ | _____ | _____ _____ |
| 2._____ | _____ | _____ | _____ _____ |
| 3._____ | _____ | _____ | _____ _____ |
| 4._____ | _____ | _____ | _____ _____ |
| 5._____ | _____ | _____ | _____ _____ |

**Gynecologic History:**

Date of last pap smear?_____ Was it normal?_____
History of cryotherapy (freezing of cervix), LEEP, LETZ or cone biopsy?_____

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?_____

When is your menstrual cycle **most** uncomfortable? (Please check one)

☐ Day before bleeding starts
☐ First day of bleeding
☐ Middle of period (cycle days 2 to 4)
☐ 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 been 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 (called an "HSG" or Hysterosalpingogram) to determine if your fallopian tubes are open? _____
If yes, when? _____ Where?_____
***If an HSG has been done previously, please send a copy of the report to our office prior to your New Patient appointment.

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

Previous Fertility Treatment: (Please check all that apply)
_☐_Clomid If yes, number of cycles:_____
_☐_Femara If yes, number of cycles:_____
_☐_IUI If yes, number of cycles:_____
_☐_IVF If yes, number of cycles:_____

**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 (Gastrointestinal)
_☐_Problems with 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)

**Family History:**
Please check if any of your close relatives (parents, grandparents or siblings) have the following health problems:

| **Diagnosis** | Mother | Father | Brother | Sister | Grandparent |
|---|---|---|---|---|---|
| Diabetes Mellitus | | | | | |
| High blood pressure | | | | | |
| Stroke | | | | | |
| Breast Cancer | | | | | |
| Colon Cancer | | | | | |
| Uterine Cancer | | | | | |
| Ovarian Cancer | | | | | |
| Bleeding or Clotting Disorder | | | | | |
| Birth Defects | | | | | |
| Cystic Fibrosis | | | | | |

**Male Factors:**

Husband or Partner's Name:_____Age_____
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, date performed?_____Where?_____
Were results normal?_____
***If a semen analysis has been done previously, please send a copy of the report to our office prior to your New Patient appointment.

**Thank you so much for completing this. We look forward to meeting you!**

*Revised 09/21/2015*