Overlake Reproductive Health

NEW FERTILITY PATIENT QUESTIONNAIRE

IDENTIFYING INFORMATION: Date: _____/____/____ (of first visit)

Name: _____

Age: _____ yrs Birth date: _____/____/____

Partner's Name: _____

Age: _____ yrs Birth date: _____/____/____

Address: _____

City/State/Zip: _____

Telephone (day): (_____)_____ (evening): (_____)_____

Occupation: _____ Company: _____

Reason for visit: _____

_____

What are your expectations for this visit? _____

_____

What questions do you want answered at this visit? _____

_____

How did you hear about us? (Please be as specific as possible)

☐ Physician

Name _____ Phone (_____)_____

Address _____

☐ Former Patient/Friend _____

☐ Web Site _____ ☐ Advertisement_____

☐ Insurance (Name of Insurance) _____

Who is your OB/GYN?

Name _____ Phone (_____)_____

Address _____

Who is your Primary Care Physician?

Name _____ Phone (_____)_____

Address _____

ETHNICITY: See Genetics Table

Are you of Caucasian ancestry?..... yes .....no

If yes, have you been tested as a carrier of Cystic Fibrosis? ..... yes .....no

Results: ☐ carrier ☐ non-carrier

Are you of French Canadian ancestry?..... yes .....no

If yes, have you been tested for Tay Sachs disease? ..... yes .....no

Results: ☐ carrier ☐ non-carrier

Are you of Jewish ancestry? ..... yes .....no

If yes, (info at www.jewishgeneticscenter.org/what/) have you been tested as a carrier of the following:

—Tay Sachs disease? ..... ☐ carrier ☐ non-carrier

—Gaucher's disease? ..... ☐ carrier ☐ non-carrier

—Nieman-Pick? ..... ☐ carrier ☐ non-carrier

—Canavan's disease? ..... ☐ carrier ☐ non-carrier

—Fanconi Anemia? ..... ☐ carrier ☐ non-carrier

—Bloom Syndrome? ..... ☐ carrier ☐ non-carrier

—Dysautonomia ? ..... ☐ carrier ☐ non-carrier

Are you of Black ancestry? ..... yes .....no

If yes, have you been tested for Sickle Cell disease? ..... yes .....no

Results: ☐ carrier ☐ non-carrier

Are you of Mediterranean (Greek or Italian) ancestry? ..... yes ..... no

Are you of Asian ancestry? ..... yes .... no

Are you of Middle Eastern ancestry? ..... yes ..... no

Are you of Caribbean, Mexican, or Central American ancestry? ..... yes .... no

If yes to any of the above 4 questions, have you been tested as a carrier of Thalassemia?

..... yes .... no

Results: ☐ carrier ☐ non-carrier

☐ I do not wish to proceed with further testing. _____

The appropriate available prenatal screens have been discussed (initial)_____

I. FERTILITY HISTORY:

FEMALE Menstrual and Pregnancy History (M or M/M couples skip)

How long have you been having intercourse without using contraception? _____

How long have you been "working" at becoming pregnant? _____

When did you first see a doctor for infertility? _____

Total # of all pregnancies: _____

Please list all pregnancies (include all miscarriages, abortions, tubals, etc)

Date Pregnancy ended or delivered	Length of Pregnancy	How long to conceive	Result	Infertility Therapy?	Current Partner?
1.	wks				☐ Yes ☐ No
2.	wks				☐ Yes ☐ No
3.	wks				☐ Yes ☐ No
4.	wks				☐ Yes ☐ No
5.	wks				☐ Yes ☐ No

Were there any complications or problems during, including high blood pressure, preeclampsia, intrauterine growth retardation, or gestational diabetes?

Explain: 1. _____

2. _____

3. _____

4. _____

Did you require? (circle pregnancies that apply):

C-section	1	2	3	4	5
Surgery	1	2	3	4	5
Blood transfusion	1	2	3	4	5
Antibiotics	1	2	3	4	5
D & C	1	2	3	4	5
Other	1	2	3	4	5

Explain: 1. _____

2. _____

3. _____

4. _____

Patient Name _____

PRINT ENTIRE FORM
SINGLE SIDED

Age at first period _____yrs.

Age when you first noticed: Breast development ___yrs Pubic hair ___yrs Underarm hair ___yrs

Date of the **first day** of your last period _____/_____/_____

If your menstrual cycles are regular, what is the usual number of days from the first day of one period to the first day of the next? _____

How many days does your menstrual flow last? _____

Do you consider your menstrual flow abnormal? Yes No
(circle): light heavy short long painful other _____

Do you have severe cramping or pelvic pain with your periods?
Yes: ___ Always ___ Sometimes ___ Recently ___ In the past No

Do you have pain with intercourse? Yes No

Do you spot or bleed between periods? Yes No

Do you have pelvic pain between periods? (If it is a significant problem, please complete pelvic pain questionnaire)
Yes No

Do you have premenstrual symptoms other than cramps? Yes No

Do you need medication to bring on a period? Yes No

Are your periods now, or have they ever been irregular or unpredictable? Yes No
If yes:
1. When _____
2. Average # of periods in a year _____
3. Shortest time in between periods _____
4. Longest time spent without menstruating _____

(M.D. use only) _____
_____
_____
_____
_____

Do you have acne or oily skin? Yes No

Do you have a breast discharge? Yes No

Are you currently breast feeding? Yes No

Do you have extra body hair? Yes: Where? _____ No

What has been your maximum weight? _____ When? _____

What has been your minimum adult weight? _____ When? _____

Have you ever had a sudden weight change? Yes: When? _____ No

Do you feel that you are underweight? Yes No

Do you feel that you are overweight? Yes No

How many meals do you usually eat per day? _____

Do you follow a particular food diet or have any special dietary habits? Yes No

Have you ever been diagnosed with an eating disorder, such as anorexia or bulimia? Yes No

Have you ever used self-induced vomiting to control overeating? Yes No

Do you regularly participate in any vigorous exercise? Yes No

What: _____

Number of hours _____/week Number of miles _____/week

FEMALE Contraceptive History (M or M/M couples skip)

Have you ever taken oral contraceptives ("Pill")?

Name _____ From _____ To _____

Name _____ From _____ To _____

Name _____ From _____ To _____

Did you or your doctor note any problems? Yes No

Explain _____

_____

Was it stopped because of a problem? Yes No

Explain_____

_____

Were there any problems with your cycles after stopping the "pills"? Yes No

Explain_____

_____

Have you ever used injectable contraception (Depo-Provera®, Lunelle™, etc.)?

Yes: Dates of use_____ Complications? _____ No

Have you ever used an IUD? Yes No

Name _____; From _____ To _____

Name _____; From _____ To _____

Did you note any problems? Yes No

(Circle) Pain Bleeding Fever Infection

Was it removed because of a problem? Yes No

Explain_____

_____

Have you had tubal sterilization procedure (tubes tied)? Yes: _____ Date (mnth/yr) No

If yes, have you had a tubal reversal (tubes untied)? Yes: _____ Date (mnth/yr) No

FEMALE Uterine, Tubal, Pelvic (M or M/M couples skip)

Have you ever had any of the following sexually transmitted diseases or pelvic infections?

Yes (check all that apply) No

☐ Chlamydia: date _____ ☐ Gonorrhea: date _____ ☐ Herpes: date _____ ☐ Genital warts/HPV: date _____

☐ Syphilis: date _____ ☐ HIV/AIDS: date _____ ☐ Hepatitis: date _____ ☐ Other_____: date _____

Have you had your appendix removed? Yes No

(Circle one): Uncomplicated Ruptured Complicated Infection

Did your mother take any hormones when she was pregnant with you? Yes No

Have you ever had a D&C for an abortion, to end a miscarriage, following childbirth, or for abnormal bleeding? Yes No

Explain: _____

_____

FEMALE Testing and Treatment (M or M/M couples skip)

Please indicate the tests you have had to check for ovulation and a normal cycle. Also briefly indicate the test results.

TEST	RESULTS
_____ Basal Temperatures	_____
	_____
_____ Urine L.H. Tests (ovulation predictor)	_____
	_____
_____ Follicle Ultrasound	_____
	_____
_____ Progesterone Level	_____
	_____
_____ Endometrial Biopsy	_____
	_____
_____ Post-Coital Test	_____
	_____

Have you ever had any of the following?

Procedure	**Dates**	**Results**
Hysterosalpingogram:		
Hysteroscopy:		
Laparoscopy:		
Tubal Surgery:		
Abdominal Surgery:		
Other Pelvic Surgery:		

Have you ever been noted to have or been treated for endometriosis? Yes No

Treatment: _____

_____

Prior Treatment:

Have you ever taken any of the following medications to induce ovulation or normalize your cycle? (circle)

Clomid	Serophene	Parlodel	Repronex	HCG
Letrozole	Progesterone	Bravelle	Pergonal	GNRH
Prednisone	Lupron	Other		

Dates	Medication	Dose	Results	Comments

Prior Treatment: Check all that apply:

	# of cycles	Dates (mo/yr) (mo/yr)	Outcome
☐ Intrauterine insemination:	_____	From__/__to__/__	___Pregnant: __Delivered __Ectopic __Miscarriage ___Not Pregnant
☐ Clomiphene citrate with timed intercourse: Maximum # tablets/day? _____	_____	From__/__to__/__	___Pregnant: __Delivered __Ectopic __Miscarriage ___Not Pregnant
☐ Clomiphene citrate with insemination: Maximum # tablets/day? _____	_____	From__/__to__/__	___Pregnant: __Delivered __Ectopic __Miscarriage ___Not Pregnant
☐ Daily fertility drug injections with insemination: Maximum # vials/day? _____	_____	From__/__to__/__	___Pregnant: __Delivered __Ectopic __Miscarriage ___Not Pregnant
☐ Completed in vitro fertilization cycle(s): 1. #eggs___ #embryos transferred___#frozen___ 2. #eggs___ #embryos transferred___#frozen___ 3. #eggs___ #embryos transferred___#frozen___ 4. #eggs___ #embryos transferred___#frozen___	_____	_____/_____ _____/_____ _____/_____ _____/_____	___Pregnant: __Delivered __Ectopic __Miscarriage ___Not Pregnant ___Pregnant: __Delivered __Ectopic __Miscarriage ___Not Pregnant ___Pregnant: __Delivered __Ectopic __Miscarriage ___Not Pregnant ___Pregnant: __Delivered __Ectopic __Miscarriage ___Not Pregnant
☐ Frozen embryo transfers: 1. #embryos transferred_____ 2. #embryos transferred_____ 3. #embryos transferred_____ 4. #embryos transferred_____	_____	_____/_____ _____/_____ _____/_____ _____/_____	___Pregnant: __Delivered __Ectopic __Miscarriage ___Not Pregnant ___Pregnant: __Delivered __Ectopic __Miscarriage ___Not Pregnant ___Pregnant: __Delivered __Ectopic __Miscarriage ___Not Pregnant ___Pregnant: __Delivered __Ectopic __Miscarriage ___Not Pregnant
Cancelled in vitro fertilization attempt(s):	_____		
Any other prior treatment (describe): _____			

Additional Information/Complications: _____

_____

_____

_____

MALE FACTORS (M/F couples only)

Partner's Name:_____Age: _____

Occupation: _____

ETHNICITY OF PARTNER: See Genetics Table

Is your partner of Caucasian ancestry? ..... yes .....no
If yes, has he been tested as a carrier of Cystic Fibrosis? ..... yes .....no
Results: ☐ carrier ☐ non-carrier

Is he of French Canadian ancestry?..... ..... yes .....no
If yes, has he been tested for Tay Sachs disease? ..... yes .....no
Results: ☐ carrier ☐ non-carrier

Is he of Jewish ancestry? ..... yes .....no
If Yes, (info at www.jewishgeneticscenter.org/what/) has he been tested as a carrier of the following:
—Tay Sachs disease? ..... ☐ carrier ☐ non-carrier
—Gaucher's disease? ..... ☐ carrier ☐ non-carrier
—Nieman-Pick? ..... ☐ carrier ☐ non-carrier
—Canavan's disease? ..... ☐ carrier ☐ non-carrier
—Fanconi Anemia? ..... ☐ carrier ☐ non-carrier
—Bloom Syndrome? ..... ☐ carrier ☐ non-carrier
—Dysautonomia ? ..... ☐ carrier ☐ non-carrier

Is he of Black ancestry? ..... yes .....no
If yes, has he been tested for Sickle Cell disease? ..... yes .....no
Results: ☐ carrier ☐ non-carrier

Is he of Mediterranean (Greek or Italian) ancestry? ..... yes .....no
Is he of Asian ancestry? ..... yes ....no
Is he of Middle Eastern ancestry? ..... yes .....no
Is he of Caribbean, Mexican, or Central American ancestry? ..... yes ....no
If yes to any of the above 4 questions, has he been tested as a carrier of Thalassemia? .
..... yes ..... no
Results: ☐ carrier ☐ non-carrier

☐ My partner does not wish to proceed with further testing (initial) _____

The appropriate prenatal screens have been discussed (initial) _____

Has your partner previously conceived with another woman? Yes - how many times?___ No
If no, was birth control used? Yes No

Has your partner had a semen analysis? Yes No

Dates	Results

Has your partner been seen by a urologist? Yes No

Dates	Results

Has your partner had difficulty with erections? Yes No

Does he have retrograde ejaculation of sperm into the bladder? Yes No

Has he had any of the following sexually transmitted diseases or pelvic infections?

Yes (check all that apply) No

☐ Chlamydia: date _____ ☐ Gonorrhea: date _____ ☐ Herpes: date _____ ☐ Genital warts/HPV: date _____

☐ Syphilis: date _____ ☐ HIV/AIDS: date _____ ☐ Hepatitis: date _____ ☐ Other_____: date _____

Has your partner had a history of undescended testicles? Yes - one side___ both___ No

Does he have scrotal or testicular pain? Yes No

Did he have the mumps after puberty? Yes No

Has he had prior injury to his testicles requiring hospitalization? Yes No

Has your partner been diagnosed with any of the following diseases?

Yes (check all that apply) No

☐ Diabetes Mellitus ☐ Prostatic Infections ☐ Cancer

☐ Multiple Sclerosis ☐ Urinary Infections ☐ Other neurologic problems

☐ High Blood Pressure - if yes, any medications: _____

Has your partner had any fever in the last 3 months? Yes No

Has he had a vasectomy? Yes - date _____ No

If yes, has he had a vasectomy reversal? Yes - date _____ No

Has he had surgery for varicocele repair? Yes No

Has he had hernia surgery? Yes No

Did your partner undergo any bladder or penis surgery as a child? Yes No

Is he exposed to prolonged heat in the workplace? Yes No

Is he exposed to any radiation or harmful chemicals in the workplace? Yes No

Has he had chemotherapy for cancer? Yes No

Is he allergic to any medications? Yes (please list and describe reactions) No

_____

_____

_____

List his current medications: _____

List any current medical problem(s): _____

_____

Has your partner had treatment to improve his fertility? Yes No

Dates	**Results**

How many caffeinated beverages does he drink per day? _____ None

Does he use or has he ever used:

1. Alcohol, (# of glasses per week) Yes No
   Wine _____ Beer _____ Cocktails _____
2. Cigarettes, (present _____ prior _____) Yes No
   # packs per day _____ # of years _____
3. Illicit or recreational drugs (specify) Yes No

   _____

   _____

Have you or your partner ever been in a program for limiting or discontinuing use of drugs or alcohol? Yes No

Does your partner use herbal medicines/vitamins or health food store supplements?

Yes (describe) _____ No

Are you aware of any radiation/toxic materials exposure? Yes No

Does your partner use hot tubs regularly? Yes No

Did his mother take DES during pregnancy to prevent miscarriage? Yes No

Have any of his immediate family members had difficulty conceiving a child?

Yes (describe) _____ No

COUPLE FACTORS (M/F couples only)

How frequently do you have sexual intercourse?

- More than once a day _____
- Daily or almost daily _____
- 3-5 times a week _____
- 1-2 time a week _____
- Less than once a week _____
- Irregularly _____

Which of the following best describes how you feel about your sex life?

- Very satisfied _____
- Fairly satisfied _____
- Fairly unsatisfied _____
- Very unsatisfied _____

Which of the following best describes how you think your partner feels about your mutual sex life?

- Very satisfied _____
- Fairly satisfied _____
- Fairly unsatisfied _____
- Very unsatisfied _____

Do any of these statements describe sex with your partner?

It is sometimes difficult	_____
It is almost always difficult	_____
It is sometimes painful	_____
It is almost always painful	_____
It is sometimes unpleasant	_____
It is almost always unpleasant	_____
It is sometimes enjoyable	_____
It is almost always enjoyable	_____

Do you or your partner have problems with initiating or completing sexual intercourse? Yes No

Do you plan intercourse for a specific time of your cycle? Yes No
When: _____

Do you use lubricant for intercourse? Yes No

Do you douche before or after intercourse? Yes No

Do you feel that your fertility problem is:

1. Causing personal stress Yes No
2. Causing stress between you and your husband Yes No
3. Interfering with a satisfactory sex life Yes No

II. FAMILY HISTORY

MALE FAMILY HISTORY (F or F/F couples skip)

Relative	Alive/Dead		Age
Mother _____	A/D	_____	_____
Father _____	A/D	_____	_____
Sisters/Brothers:			
1. S / B _____	A/D	_____	_____
2. S / B _____	A/D	_____	_____
3. S / B _____	A/D	_____	_____
4. S / B _____	A/D	_____	_____

Have any of your partner's relatives ever had the diseases or conditions listed below?

Condition	Mother	Father	Brother/Sister	Other
Alcoholism	M	F	S	O
Anemia	M	F	S	O
Diabetes	M	F	S	O
Cancer	M	F	S	O
Bleeding disorders	M	F	S	O
Heart disease	M	F	S	O
High blood pressure	M	F	S	O
Kidney disease	M	F	S	O
Stroke	M	F	S	O
Blood clots	M	F	S	O
Thyroid disease	M	F	S	O
Excess hair growth	M	F	S	O
Epilepsy	M	F	S	O
Birth defects	M	F	S	O
Muscular dystrophy	M	F	S	O
Cystic fibrosis	M	F	S	O
Mental retardation	M	F	S	O
Physical retardation	M	F	S	O
Downs syndrome	M	F	S	O
Other chromosome defects	M	F	S	O
Obesity	M	F	S	O
Psychiatric problems	M	F	S	O

Do any hereditary diseases or abnormal conditions run in his family? Yes No

FEMALE FAMILY HISTORY (M or M/M couples skip)

Relative	Alive/Dead		Age
Mother _____	A/D	_____	_____
Father _____	A/D	_____	_____
Sisters/Brothers:			
1. S / B _____	A/D	_____	_____
2. S / B _____	A/D	_____	_____
3. S / B _____	A/D	_____	_____
4. S / B _____	A/D	_____	_____

Have any of your blood relatives ever had the diseases or conditions listed below?

Condition	Mother	Father	Brother/Sister	Other
Alcoholism	M	F	S	O
Anemia	M	F	S	O
Diabetes	M	F	S	O
Cancer	M	F	S	O
Bleeding disorders	M	F	S	O
Heart disease	M	F	S	O
High blood pressure	M	F	S	O
Kidney disease	M	F	S	O
Stroke	M	F	S	O
Blood clots	M	F	S	O
Thyroid disease	M	F	S	O
Excess hair growth	M	F	S	O
Epilepsy	M	F	S	O
Birth defects	M	F	S	O
Muscular dystrophy	M	F	S	O
Cystic fibrosis	M	F	S	O
Mental retardation	M	F	S	O
Physical retardation	M	F	S	O
Downs syndrome	M	F	S	O
Other chromosome defects	M	F	S	O
Frequent miscarriages	M	F	S	O
Stillbirths	M	F	S	O
Twins	M	F	S	O
Early menopause (before age 40)	M	F	S	O
Endometriosis	M	F	S	O
Infertility	M	F	S	O
Irregular periods	M	F	S	O
Obesity	M	F	S	O
Psychiatric problems	M	F	S	O

Do any hereditary diseases or abnormal conditions run in your family (including breast, bowel or ovarian cancer)? Yes No

III. FEMALE MEDICAL HISTORY (M or M/M couples skip)

Do you have or have you ever had (circle all that apply):

Scarlet fever	High blood pressure	Neurological problems
Rheumatic fever	Gallbladder problems	Seizures
Tuberculosis	Liver problems	Epilepsy
Hepatitis	Ulcers	Dizziness
Heart murmur	Appendicitis	Loss of balance
Pelvic infection	Colitis	Chronic headaches
Chicken pox	Anemia	Vaginitis
Thyroid problems	Arthritis	Pneumonia
Cancer	Breast lump	Parasites
Kidney infection	Breast problems	Ovarian cysts
Heart disease	Breast discharge	Other _____

Comments _____

Patient Name _____

PRINT ENTIRE FORM
SINGLE SIDED

PAP SMEAR HISTORY

When was your last pap smear? (month/year) _____/_____ ☐ Normal ☐ Abnormal

When was your last abnormal pap smear? _____/_____ ☐ Not applicable

Have you undergone any procedures as a result of an abnormal pap smear?

Yes (check all that apply) No

☐ Colposcopy ☐ Cryosurgery (freezing) ☐ Laser treatment ☐ Conization ☐ LEEP procedure

BREAST SCREENING HISTORY

Have you ever had a mammogram?

Yes - date _____ Result: ☐ normal ☐ abnormal - explain _____ No

Do you perform breast self exams? Yes No

Have you ever had Rubella (German measles)? Yes No

Have you received Rubella immunization? Yes No

Have you ever undergone surgery? Yes No

Date	Type	Hospital

Were there:

Complications? Yes No

Anesthesia problems? Yes No

Bleeding problems? Yes No

Comments _____

_____

_____

Are you allergic to any medication, drugs, foods, metals, other? Yes (list and describe reactions) No

_____

_____

_____

Do you regularly take medications? Yes No

1. Over the counter (list) Yes No

   _____

2. Prescriptions (list) Yes No

   _____

   _____

3. Are you taking any now (list) Yes No

   _____

   _____

   _____

Do you use or have you ever used:

1. Alcohol, (# of glasses per week) Wine ____ Beer ____ Cocktails ____ Yes No
2. Cigarettes, (present _____ prior _____) Yes No
   # packs per day _____ # of years _____
3. Illicit or recreational drugs (specify) Yes No

   _____

   _____ **Past / Present (circle)**

IV. REVIEW OF SYSTEMS

General:
- ☐ Recent weight gain or loss
- ☐ Anorexia/Bulimia
- ☐ Lack of energy
- ☐ Fever/Chills
- ☐ Other _____
- ☐ none

Endocrine/Hormonal:
- ☐ Diabetes ☐ Hair loss
- ☐ Thyroid gland problems
- ☐ Rapid weight gain or loss
- ☐ Excessive hunger/thirst
- ☐ Temperature intolerance - hot flashes or feeling cold
- ☐ Other _____
- ☐ none

Gastrointestinal:
- ☐ Nausea/Vomiting ☐ Ulcers
- ☐ Hepatitis ☐ Diarrhea
- ☐ Blood in your stools ☐ Constipation
- ☐ Irritable Bowel Syndrome
- ☐ Change in bowel habits
- ☐ Colitis (Ulcerative or Crohn's)
- ☐ Other _____
- ☐ none

Musculoskeletal:
- ☐ Unusual muscle weakness
- ☐ Decreased energy/stamina
- ☐ Rheumatoid arthritis
- ☐ Lupus Erythematosus
- ☐ Myasthenia gravis
- ☐ Other _____
- ☐ none

Mental Health Problems:
- ☐ Depression ☐ Anxiety disorder
- ☐ Schizophrenia
- ☐ Other _____
- ☐ none

Head, Eyes, Ears, Nose and Throat:
- ☐ Dizziness ☐ Loss of sense of smell
- ☐ Headaches ☐ Chronic nasal congestion
- ☐ Blurred vision ☐ Ringing ears
- ☐ Hearing loss/deafness
- ☐ Other _____
- ☐ none

Breasts:
- ☐ Discharge: clear __ bloody __ milky __
- ☐ Lumps ☐ Pain ☐ Cancer
- ☐ Abnormal mammogram
- ☐ Reduction
- ☐ Augmentation/Breast implants
  Saline __ Silicone __
- ☐ Other _____
- ☐ none

Genito-Urinary:
- ☐ Bladder infections
- ☐ Kidney infections
- ☐ Vaginal infections
- ☐ Frequent urination ☐ Leaking urine
- ☐ Blood in the urine
- ☐ Herpes
- ☐ Other _____
- ☐ none

Hematologic:
- ☐ Blood clotting disorder/Blood clot
- ☐ Sickle Cell Anemia ☐ Thrombophlebitis
- ☐ Easy bruising
- ☐ Swollen glands/lymph nodes
- ☐ Blood transfusions (dates/reasons _____)
- ☐ Other _____
- ☐ none

Respiratory:
- ☐ Shortness of breath
- ☐ Asthma ☐ Bronchitis
- ☐ Pneumonia ☐ Tuberculosis
- ☐ Bloody cough
- ☐ Other _____
- ☐ none

Neurological Problems:
- ☐ Weakness/Loss of balance
- ☐ Seizures/Epilepsy
- ☐ Headaches
- ☐ Migraine headaches
- ☐ Numbness
- ☐ Memory loss
- ☐ Other _____
- ☐ none

Skin/Extremities:
- ☐ Unexplained rash/inflammation
- ☐ Acne
- ☐ Skin cancer
- ☐ Burn injury
- ☐ Moles changing in appearance
- ☐ Excess hair growth
- ☐ Other _____
- ☐ none

Cardiovascular:
- ☐ Palpitations/Skipped beats
- ☐ Chest pain ☐ Heart attack
- ☐ Stroke ☐ Murmurs
- ☐ High blood pressure
- ☐ Rheumatic fever
- ☐ Mitral valve prolapse (need antibiotics before dental procedures? Yes ___ No ___)
- ☐ Other _____
- ☐ none

Physician Notes (for office use only) _____

_____

_____

_____

V. PHYSICAL EXAM:

Office Use Only

Height _____ Weight _____ Pulse _____ B.P. _____

Stature _____ Race _____

General Appearance: ☐ Well developed ☐ Well nourished ☐ Normal mood/affect ☐ Oriented x3 ☐ No acute distress

Skin: ☐ Acne ☐ XS Sebum ☐ Hirsuitism (facial, chest, back, areolar, abd., thigh) ☐ No lesions ☐ No abnormal moles

Neck: ☐ Supple ☐ Without masses

Thyroid: ☐ WNL ☐ No masses ☐ Without thyromegaly

Breast: ☐ No dominant masses ☐ No skin changes ☐ No nipple discharge

Lungs: ☐ Clear to auscultation bilaterally ☐ Normal respiratory effort

Heart: ☐ Regular rhythm and rate ☐ No murmurs/gallops

Abdomen: ☐ Soft, non-distended ☐ No masses/HSM ☐ No hernias

Back: ☐ No CVA tenderness

Lymphatic: ☐ No neck ☐ No axillary ☐ No groin lymphadenopathy

Extremities: ☐ Without varicosities ☐ Without edema ☐ Nontender calves

Pelvic Exam: ☐ Normal external genitalia ☐ Adnexa NT

Urethral meatus/urethra: ☐ Without lesions, tenderness or prolapse

Bladder: ☐ Without masses, tenderness ☐ Well supported

Vagina: ☐ Well supported ☐ No lesions ☐ No abnormal discharge

Cervix: ☐ Without lesions ☐ No CMT

Uterus Position: ☐ Normal size & shape ☐ Nontender ☐ Without descent

Adnexa: ☐ Normal size ☐ No adnexal masses ☐ No tenderness

Anus/Perineum: ☐ No lesions

Rectal: ☐ Normal sphincter tone ☐ No hemorrhoids ☐ No tenderness

Other Findings:

The above was discussed with the patient at the New Patient Consultation.

Signed: _____ Date: _____

WHAT OTHER GROUPS OF PEOPLE HAVE SPECIFIC GENETIC DISEASES?

It is estimated that we all carry 6 - 8 disease-producing genes which would be harmful if passed on to our children by both mother and father.

Many other racial and ethnic groups have “their own” genetic disorders - disorders which are not unique to the group, but which are more common in the group.

Ancestry	Disease	Carrier Frequency	Disease Incidence
Blacks	Sickle Cell Anemia	1 in 12	1 in 600
Ashkenazi Jews	Tay-Sachs disease	1 in 30	1 in 3,600
Ashkenazi Jews	Canavan disease	1 in 35 - 40	1 in 6,000
Greeks, Italians	beta-thalassemia	1 in 30	1 in 3,600
SE Asians, Chinese	alpha-thalassemia	1 in 25	1 in 2,500
N. Europeans	Cystic fibrosis	1 in 25	1 in 2,500