

# Palm Beach Fertility Center

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Reproductive Endocrinologist

## New Patient Information Form

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Name \_\_\_\_\_  
Last First Middle

Age \_\_\_\_\_ Date Of Birth \_\_\_\_\_ Birthplace \_\_\_\_\_

Single \_\_\_\_\_ Divorced \_\_\_\_\_ Married \_\_\_\_\_ Widow \_\_\_\_\_

Occupation \_\_\_\_\_

Reason for today's visit: (Please list all symptoms)

Please do not write in this space

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Gynecological History

Date of last period \_\_\_\_\_

Age at onset \_\_\_\_\_

Regular? Yes \_\_\_\_\_ No \_\_\_\_\_

When was your last mammogram? \_\_\_\_\_

Cycle: \_\_\_\_\_ days (from start of one period to start of next.)

What medicines do you take regularly?

Usual duration: \_\_\_\_\_ days.

Heavy \_\_\_\_\_ Medium \_\_\_\_\_ Light \_\_\_\_\_

Pains or cramps: Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have bleeding between periods?

Yes \_\_\_\_\_ No \_\_\_\_\_

Have you had a pap smear within the

Do you have bleeding after intercourse? last year? \_\_\_\_\_ Date \_\_\_\_\_

Yes \_\_\_\_\_ No \_\_\_\_\_

Was your last pap smear normal or abnormal? \_\_\_\_\_

Do you have a vaginal discharge today?

Yes \_\_\_\_\_ No \_\_\_\_\_

### Pregnancy History

	Year	End in Abortion?	End in Miscarriage?	Ectopic Pregnancy?	Infertility Treatment?	Time to Conceive?	Baby born alive?	Current partner the father?
1st Pregnancy								
2nd Pregnancy								
3rd Pregnancy								
4th Pregnancy								
5th Pregnancy								
6th Pregnancy								

Do you currently smoke? No \_\_\_\_\_ Yes \_\_\_\_\_ Packs per day currently

If not smoking now, have you ever smoked? No \_\_\_\_\_ Yes \_\_\_\_\_

How long has it been since you last smoked? # of months \_\_\_\_\_ # of years \_\_\_\_\_

Do you drink alcoholic beverages? No \_\_\_\_\_ Yes \_\_\_\_\_

Do you have any sexual concerns you would like to discuss? \_\_\_\_\_

## Personal Medical History

(Please circle all that apply)

high blood pressure  
 heart disease  
 heart attack  
 stroke  
 phlebitis  
 emphysema  
 asthma  
 bronchitis  
 pneumonia  
 tuberculosis  
 ulcer  
 colitis  
 gall bladder disease  
 hepatitis  
 mononucleosis  
 thyroid problems  
 diabetes  
 urinary infection  
 kidney stones  
 epilepsy  
 nervous or psychiatric condition  
 arthritis

syphilis  
 herpes  
 chlamydia  
 venereal warts  
 PID  
 mumps  
 chicken pox  
 German measles  
 measles  
 rheumatic fever  
 cancer (type)  
 HIV  
 gonorrhea  
 blood transfusions  
 other: \_\_\_\_\_

**ALLERGIES:** Are you allergic to:  
 Betadine  
 Novocain  
 penicillin  
 sulfa  
 aspirin  
 codeine  
 Any other drug(s): \_\_\_\_\_

concussion or head injury  
 car accident or injury  
 ever been knocked unconscious?  
 other: \_\_\_\_\_

**SURGICAL HISTORY:**  
 Please circle all that apply:  
 tonsillectomy  
 appendix operation  
 hernia operation  
 hemorrhoid operation  
 thyroid operation  
 gallbladder operation  
 varicose vein operation  
 D & C  
 laparoscopy  
 laparotomy  
 tubal ligation  
 removal of tube(s) or ovary(s)  
 hysterectomy  
 breast biopsy  
 other: \_\_\_\_\_

**INJURIES:** Have you had:

**Family History**

Age	If Living-Please List All Medical Conditions and Illnesses	Age at Death	If Deceased-- Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Brother	_____	_____	_____
Brother	_____	_____	_____
Sister	_____	_____	_____
Sister	_____	_____	_____

Have any relatives ever had breast or ovarian cancer ?  
 \_\_\_\_\_  
 \_\_\_\_\_

Name of physicians that are familiar with your medical history:  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you currently have a gynecologist? If so, whom?  
 \_\_\_\_\_

How were you referred to Dr. Denker? Please circle all that apply.

- |                         |                                  |
|-------------------------|----------------------------------|
| Web Site                | Mailing                          |
| My gynecologist         | Yellow Pages                     |
| Another patient         | A lecture or seminar             |
| Newspaper advertisement | Health plan or insurance company |
| Television              | A friend                         |
| Internet                |                                  |

## Fertility Testing

Have you had the following tests? If yes, when and what were the results?

Ultrasound to monitor egg development? \_\_\_\_\_

Urine test kits for ovulation? \_\_\_\_\_

Basal body temperature chart (BBT)? \_\_\_\_\_

Endometrial biopsy? \_\_\_\_\_

Estradiol, FSH, LH, Thyroid levels? \_\_\_\_\_

Progesterone levels? \_\_\_\_\_

HSG (x-ray of fallopian tubes)? \_\_\_\_\_

Laparoscopy? \_\_\_\_\_

Husband Semen Analysis \_\_\_\_\_

## Fertility Treatment History

Circle the maximum number of treatment cycles that you have had of the following:

Intrauterine inseminations (IUI)	1	2	3	4	5	6	>6
Clomid or Serophene	1	2	3	4	5	6	>6
Clomid or Serophene with IUI	1	2	3	4	5	6	>6
Injectable fertility drugs (Metrodin, Pergonal, Humegon, with or without IUI)	1	2	3	4	5	6	>6
IVF, GIFT, ZIFT	1	2	3	4	5	6	>6

Draw a second circle around any cycle in which you became pregnant.

***Thank you for your response to the above questions!***

# Palm Beach Fertility Center

## Male Partner New Patient Information Form

Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Name \_\_\_\_\_

Age \_\_\_\_\_ Date Of Birth \_\_\_\_\_ Occupation \_\_\_\_\_  
Last First

Weight \_\_\_\_\_ Height \_\_\_\_\_ Blood Type \_\_\_\_\_ Allergies \_\_\_\_\_

Are you or have you ever been exposed to any of the following:

\_\_\_\_ Extreme heat \_\_\_\_ Chemicals \_\_\_\_ Toxic fumes \_\_\_\_ Other \_\_\_\_\_

Do you frequently take saunas or steam baths? \_\_\_\_\_

Have you ever had X-rays in the pelvic area? \_\_\_\_\_

Are you taking any prescription medicine? \_\_\_\_\_

Are you taking any over the counter medicine? \_\_\_\_\_

Do you drink alcohol? How many glasses/drinks per week \_\_\_\_\_

Do you smoke? How many packs/cig. per day \_\_\_\_\_

Do you take recreational drugs? \_\_\_\_\_

Have you ever produced a child with another partner? \_\_\_\_\_ # \_\_\_\_\_ ages \_\_\_\_\_

Do you have trouble with ejaculations? Premature \_\_\_\_\_ Retrograde \_\_\_\_\_

Do you have difficulty maintaining an erection \_\_\_\_\_

Cancer specify which \_\_\_\_\_

### MEDICAL HISTORY (Please check all the apply)

Anemia

Appendicitis

Arthritis

Blood Transfusion

Chlamydia

Crohn's disease

Chronic Headaches

Cystic Fibrosis

Diabetes

Depression

Gonorrhea

Heart Disease

Herpes

Hypertension

Kidney disease

Liver disease

Measles/mumps

Mononucleosis

Prostatis

Seizures

Testicular injury

Testicular tumor

Thyroid disease

Ulcers

Varicocele repair

Vasectomy reversal

**Surgical History** \_\_\_\_\_

### Family History

Father \_\_\_\_\_ Mother \_\_\_\_\_

### Which of the following tests have you had?

Date results

Semen Analysis

Chlamydia/GC culture

Sperm Antibody Test

Chromosomal Test

Hormonal Tests

Testicular biopsy