Baystate Health | ADVANCING CARE. ENHANCING LIVES.

PATIENT INTAKE FORM

____/____/____
Month day year

Label Space

Patients *– please complete all pages of this form.*

NAME: _____ _____AGE: _____ DOB: ____/____/_____
LAST FIRST Month day year
PREFERRED PRONOUN: She/ He/ They

PARTNER'S NAME: _____ _____ AGE: _____ DOB: ____/____/_____
LAST FIRST Month day year

\Who referred you to Baystate Reproductive Medicine: _____

Address for the above physician:
_____

Who is your OB/GYN: _____ Location: _____

MARITAL STATUS: ☐ Single ☐ Separated ☐ Divorced ☐ Married _____ years

REASON FOR VISIT:
_____

TRYING TO CONCEIVE? ☐ No ☐ Yes if so, how long without protection since? Month _____ Year _____

Please answer the following questions. Do not write in shaded areas. Enter additional comments on reverse side under section "Patient Comments."

Current Medications ☐ Yes ☐ No

If yes, which ones:
_____

_____

Do you take herbal remedies? ☐ Yes ☐ No
Do you take folic acid or prenatal vitamins? ☐ Yes ☐ No

Allergies ☐ Yes ☐ No

If yes, describe: _____

_____

Menstrual History ***Comments:***

Age you started to have periods _____ years

Are your periods regular? ☐ Yes ☐ No

If cycles irregular,
Number cycles/year _____ cycles

On average, how many days
between periods? (Day 1 to Day 1) _____ days

How long do your periods last? _____ days

Menstrual flow: ☐ Normal ☐ Light ☐ Heavy

Pain with your periods? ☐ None ☐ Mild ☐ Mod ☐ Severe

Pain not associated with your periods? ☐ Yes ☐ No

Bleeding between periods ☐ Yes ☐ No

Date of last menstrual period _____/_____/_____

Gynecological History: Have you ever had any of the following (date: mm/yy):

Gonorrhea	☐ Yes ☐ No	Chlamydia	☐ Yes ☐ No
Pelvic infection	☐ Yes ☐ No	Herpes	☐ Yes ☐ No
Painful sex	☐ Yes ☐ No	Excessive hair	☐ Yes ☐ No
Breast discharge	☐ Yes ☐ No	Prior IUD use	☐ Yes ☐ No
Birth control pill	☐ Yes ☐ No	Mom took DES	☐ Yes ☐ No
Vaginal lubricants	☐ Yes ☐ No	Physical abuse	☐ Yes ☐ No
Sexual abuse	☐ Yes ☐ No	Mammogram	☐ Yes ☐ No If yes, when _____
Abnormal Pap	☐ Yes ☐ No	Acne	☐ Yes ☐ No
Date last pap:_____/_____/_____		Other: _____	

Was your abnormal pap treated ☐ Yes ☐ No, how _____

Frequency of intercourse (per week) _____

Obstetric History ***Comments:***

Date *(mo/yr)* ***Outcome*** *(check one)* ***Comments/Complications?***

_____/_____ ☐ Miscar ☐ Nml delivery ☐ Cesar ☐ Tubal ☐ Abortion _____

_____/_____ ☐ Miscar ☐ Nml delivery ☐ Cesar ☐Tubal ☐ Abortion _____

_____/_____ ☐ Miscar ☐ Nml delivery ☐ Cesar ☐Tubal ☐ Abortion _____

_____/_____ ☐ Miscar ☐ Nml delivery ☐ Cesar ☐Tubal ☐ Abortion _____

Prior Infertility Evaluation (if applicable)

			Year	**Result**	
Basal temp records	☐ Yes	☐ No	_____	☐ Normal	☐ Abnormal
Urine ovulation kits	☐ Yes	☐ No	_____	☐ Normal	☐ Abnormal
Endometrial biopsy	☐ Yes	☐ No	_____	☐ Normal	☐ Abnormal
Semen analysis	☐ Yes	☐ No	_____	☐ Normal	☐ Abnormal
Hysterosalpingogram	☐ Yes	☐ No	_____	☐ Normal	☐ Abnormal
Laparoscopy	☐ Yes	☐ No	_____	☐ Normal	☐ Abnormal
Hysteroscopy	☐ Yes	☐ No	_____	☐ Normal	☐ Abnormal
FSH blood test	☐ Yes	☐ No	_____	☐ Normal	☐ Abnormal

Prior Infertility Treatments (If applicable)

			Year	
Clomid or Serophene	☐ No	☐ Yes	_____	# cycles_____# with IUI_____
hCG injectable med.	☐ No	☐ Yes	_____	# cycles_____
FSH injectable meds.	☐ No	☐ Yes	_____	# cycles_____# with IUI_____
Intrauterine insemination	☐ No	☐ Yes	_____	# cycles_____
IVF Treatment	☐ No	☐ Yes	_____	# Fresh stims_____ # Retrievals_____
				# Fresh transfers_____ # Frozen Transfers_____

Where did you receive past Fertility Treatment? _____

Any Past Surgeries? ☐ Yes ☐ No

If yes, state : Type Date Hospital:

Prior Tubal Ligation ☐ Yes ☐ No Reversal of Sterilization ☐ Yes ☐ No

Current Social History (Circle & fill in blanks)

Tobacco Use: Never Past Current Packs/day_____
Quit Date_____

Caffeine ☐ Yes ☐ No cups/day_____

Weight Change ☐ Yes ☐ No lbs. up or down_____

Current Weight_____

Physical Condition: Poor Fair Good Excellent

Regular exercise ☐ Yes ☐ No hours/week_____

Years of education_____ degree? _____

Occupation: _____

Do you feel safe at home ☐ Yes ☐ No

IV Drugs Never Past Current

Marijuana Never Past Current

Cocaine Never Past Current

Alcohol Use: ☐ Yes Drinks per week _____
☐ None

Medical History (Review of Systems)

Have you ever had any of the following?

Abdominal pains	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Excessive thirst	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Fainting	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Fibroids	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Severe headaches	☐ Yes ☐ No
Blood Clots	☐ Yes ☐ No	Urinary infections	☐ Yes ☐ No
Blood in stool	☐ Yes ☐ No	Heart disease	☐ Yes ☐ No
Blood transfusion	☐ Yes ☐ No	Heat/cold intolerance	☐ Yes ☐ No
Problem with vision	☐ Yes ☐ No	Hepatitis, liver prob.	☐ Yes ☐ No
Breast discharge	☐ Yes ☐ No	High blood pressure	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Hot flashes, sweats	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Lack bladder control	☐ Yes ☐ No
Dizziness	☐ Yes ☐ No	Anxiety	☐ Yes ☐ No
Easy bruising	☐ Yes ☐ No	Kidney problems	☐ Yes ☐ No
Endometriosis	☐ Yes ☐ No	Mitral valve prolapse	☐ Yes ☐ No
Neck back pain	☐ Yes ☐ No	Thrombophlebitis	☐ Yes ☐ No
Neurological prob.	☐ Yes ☐ No	Thyroid problem	☐ Yes ☐ No
Nose/gum bleeds	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Palpitations	☐ Yes ☐ No	Shortness of breath	☐ Yes ☐ No
Stomach problems	☐ Yes ☐ No	Swollen joints	☐ Yes ☐ No
German measles	☐ Yes ☐ No	Chicken pox	☐ Yes ☐ No
Exces. Constipation	☐ Yes ☐ No	Other: _____	

Do you feel depressed or have you had any history of depression (this included postpartum) ☐ Yes ☐ No

Family History

Ancestral Background

There are certain ancestral backgrounds that have an increased frequency of some genetic diseases. Please indicate if either your mother or father are of any of the following backgrounds:

☐ African ☐ Caribbean ☐ Jewish ☐ Indian ☐ Native American
☐ French-Canadian ☐ Latin-American ☐ Mediterranean ☐ Asian

Have you had testing for? :
Cystic Fibrosis result_____ Sickle Cell result_____
Tay Sach's disease result_____ Other genetic condition_____

Family History:

Indicate which family member (maternal/paternal side)

Early menopause ☐ Yes ☐ No _____
Ovarian cancer ☐ Yes ☐ No _____
Stillbirth ☐ Yes ☐ No _____
Cystic fibrosis ☐ Yes ☐ No _____
Tay-Sachs ☐ Yes ☐ No _____
Down's Syndrome ☐ Yes ☐ No _____
Birth defects ☐ Yes ☐ No _____
Thyroid disease ☐ Yes ☐ No _____
Diabetes ☐ Yes ☐ No _____
High blood press. ☐ Yes ☐ No _____
Hemophilia ☐ Yes ☐ No _____
Deafness ☐ Yes ☐ No _____
Polycystic kidneys ☐ Yes ☐ No _____
Bleeding disorders ☐ Yes ☐ No _____

Breast cancer ☐ Yes ☐ No _____
Muscular dystrophy ☐ Yes ☐ No _____
Sickle-cell anemia ☐ Yes ☐ No _____
Intellectual Disabilities ☐ Yes ☐ No _____
Spina bifida ☐ Yes ☐ No _____
Tuberous sclerosis ☐ Yes ☐ No _____
Heart attack (<50yrs) ☐ Yes ☐ No _____
Psychiatric disease ☐ Yes ☐ No _____
Blindness ☐ Yes ☐ No _____
Chromosome problem ☐ Yes ☐ No _____
Recurrent miscarriage ☐ Yes ☐ No _____
Other/Genetic Issues: ☐ Yes ☐ No _____
_____
_____