


PATIENT NAME: _____
 BIRTH DATE: _____ AGE _____
 ID NO.: _____
 DATE: _____


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 Infertility

PHYSICIAN HISTORY

<input type="checkbox"/> NEW PATIENT	<input type="checkbox"/> ESTABLISHED PATIENT	<input type="checkbox"/> CONSULTATION	<input type="checkbox"/> REPORT SENT: / /
PRIMARY CARE PHYSICIAN:		WHO SENT PATIENT:	
OTHER PHYSICIAN(S):			
CHIEF COMPLAINT (CC) (REQUIRED FOR ALL VISITS EXCEPT PREVENTIVE):		CURRENT PRESCRIPTION MEDICATIONS: <input type="checkbox"/> NONE	
HISTORY OF PRESENT ILLNESS (HPI):		CURRENT NONPRESCRIPTION, COMPLEMENTARY, AND ALTERNATIVE MEDICATIONS: <input type="checkbox"/> NONE	
CHANGES SINCE LAST VISIT		NOTES	
ILLNESSES	YES <input type="checkbox"/> NO <input type="checkbox"/>		
SURGERY	YES <input type="checkbox"/> NO <input type="checkbox"/>		
NEW MEDICATIONS	YES <input type="checkbox"/> NO <input type="checkbox"/>		
CHANGE IN FAMILY HISTORY	YES <input type="checkbox"/> NO <input type="checkbox"/>		
NEW ALLERGIES	YES <input type="checkbox"/> NO <input type="checkbox"/>		
CHANGE IN GYNECOLOGIC HISTORY	YES <input type="checkbox"/> NO <input type="checkbox"/>		
CHANGE IN OBSTETRIC HISTORY	YES <input type="checkbox"/> NO <input type="checkbox"/>		
ALLERGIES (DESCRIBE REACTION): <input type="checkbox"/> NONE			
LAST CERVICAL CANCER SCREENING: <input type="checkbox"/> CYTOLOGY / / <input type="checkbox"/> HPV TEST / /			
LAST MAMMOGRAM: / /			
LAST COLORECTAL SCREENING: / /			

GYNECOLOGIC HISTORY (PH)

LMP: / /	AGE AT MENARCHE: _____	LENGTH OF FLOW: _____	INTERVAL BETWEEN PERIODS: _____	RECENT CHANGES: _____
SEXUALLY ACTIVE <input type="checkbox"/> YES <input type="checkbox"/> NO	EVER HAD SEX <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF PARTNERS (LIFETIME): _____		
PARTNERS ARE: <input type="checkbox"/> MEN <input type="checkbox"/> WOMEN <input type="checkbox"/> BOTH				
CURRENT METHOD OF CONTRACEPTION:		PAST CONTRACEPTIVE HISTORY:		

OBSTETRIC HISTORY (PH)

	NUMBER		NUMBER	NUMBER		
PREGNANCIES		ABORTIONS		MISCARRIAGES		
PREMATURE BIRTHS (<37 WEEKS)		LIVE BIRTHS		LIVING CHILDREN		
NO.	BIRTH DATE	WEIGHT AT BIRTH	BABY'S SEX	WEEKS PREGNANT	TYPE OF DELIVERY (VAGINAL, CESAREAN, ETC.)	PHYSICIAN'S NOTES
1.						
2.						
3.						
4.						
ANY PREGNANCY COMPLICATIONS?						
<input type="checkbox"/> DIABETES <input type="checkbox"/> HYPERTENSION/HIGH BLOOD PRESSURE <input type="checkbox"/> PREECLAMPSIA/TOXEMIA <input type="checkbox"/> OTHER						
ANY HISTORY OF DEPRESSION BEFORE OR AFTER PREGNANCY? <input type="checkbox"/> NO <input type="checkbox"/> YES, HOW TREATED						

PAST HISTORY (PH)

<input type="checkbox"/> NONCONTRIBUTORY <input type="checkbox"/> NO INTERVAL CHANGE SINCE: / /
SURGERIES:
ILLNESSES (PHYSICAL AND MENTAL):
INJURIES:
VACCINATIONS/TUBERCULOSIS TEST:

PHYSICIAN HISTORY (Continued)

Magdalene Karon, M.D.

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FAMILY HISTORY (FH)

<input type="checkbox"/> NONCONTRIBUTORY <input type="checkbox"/> NO INTERVAL CHANGE SINCE: / /			
MOTHER: <input type="checkbox"/> LIVING <input type="checkbox"/> DECEASED-CAUSE:	AGE:	FATHER: <input type="checkbox"/> LIVING <input type="checkbox"/> DECEASED-CAUSE:	AGE:
SIBLINGS: NUMBER LIVING:	NUMBER DECEASED:	CAUSE(S)/AGE(S):	
CHILDREN: NUMBER LIVING:	NUMBER DECEASED:	CAUSE(S)/AGE(S):	
(IF YES, INDICATE WHOM AND AGE AT DIAGNOSIS)			
<input type="checkbox"/> DIABETES	<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> HYPERLIPIDEMIA	
<input type="checkbox"/> CANCER	<input type="checkbox"/> HYPERTENSION	<input type="checkbox"/> DEEP VEIN THROMBOEMBOLISM/PULMONARY EMBOLISM	
<input type="checkbox"/> OSTEOPOROSIS	<input type="checkbox"/> OTHER ILLNESSES		

SOCIAL HISTORY (SH)

<input type="checkbox"/> NONCONTRIBUTORY <input type="checkbox"/> NO INTERVAL CHANGE SINCE: / /							
	YES	NO	NOTES		YES	NO	NOTES
TOBACCO USE	<input type="checkbox"/>	<input type="checkbox"/>		DIET DISCUSSED	<input type="checkbox"/>	<input type="checkbox"/>	
ALCOHOL USE—SPECIFY AMOUNT AND TYPE (12 OZ BEER = 5 OZ WINE = 1 1/2 OZ LIQUOR)	<input type="checkbox"/>	<input type="checkbox"/>		FOLIC ACID INTAKE	<input type="checkbox"/>	<input type="checkbox"/>	
ILLEGAL/STREET DRUG USE	<input type="checkbox"/>	<input type="checkbox"/>		CALCIUM INTAKE	<input type="checkbox"/>	<input type="checkbox"/>	
MISUSE OF PRESCRIPTION DRUGS	<input type="checkbox"/>	<input type="checkbox"/>		REGULAR EXERCISE	<input type="checkbox"/>	<input type="checkbox"/>	
INTIMATE PARTNER VIOLENCE	<input type="checkbox"/>	<input type="checkbox"/>		CAFFEINE INTAKE	<input type="checkbox"/>	<input type="checkbox"/>	
SEXUAL ABUSE	<input type="checkbox"/>	<input type="checkbox"/>		ADVANCE DIRECTIVE (LIVING WILL)	<input type="checkbox"/>	<input type="checkbox"/>	
HEALTH HAZARDS AT HOME/WORK	<input type="checkbox"/>	<input type="checkbox"/>		ORGAN DONATION	<input type="checkbox"/>	<input type="checkbox"/>	
SEAT BELT USE	<input type="checkbox"/>	<input type="checkbox"/>		OTHER			
				<input type="checkbox"/> NO CHANGES SINCE: / /			

REVIEW OF SYSTEMS (ROS)

1. CONSTITUTIONAL	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> WEIGHT LOSS	<input type="checkbox"/> WEIGHT GAIN	
	<input type="checkbox"/> FEVER	<input type="checkbox"/> FATIGUE	<input type="checkbox"/> OTHER	TALLEST HEIGHT: _____
2. EYES	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> VISION CHANGE	<input type="checkbox"/> GLASSES/CONTACTS	
	<input type="checkbox"/> OTHER			
3. EAR, NOSE, AND THROAT	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> UICERS	<input type="checkbox"/> SINUSITIS	
	<input type="checkbox"/> HEADACHE	<input type="checkbox"/> HEARING LOSS	<input type="checkbox"/> OTHER	
4. CARDIOVASCULAR	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> ORTHOPNEA	<input type="checkbox"/> CHEST PAIN	<input type="checkbox"/> DIFFICULTY BREATHING ON EXERTION
	<input type="checkbox"/> EDEMA	<input type="checkbox"/> PALPITATION	<input type="checkbox"/> OTHER	
5. RESPIRATORY	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> WHEEZING	<input type="checkbox"/> HEMOPTYSIS	
	<input type="checkbox"/> SHORTNESS OF BREATH		<input type="checkbox"/> COUGH	<input type="checkbox"/> OTHER
6. GASTROINTESTINAL	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> DIARRHEA	<input type="checkbox"/> BLOODY STOOL	<input type="checkbox"/> NAUSEA/VOMITING/INDIGESTION
	<input type="checkbox"/> CONSTIPATION	<input type="checkbox"/> FLATULENCE	<input type="checkbox"/> PAIN	<input type="checkbox"/> FECAL INCONTINENCE <input type="checkbox"/> OTHER
7. GENITOURINARY	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> HEMATURIA	<input type="checkbox"/> DYSURIA	<input type="checkbox"/> URGENCY
	<input type="checkbox"/> FREQUENCY	<input type="checkbox"/> INCOMPLETE EMPTYING		<input type="checkbox"/> INCONTINENCE
	<input type="checkbox"/> DYSpareunia	<input type="checkbox"/> ABNORMAL OR PAINFUL PERIODS		<input type="checkbox"/> PMS
	<input type="checkbox"/> ABNORMAL VAGINAL BLEEDING	<input type="checkbox"/> ABNORMAL VAGINAL DISCHARGE		<input type="checkbox"/> OTHER
8. MUSCULOSKELETAL	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> MUSCLE WEAKNESS		
	<input type="checkbox"/> MUSCLE OR JOINT PAIN	<input type="checkbox"/> OTHER		
9a. SKIN	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> RASH	<input type="checkbox"/> UICERS	
	<input type="checkbox"/> DRY SKIN	<input type="checkbox"/> PIGMENTED LESIONS	<input type="checkbox"/> OTHER	
9b. BREAST	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> MASTALGIA		
	<input type="checkbox"/> DISCHARGE	<input type="checkbox"/> MASSES	<input type="checkbox"/> OTHER	
10. NEUROLOGIC	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> SYNCOPE	<input type="checkbox"/> SEIZURES	<input type="checkbox"/> NUMBNESS
	<input type="checkbox"/> TROUBLE WALKING	<input type="checkbox"/> SEVERE MEMORY PROBLEMS	<input type="checkbox"/> OTHER	
11. PSYCHIATRIC	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> DEPRESSION	<input type="checkbox"/> CRYING	
	<input type="checkbox"/> SEVERE ANXIETY	<input type="checkbox"/> OTHER		
12. ENDOCRINE	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> DIABETES	<input type="checkbox"/> HYPOTHYROID	<input type="checkbox"/> HYPERTHYROID
	<input type="checkbox"/> HOT FLASHES	<input type="checkbox"/> HAIR LOSS	<input type="checkbox"/> HEAT/COLD INTOLERANCE	<input type="checkbox"/> OTHER
13. HEMATOLOGIC/LYMPHATIC	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> BRUISES		
	<input type="checkbox"/> BLEEDING	<input type="checkbox"/> ADENOPATHY	<input type="checkbox"/> OTHER	
14. ALLERGIC/IMMUNOLOGIC	[SEE FIRST PAGE]			

ACOG WOMAN'S HEALTH RECORD (FORM A—PHYSICIAN HISTORY) PAGE 2 OF 4