Duke Fertility Center

Date: _____

# Duke Fertility Center
# Reproductive Endocrinology and Gynecology Intake Form

Referring Physician: _____
Patient Name: _____
Date of Birth: _____
Race: _____ Hispanic or Latino: ☐
Occupation: _____
Marital Status: _____

Pronouns
☐ She/her/hers ☐ He/him/his ☐ They/them/their
Other: _____

What is the reason for your visit today? _____

_____

_____

**MEDICAL HISTORY:** Do you have or have you EVER had (please check all that apply):

- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Arthritis
- ☐ Cancer
- ☐ Chronic Bronchitis
- ☐ Chronic Back Pain
- ☐ Colitis
- ☐ Depression
- ☐ Diabetes
- ☐ Gallbladder Problems
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Migraines
- ☐ Neurological Problems
- ☐ Pneumonia
- ☐ Seizures
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Other: _____

Current Medications, Vitamins and/or Supplements: _____

_____

_____

Are you allergic to any medications? ☐ Yes ☐ No
If so, what: _____

_____

Have you ever had surgery before? ☐ Yes ☐ No
Date and type of surgery: _____

_____

## GYNECOLOGICAL HISTORY

How old were you when you started having periods? _____

Date of your last period? _____

Are your periods regular? ☐ Yes ☐ No

If YES, how many days between periods (start until start)? _____

If NO, how many periods per year do you have? _____

Do you have cramps with your periods? ☐ Yes ☐ No If YES, circle one: ☐ Mild ☐ Moderate ☐ Severe

Have you ever missed work or school due to menstrual cramps? ☐ Yes ☐ No

Do you have pain with intercourse? ☐ Yes ☐ No

Were you ever diagnosed with endometriosis? ☐ Yes ☐ No

Were you ever diagnosed with ibroids? ☐ Yes ☐ No

What type of contraception have you used in the past?

☐ Oral contraceptives ☐ Tubal ligation ☐ IUD ☐ Implanon

☐ Depo Provera (BC shots) ☐ Withdrawal ☐ Nuvaring ☐ Condoms ☐ Rhythm

Are you currently using contraception? ☐ Yes ☐ No

When was your last PAP smear? Date: _____

Have you ever had an abnormal PAP smear? ☐ Yes ☐ No

If YES, when? _____

If YES, what was done about it? _____

Have you ever had any of the following? Please check all that apply.

☐ BV ☐ Gonorrhea ☐ Chlamydia ☐ Veneral Warts

☐ Genital Herpes ☐ Syphilis ☐ Pelvic Inflammatory Disease ☐ Trichomoniasis

Have you ever had a Mammogram? ☐ Yes ☐ No

If YES, when? _____

If YES, check one: ☐ Normal Mammogram ☐ Abnormal Mammogram

## PREGNANCY HISTORY

How many pregnancies (including abortions) have you had? _____

| Pregnancies | When? (year) | How long to conceive? (months) | Fertility therapy used? Y/N | Duration of pregnancy (months) | Outcome* | Complica-tions |
|---|---|---|---|---|---|---|
| 1st pregnancy | | | | | | |
| 2nd pregnancy | | | | | | |
| 3rd pregnancy | | | | | | |
| 4th pregnancy | | | | | | |
| 5th pregnancy | | | | | | |

*Outcomes: Vaginal delivery = VD; Cesarean section = CS; Abortion = AB; Miscarriage = MS; Ectopic= EP

**SOCIAL HISTORY**

Current or recent employer/position: _____

Do you drink alcohol? ☐ Yes ☐ No

Number of drinks per week: _____

Do you smoke? ☐ Yes ☐ No

Number of cigarettes per day: _____

Do you now, or have you ever, used illicit drugs? ☐ Yes ☐ No

Do you have a special exercise program? ☐ Yes ☐ No

If yes, please explain: _____

Are you on a special diet? ☐ Yes ☐ No

Type: _____

**REVIEW OF SYSTEMS**

Have you had more than a 10-pound weight gain or loss in the past 12 months? ☐ Yes ☐ No

Do you have problems with your vision (besides usual glasses), hearing, swallowing, sinuses or throat?

☐ Yes ☐ No

If yes, specify: _____

Do you have heart problems, chest pain, irregular heartbeat or mitral valve prolapse? ☐ Yes ☐ No

If yes, specify: _____

Do you have asthma, wheezing, shortness of breath or trouble breathing? ☐ Yes ☐ No

If yes, specify: _____

Do you have breast pain, breast discharge or a lump in your breast? ☐ Yes ☐ No

If yes, specify: _____

Do you have chronic nausea or vomiting, stomach pain, diarrhea or constipation, blood in your stool or a history of ulcers? ☐ Yes ☐ No

If yes, specify: _____

Do you have urinary burning, incontinence, kidney stones or blood in your urine? ☐ Yes ☐ No

If yes, specify: _____

Do you have chronic joint pain or muscle pain or swelling? ☐ Yes ☐ No

If yes, specify: _____

Do you have any chronic skin rashes or moles that have changed in size or appearance? ☐ Yes ☐ No

If yes, specify: _____

Do you have changes in cold or hot tolerance, changes in skin tone or color or changes in your nails or body hair growth? ☐ Yes ☐ No

If yes, specify: _____

Do you have any history of seizures, recurrent headaches or numbness in your extremities? ☐ Yes ☐ No

If yes, specify: _____

Do you have any symptoms of depression, such as sadness, frequent crying or anger or emotional lability?

☐ Yes ☐ No

If yes, specify: _____

## FAMILY HISTORY

Did your mother take diethylstilbestrol (DES; a tablet given to women with a history of miscarriage or bleeding during pregnancy) when she was pregnant with you? ☐ Yes ☐ No

Do any family members have any of these health problems? Check all that apply.

☐ Breast Cancer
If so, who? _____

☐ Ovarian Cancer
If so, who? _____

☐ Colon Cancer
If so, who? _____

☐ Early Menopause
If so, who? _____

## ADDITIONAL HEALTH INFORMATION

_____

_____

_____

_____