Health Care

Reproductive Health and Fertility Center
500 North Keene Street, Suite 203
Columbia, MO 65201
Phone 573-817-3101
Fax 573-499-6065

Gynecological Information Form

Name ____ Date of Birth _______________ Sex __________ Gender __________
(include maiden name if applicable)

Address ____ Phone (H) ___________________(W) __________________
(Street, City, State, Zip Code)

Birthplace ____ Occupation ____________________________________

Referring Physician: ____ Primary Care Physician: ___________________________

Partner's Name _______________________________________ Partner's Date of Birth ______________________________________

Address (if different): ______________________________________

PREGNANCY HISTORY

	When? (Year)	Natural cycle pregnancy, or after infertility treatment?	Baby born alive?	Miscarriage?	Ectopic pregnancy?	How long to Conceive?	Is Current Partner the Father? (yes/no)
1st Pregnancy							
2nd Pregnancy							
3rd Pregnancy							
4th Pregnancy							
5th Pregnancy							

FERTILITY HISTORY

Have you had prior fertility care (mark all that apply):

□ Clomid □ Letrozole □ Injectable medications □ Intrauterine inseminations (IUI) □ In Vitro Fertilization (IVF) □ Frozen embryos
□ Other: __________________

Tell us what led you to see us? What questions can we answer for you during your visit?

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MENSTRUAL HISTORY

When was your last menstrual period? ______________ yes no

Are your periods regular? ……………………………………………………………………………………….. □ □

If yes, what is the usual number of days between periods? ______________________________

If no, how many times per year do you menstruate? ____________________________________

What is the usual duration of your period? ______________

Are cramps present before, during or after your period? ______________________________ Are cramps □ Mild □ Moderate □ Severe

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CONTRACEPTIVE/SEXUAL HISTORY

What form(s) of contraception do you use now, or have you used in the past? Check all that apply:

□ Pills Name: ____________ □ IUD Name: ____________ □ Diaphragm □ Withdrawal
□ Foams/Jellies □ Condoms □ Rhythm Method □ None □ Other: __________________

	yes	no
If you've ever been on oral contraceptives (pills), were your periods regular after stopping them?	□	□

How many times per week do you and your partner have sexual intercourse? ______________________________________

Is intercourse painful or difficult for you?	□	□
Have you ever had surgery before?	□	□

If yes, specify: ____

Have you ever been treated for cancer or have a family history of cancer?	□	□

If yes, specify type of cancer and whom (self, mother, sister, etc.): ____

Are you taking any medications (prescription or over-the-counter?	□	□

If yes, please list: ____

Do you use or have you ever used:

Alcohol – How many glasses per week do you usually drink? ________________________

Cigarettes – Number of packs per day: _____

Illicit or Recreational Drugs (Marijuana, Cocaine, etc.) Specify: ____

	yes	no
Have you recently traveled outside of the country?	□	□
Do you have any travel planned outside of the country?	□	□

MEDICAL HISTORY

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

□ Scarlet Fever
□ Rheumatic Fever
□ Tuberculosis
□ Hepatitis
□ Syphilis
□ Gonorrhea
□ Pelvic Infection
□ Chlamydia
□ Herpes
□ Mumps
□ Arthritis
□ Thyroid Problems
□ Measles: Regular
□ Measles: German
□ Pneumonia
□ Nongonococcal Urethritis
□ Parasitic Infection

□ Heart Disease
□ High Blood Pressure
□ Hirsutism
□ Gallbladder Problems
□ Liver Problems
□ Ulcers
□ Appendicitis
□ Colitis
□ Diabetes
□ Anemia
□ Chronic Headaches
□ Blood Transfusions
□ Immunizations: German Measles
□ Endometriosis
□ Kidney Infection
□ Varicose
□ Ovarian Cysts

□ Breast Tenderness
□ Breast Soreness
□ Breast Discharge
□ Neurological Problems
□ Seizures
□ Epilepsy
□ Visual Disturbances
□ Poor Sense of Smell
□ Dizziness
□ Loss of Balance
□ Chronic Bronchitis
□ Phlebitis
□ Vaginitis (Trichomoniasis, yeast) , # of episodes ____________
□ Muscular Dystrophy
□ Cystic Fibrosis
□ Other

MU Health Care

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Male Partner Information Form

Name ____ Date of Birth _______________ Sex __________ Gender __________

Occupation ____ Phone (H) ____________________(W) ______________________

Relationship (circle): Husband Fiance Live-in Partner Other: ____
(please explain)

Partner's Name ____ Date of Birth ___________________________

	yes	no
Do you have children?	□	□

List number of children and age of each child? ____

MEDICAL HISTORY

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

- □ Scarlet Fever
- □ Rheumatic Fever
- □ Hirsutism
- □ Hepatitis
- □ Syphilis
- □ Gonorrhea
- □ Pelvic Infection
- □ Chlamydia
- □ Herpes
- □ Mumps
- □ Arthritis
- □ Thyroid Problems
- □ Measles: Regular
- □ Measles: German
- □ Heart Disease
- □ High Blood Pressure
- □ Cystic Fibrosis
- □ Gallbladder Problems
- □ Liver Problems
- □ Ulcers
- □ Appendicitis
- □ Colitis
- □ Diabetes
- □ Anemia
- □ Chronic Headaches
- □ Blood Transfusions
- □ Immunizations: German Measles
- □ Pneumonia
- □ Parasitic Infection
- □ Tuberculosis
- □ Kidney Infection
- □ Neurological Problems
- □ Seizures
- □ Epilepsy
- □ Visual Disturbances
- □ Poor Sense of Smell
- □ Dizziness
- □ Loss of Balance
- □ Chronic Bronchitis
- □ Phlebitis
- □ Nongonococcal Urethritis
- □ Muscular Dystrophy

	yes	no
Have you ever had surgery before?	□	□
If yes, specify: ____		
Have you ever been treated for cancer or have a family history of cancer?	□	□
If yes, specify type of cancer and whom (self, mother, sister, etc.): ____		
Are you taking any medications (prescription or over-the-counter?	□	□
If yes, please list:		

Do you use or have you ever used:

Alcohol – How many glasses per week do you usually drink? ______________________

Cigarettes – Number of cigarettes per day: _____

Illicit or Recreational Drugs (Marijuana, Cocaine, etc.) Specify: ____

	yes	no
Have you recently traveled outside of the country?	□	□
Do you have any travel planned outside of the country?	□	□

Email Address: ____

We will sign you up for our secure health portal which will allow you to receive any results, view your clinic notes and communicate with your physician.