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NAPROTECHNOLOGY CONSULTATION
PATIENT HISTORY FORM

Name: ____ Date of Birth: ______________

How were you referred to Dr Smith? ____

____

Who is your Primary Care Physician? ____
Who is your Gynecologist (if applicable)? ____
Please list any other physicians/specialists you see regularly: _____________________________

____

Please describe your main reason(s) for your consultation: ______________________________

____

____

Medical History
Please circle if you have ever been diagnosed with any of the following conditions:

Anemia	Asthma	Anxiety	Blood clots
Cancer	Depression	Diabetes	Endometriosis
Epilepsy	Factor V Leiden	Fibromyalgia	Herpes
Hypertension	Kidney Stones	Liver Disease	Lupus
Migraines	MTHFR	PCOS	Stroke
Thyroid Disorder	IBS	Autoimmune	Allergies

Family History

Please comment on any that apply to your family.

Condition	Family Member	Age at Diagnosis
Breast Cancer		
Blood Clots (DVT, PE)		
Factor V Leiden		
Endometriosis		
PCOS		
Infertility		
Ovarian Cancer		
Uterine (Endometrial) Cancer		

Gynecologic History

Age at First Menses: _____________ Cycles during Teen Years (circle): Regular Irregular Unsure

Hormone Treatments or Contraceptives Used to Treat Problems? Please describe: ___________________

____

Please circle any of the following that apply to your menstrual cycles:

Regular (every 24-36 days)	Irregular	No periods	Heavy	Clotting
Spotting/bleeding between periods	Spotting before periods	Spotting after periods	Brown spotting or bleeding	Pain with Periods
Rectal bleeding during periods	Painful bowel movements during periods	Excessive vaginal discharge	Pain with ovulation	Pain with Intercourse

Maximum Number of Tampons per Day: __________ Maximum Number of Pads per Day: __________

Do you have to take medication for painful periods (ibuprofen, acetaminophen, etc.): Yes No

Have you ever been sexually active? Yes No How Many Sexual Partners Have You had?: ________

Have you ever been a victim of sexual abuse? Yes No

Have you ever been diagnosed with or treated for any of the following?:

	YES	NO	When?		YES	NO	When?
Gonorrhea				Herpes			
Chlamydia				HPV			
Hepatitis				Abnormal Pap Smear			
HIV				Genital Warts			
Syphilis				Other:			

Do you experience any of the following symptoms with your menstrual cycles?:

	YES	NO	How many days before your period starts?
Breast Tenderness			
Bloating			
Weight Gain			
Cramps			
Food Cravings			
Anxiety / Tension / Irritability			
Anger			
Tearfulness / Depression			
Pelvic Pain			
Fatigue			
Trouble Sleeping			
Headaches / Migraines			

Family Planning History

Please indicate which method(s) you use or have used in the past and your experience with them:

Type of Contraception	Dates of Use	Reasons for Use (contraception or health treatment?)	Reason Stopped
Natural Family Planning:			
Birth Control Pill			
Depo Provera Injection			
NuvaRing			
Patch			
IUD (Mirena, Skyla, Paragard, etc)			
Arm Implant (Nexplanon)			
Condoms			

Please circle any of the following that apply to your situation:

Hysterectomy Partner/Husband Vasectomy Tubal Ligation ("tubes tied")

Essure Uterine Ablation Adiana

What is your current pregnancy intention? (circle): Achieve Avoid Not applicable

Pregnancy History

Total Pregnancies: ______ / Full Term: ______ / Preterm: ______ / Miscarriage: ______ / Abortion: ______ / Ectopic: ______ / Living: ______
Multiple Gestation Pregnancies: ______

Date	# Weeks	Birth Weight	Gender	Type of Delivery	Comments/Complications

Surgical History

Please indicate whether you have had any of the following procedures:

Procedure	Year	Procedure	Year	Procedure	Year
Diagnostic Laparoscopy		Diagnostic Hysteroscopy		Hysterosalpingogram	
Endometriosis Surgery		Ovarian Cyst Surgery		Removal of Tubes/ Ovaries	
Removal of Fibroids		D&C		Breast Surgery	

Review of Systems

Please circle any of the following that you have experienced recently / currently:

General: weight gain   weight loss   fatigue   fever   chills   NONE
Eyes: blurred vision   irritation   pain   redness   NONE
Head/Neck: hearing loss   bloody noses   snoring   voice changes   NONE
Cardiovascular: chest pain   palpitations   fainting   swelling   NONE
Respiratory: cough   wheezing   shortness of breath   NONE
Breasts: discharge (clear, bloody, milky)   pain   lumps   NONE
Gastrointestinal: nausea   vomiting   constipation   diarrhea   bloody stool   NONE
Genitourinary: frequent   painful   blood in urine   urine leakage   NONE
Musculoskeletal: back pain   muscle pain   joint pain   weakness   NONE
Skin: rash   acne   dermographism*[1]   excess hair growth   NONE
Neurological: headache   dizziness   seizures   numbness/tingling   NONE
Psychological: eating disorder   anxiety   depression   sleep problems   NONE
Endocrine: hair loss   brittle nails   intolerance to heat/cold   NONE
Hematologic: easy bruising   easy bleeding   enlarged lymph nodes   NONE

[1] *Dermographism = exaggerated hive or wheal on the skin within minutes after pressure or scratching*

Infertility History

Please complete this section if you are being evaluated for infertility.

1. How many months have you been trying to achieve pregnancy? _________________
2. Do you use lubricants during intercourse? _________________
3. Have you ever been evaluated for infertility? Yes No (skip to #5)

   Check all that apply and provide details if possible:

   a. ____ Basal body temperature ____
   b. ____ Ovulation test kits ____
   c. ____ Pelvic Ultrasound ____
   d. ____ Blood tests ____
   e. ____ Hysterosalpingogram ____
   f. ____ Diagnostic Laparoscopy ____
   g. ____ Semen Analysis ____
4. Have you ever received treatments for infertility? Yes No (skip to #5)

   Check all that apply and provide details if possible:

   a. ____ Clomid ____
   b. ____ Letrozole (Femara) ____
   c. ____ Progesterone ____
   d. ____ HCG ____
   e. ____ Intrauterine Insemination ____
   f. ____ In Vitro Fertilization (IVF) ____
   g. ____ Other: ____
5. Has your husband ever fathered other children? Yes No
6. Has your husband been evaluated by a Urologist? Yes No
7. Does your husband have difficulty with erections or intercourse? Yes No
8. Does your husband have any prior diagnosis of sexually transmitted infection? Yes No
   a. Circle if applicable: Gonorrhea, Chlamydia, Herpes, Syphilis, HIV, Hepatitis
9. Does your husband have a history of undescended testicles? Yes No
10. Does your husband have any testicular or scrotal problems/concerns? Yes No
11. Has your husband been diagnosed with any of the following conditions: Yes No
    a. Diabetes, Prostate infections, Multiple sclerosis, Cancer, Urinary infections, Hypertension
12. Is your husband exposed to harmful chemicals or radiation at his job? Yes No
13. Is your husband exposed to prolonged heat or prolonged vehicle rides? Yes No
14. Does your husband use hot tubs regularly? Yes No
15. Has your husband ever had any penis, testicle, abdomen, or hernia surgeries? Yes No
    a. If yes, please specify: ____
16. Does your husband smoke cigarettes or marijuana? Yes No
17. Does your husband take medications on a regular basis? Yes No