Garrison Women's Health Center
"Supporting Women with Excellence and Compassion"
Obstetrics ~ Gynecology ~ Infertility ~ Midwifery
770 Central Avenue, Dover, NH 03820
Telephone (603) 742-0101

Female Infertility Intake Worksheet

Consult Date ___/___/_____

Patients - Please complete both sides of this form in addition to the enclosed OB/GYN Questionnaire & Genetics Questionnaire.

Name:_____ _____ Age:____ DOB:___/___/_____
Last *First*

Occupation:_____

Partner's Name:_____ _____ Age:____ DOB:___/___/_____
Last *First*

Marital Status: ☐ Single ☐ Separated ☐ Divorced ☐ Married ___ years

Please answer the following questions. Enter additional informaiton on reverse side in "Patient Comments" section.

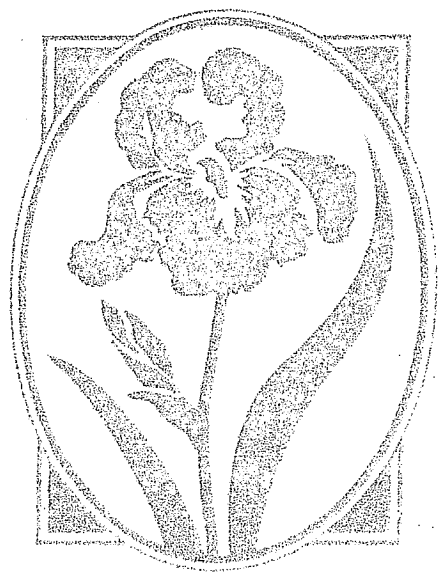
Gynecological/Medical History

Gonorrhea	☐ Yes	☐ No	Prior IUD use	☐ Yes	☐ No
Pelvic Infection	☐ Yes	☐ No	Mom took DES	☐ Yes	☐ No
Painful Sex	☐ Yes	☐ No	Douche	☐ Yes	☐ No
Breast Discharge	☐ Yes	☐ No	Physical Abuse	☐ Yes	☐ No
Birth Control Pills	☐ Yes	☐ No	Mammogram	☐ Yes	☐ No
Vaginal Lubricants	☐ Yes	☐ No	Acne	☐ Yes	☐ No
Sexual Abuse	☐ Yes	☐ No	Blood Clots	☐ Yes	☐ No
Abnormal Pap	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Date last Pap: ___/___/_____			Endometriosis	☐ Yes	☐ No
Weight Change	☐ Yes	☐ No	Excessive Thirst	☐ Yes	☐ No
Chlamydia	☐ Yes	☐ No	Fibroids	☐ Yes	☐ No
Herpes	☐ Yes	☐ No	High blood pressure	☐ Yes	☐ No
Excessive Hair	☐ Yes	☐ No	Thyroid problems	☐ Yes	☐ No

For office use

Prior Infertility Evaluation *(if applicable)*

		Date	*Result*	
Basal temp records	☐ No	_____	☐ Normal	☐ Abnormal
Urine ovulation kits	☐ No	_____	☐ Normal	☐ Abnormal
Endometrial biopsy	☐ No	_____	☐ Normal	☐ Abnormal
Semen analysis	☐ No	_____	☐ Normal	☐ Abnormal
Hysterosalpinogram	☐ No	_____	☐ Normal	☐ Abnormal
Post coital test	☐ No	_____	☐ Normal	☐ Abnormal
Laparoscopy	☐ No	_____	☐ Normal	☐ Abnormal
Hysteroscopy	☐ No	_____	☐ Normal	☐ Abnormal
FSH blood test	☐ No	_____	☐ Normal	☐ Abnormal



Prior Infertility Treatments *(if applicable)*

			Date	
Clomid or Serophene	☐ No	☐ Yes:	_____	#of cycles ____
FSH injectable meds	☐ No	☐ Yes:	_____	#of cycles ____
hCG injectable meds	☐ No	☐ Yes:	_____	#of cycles ____
Intrauterine insemin.	☐ No	☐ Yes:	_____	#of cycles ____
IVF or GIFT	☐ No	☐ Yes:	_____	#of cycles ____

Patient Comments:_____

_____

_____

_____

_____

_____

_____

_____

For Office Use:

Ht: Wt: BP: G: P: AB: LMP:

Medications:_____

Multivits: ☐ Yes ☐ No

Herbs/Supplements:_____

Myco/Ureaplasm culture: ☐ GC/CT: ☐

Comments:_____

Evaluation: ☐ CD #3 labs
☐ Baseline U/S ☐ SIS
☐ PCOS labs
☐ RPL labs
☐ HSG - 2nd cycle ovulatory
☐ Semen analysis
☐ POD #7 P4 ☐ EB

_____

_____

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Records release:_____