

Fertility & Midwifery Care Center



G# _____

Patient Health History

Patient Name: _____ Age: _____ DOB: _____

Family Doctor: _____ Referred By: _____

Reason for visit: _____ Date: _____

Past Medical History

CONDITION	CURRENT	HISTORY	NO	CONDITION	CURRENT	HISTORY	NO
Arthritis				Fibromyalgia			
Cancer				Heart Disease/Surgery			
Chronic Fatigue Syndrome				High Blood Pressure			
Cold Feet				Melanoma			
Cold Hands				Numbness in Feet			
Contact Dermatitis				Numbness in Hands			
Depression				Pain/Tightness in Chest			
Diabetes				Psoriasis			
Dizziness				Shortness of Breath			
Eczema				Tailbone Pain			
Enlarged Prostate				Thyroid Problems			
Other:							

Medical History Extended

Do you urinate more than once every 2 hours?	Yes	No	Are you sexually active at this time?	Yes	No
Do you have a sense of "urgency" to urinate?	Yes	No	Are you sexually inaction due to pain?	Yes	No
Do you have symptoms of leaking urine?	Yes	No	Are you sexually inactive for other reasons?	Yes	No
Do you have interstitial cystitis?	Yes	No	Do you have Irritable Bowel Syndrome?	Yes	No
Do you have pain in your bladder?	Yes	No	Do you leak gas or feces?	Yes	No
Do you have pain with urination?	Yes	No	Do you have constipation?	Yes	No
Do you have pain with erection?	Yes	No	Do you have pain with bowel movements?	Yes	No
Do you have pain with ejaculation?	Yes	No	1 fall with injury in the last 6 months	Yes	No
CONSISTENCY OF STOOL			2 or more falls in the last 12 months	Yes	No
___ Hard ___ Soft ___ Liquid ___ Pencil Thin			# trips/slips/near falls _____		

Operations / Surgeries

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE
1)		4)	
2)		5)	
3)		6)	

SEE BACK

Medications

(Include all prescriptions, over the counter, herbal & vitamins)

MEDICATION	DOSAGE	PRESCRIBING PHYSICIAN
1)		
2)		
3)		
4)		
5)		

Allergies

MEDICATION / FOOD	REACTION

Family Medical History

ILLNESS	YES	RELATIONSHIP	ILLNESS	YES	RELATIONSHIP
Adopted			Diabetes		
Cancer, Colon			High Blood Pressure		
Cancer, Other			Polyp - anal/rectal/colon		
Cardiovascular Disease			Thyroid Disorder		

Social History

Marital Status (circle):	Single	Married	Widowed	Divorced	Spouse/Partner Name: _____
Occupation:	_____				
Alcohol:	_____ Never	_____ Current	_____ Former	_____ Amount per week	
Drugs:	_____ Never	_____ Current	_____ Former	_____ Type	
Smoking:	_____ Never	_____ Current	_____ Former	_____ Amount per day	
Amount of Exercise?	Active	Heavy	Medium	Minimal	None (Sedentary)

Circle the words that apply to how you have been feeling lately and/or choose your own words

- | | | | | | |
|-------------------------|---------|------------|-------------|-------------|--------------------|
| Abuse | Afraid | Anxious | Overwhelmed | Overworked | “Postpartum blues” |
| Calm | Content | Depressed | Sad | Stressed | Strong |
| Energetic | Flabby | Happy | Tired | Unmotivated | Unrest |
| Lethargic | Lonely | Neglected | Unsafe | Weak | Other _____ |
| Not bonding with babies | | Optimistic | Other _____ | | |

Nutrition

Current Weight: _____ lbs

I would like to lose/gain weight? (Circle one)	I have gained/lost more than 10 lbs in the past year. (Circle one)
Are you currently on a specific diet? (Circle below if yes) Low Carb/Keto South Beach Paleo Atkins Weight Watchers Other _____	Would you say your diet is “unhealthy?” (Circle below if yes) High Amounts of Fast Food Low Vegetable Intake High Fat High Carb Other _____

Fluid Intake

What do you drink every day? (Please Circle)

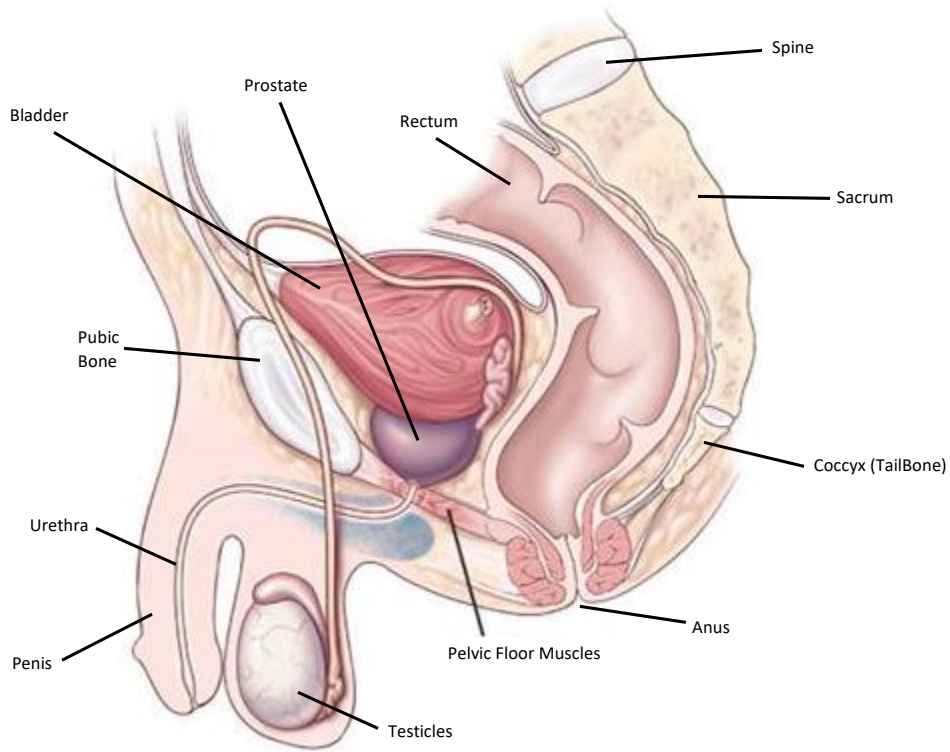
Water Diet Soda Regular Soda Tea Beer Wine

Regular Coffee Decaffeinated Coffee Liquor Milk Juice

Other _____

Tell Us About Your Perineal and Pelvic Pain

Please mark with an "X" where your pain begins and then shade in any other areas of pain.



What started this problem? _____

Circle the words that describe your pain:

Hot Burning Scalding Miserable Intense Unbearable

Searing Sharp Cutting Discomforting Tearing Annoying

Troublesome Other _____

Please circle anything that makes your pain better:

Heating pad Resting in bed Resting in a chair Medication Cream

Abstaining from sexual intercourse Ice Pack Not wearing tight clothes

What treatments (if any) have you had for this problem?

TREATMENT	DID THE TREATMENT HELP?
1)	
2)	

Indicate the level of difficulty you have with the items listed below:

(Write a number in the Score column **ONLY** that describes your level of ability from 0 – 4.

0 = Not difficult at all 1 = Hardly difficult 2 = Slightly Difficult 3 = Medium Difficulty 4 = Extreme Difficulty or **N/A**

	Score	Date		Date	Date	Date
<i>Example: Pain with urination</i>	3	Goal	Wks	Progress		
FUNCTIONAL/PERINEAL PROBLEMS						
Physician able to insert finger into the rectum for examination						
Achieve erection (with no pain)						
Achieve ejaculation (with no pain)						
Hypersensitivity to touch in perineal area						
Itching in perineal area						
Burning/pain in rectal area						
Burning/pain in the area of the penis or testicles						
Friction with clothing						
Pain with bowel movement						
Pain with urination						
Pain with full bladder						
MEASURES FOR SITTING						
Sitting 0 – 15 minutes						
Sitting 16 – 60 minutes						
Sitting 1 – 2 hours						
Sitting 2 – 4 hours						
EFFECT OF PROBLEM ON DAILY LIFE						
Affects choice of clothing						
Walking short distances						
Walking long distances						
Exercise in gym						
Ride a bike						
Ability to travel to work						
Ability to travel for longer than 2+ hours						
Interferes with social activity (movies, socializing)						
Interferes with my sex life						
Negatively impacts relationship with my partner						
Negatively impacts interaction with my family & friends						
Feelings of depression, anxiety, embarrassment, frustration or anger <i>(circle any that apply)</i>						
Pain impairs my ability to concentrate/function						
Pain impairs my ability to work “normal” work hours						
TOTAL						