Fertility & Midwifery Care Center

G#_____

Patient Health History

Patient Name: _____ **Age:** _____ **DOB:** _____

Family Doctor: _____ **Referred By:** _____

Reason for visit: _____ **Date:** _____

Are you currently pregnant? Circle: YES NO If yes, what week of gestation: _____

Past Medical History

CONDITION	CURRENT	HISTORY	NO	CONDITION	CURRENT	HISTORY	NO
Arthritis				High Blood Pressure			
Cancer				Irritable Bowel Disorder			
Chronic Fatigue Syndrome				Anxiety			
Cold Feet				Leaky Gut			
Cold Hands				Melanoma			
Colon Dysbiosis				Numbness in Feet			
Contact Dermatitis				Numbness in Hands			
Crohn's Disease				Pain/Tightness in Chest			
Depression				Psoriasis			
Diabetes				SIBO			
Dizziness				Shortness of Breath			
Eczema				Tailbone Pain			
Fibromyalgia				Thyroid Problems			
Heart Disease/Surgery				Ulcerative Colitis			
Date of Last Pap Smear: / / Normal Abnormal				Date of Last Mammogram: / / Normal Abnormal			
Date of Last Dexa Scan: / / Normal Abnormal				Date of Last Colonoscopy: / / Normal Abnormal			
Other:							

Operations / Surgeries

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

Medications

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

MEDICATION	DOSAGE	REASON FOR TAKING THIS MEDICATION

SEE BACK

Pregnancy History

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

DATE	BIRTH WEIGHT	TYPE OF DELIVERY	COMMENTS/COMPLICATIONS

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)

Additional Obstetrics/Gynecological History

	YES	NO	EXPLAIN:
Currently Breastfeeding?			
Episiotomy or Perineal Tear?			
Difficult Childbirth?			
Do you have Diastasis Recti?			
Difficulty Conceiving?			
Vaginal Dryness?			
Currently on birth control?			Brand: # of days/months on birth control:
History of physical or sexual abuse?			
History of STD's?			If past, please list cure date:
History of/current (circle one) yeast infection?			If history, how many?
History of/current (circle one) UTI?			If history, how many?
Do you use latex condoms?			
Do you use vaginal lubricants?			Brand(s):
Do you use bath salts, vaginal sprays, douches?			
Do you use any vaginal creams or medicine?			

Pelvic and Abdominal Pain

Description (circle all that apply):

None Stabbing Aching Tender Sore Burning Sharp Shooting

What *increases* your pain?

_____

What *decreases* your pain?

_____

HOW IS YOUR PAIN AFFECTED?

	UNAFFECTED	INCREASE	DECREASE		UNAFFECTED	INCREASE	DECREASE
Time of Day:				During a Bowel Movement			
Morning				After a Bowel Movement			
Afternoon				Vaginal Penetration:			
Evening				Initial Penetration			
Nighttime				Deep Penetration			
Full Bladder				Orgasm			
Urination				Following Penetration			
Bowel Urge				Contact with Clothing			

	CURRENT	HISTORY	NO	EXPLAIN:
Abdominal pain or bloating?				
Digestive issues?				
Pain from eating?				
Pain from drinking?				

Marinoff Scale – Descriptive Scale of Intercourse:

(Please circle most accurate statement)

0: No problems
1: Discomfort that does not affect completion
2: Pain interrupts or prevents completion
3: Pain prevents any attempts at intercourse

Rate your pain (0 = none, 10 = worst pain imaginable):

Current: _____/10
At Best: _____/10
At Worst: _____/10

Pain Area- Circle all that apply:

Low Back Pain
Pelvic Pain
Hip Pain (Right/Left)
Abdominal Pain
Midback Pain
Other: _____

BLADDER

(If not applicable, please disregard this section)

If there was an event associated with onset of urinary complaints, please describe:

_____

Urine Stream (circle all that apply):

Easy to Start Difficult to Start Strong Weak Starts & Stops Deflects to one side

Emptying (circle all that apply):

Complete Incomplete Pushing or Straining Retention Other: _____

Frequency of Urination

During awake hours? ____# times per day During Sleep Hours? _____# times per night

How often are you urinating? (Circle one):

Once or more every 15-30 min once or more every 30-90 min Once every 2-4 hours Once every 6-8 hours

What do you drink every day? (Circle all that apply):

Water Diet Soda Regular Soda Tea Beer Wine

Regular Coffee Decaffeinated Coffee Liquor Milk Juice

Other _____

	YES	NO	SOMETIMES		YES	NO	SOMETIMES
Is there a urinary sensation present?				Do you have pain with wiping?			
Once you get the urge to urinate, can you hold it?				Do you go to the bathroom "just in case?"			
Any dribbling after urination?				Do you hover over public toilets when you urinate?			
Can you stop your urine once started?				Did you experience urinary issues as a child?			
Do you Kegel when you urinate?				Do you have a feeling of falling out or heaviness in your pelvis?			
Do you have pain or burning with urination?				For the above question, please circle any applicable descriptions: With Menses / Standing / Straining / All the time / At End of day			

Urinary Leakage

(If not applicable, please disregard this section)

Causes of leakage (circle all that apply):

None Cough Sneeze On the way to the bathroom Sound of running water

Laugh Lift Sit to Stand Jumping Running Key in door

Walking Other _____

Frequency of Urinary leakage:

_____#episodes per Day / Week / Month (please circle one)

Urine leaking amount (circle all that apply):

None Few Drops Wets Pad Wets Underwear Wets Outerwear Other _____

	YES	NO	SOMETIMES		YES	NO	SOMETIMES
Do you wear a pad or protective device?				Have you ever taken medicine to prevent urine loss?			

Bowel Habits

(If not applicable, please disregard this section)

If there was an event associated with onset of bowel complaints, please describe:

_____

Frequency of Bowel Movements

_____# times per day _____# times per week

Evacuation Habits (Circle all that apply):

None Straining Splinting (pressure against perineum) Other _____

Is your Stool (Circle all that apply):

Normal Firm Hard Soft Liquid Pencil Thin

Other_____

	YES	NO	SOMETIMES		YES	NO	SOMETIMES
Is there a bowel sensation present?				Is there ever blood on the tissue after a bowel movement?			
Can you hold back your feces if no bathroom is present?				Do you use laxatives?			

Fecal Leakage

(If not applicable, please disregard this section)

Frequency of Fecal Leakage:

_____#episodes per Day / Week / Month (please circle one)

Fecal Leakage Amount (Please circle):

None Smear Diarrhea A few "pebbles" Full stool

Do you use any form of protection?

If yes, what type of pad? _____ # of changes required in 24 hours? _____

Quality of Life & Functional Limitations

	UNAFFECTED	AFFECTED	EXPLAIN
Social Activities			
Diet/Fluid Intake			
Physical Activity			
Occupation			
Other (Specify):			