PATIENT INFORMATION/QUESTIONNAIRE

Female: Name: _____ Age: _____

Birth date: _____ SS#: _____

Home Address: _____

_____

Home Phone: (____) _____ Work Phone: (____) _____

Employer: _____ Occupation: _____

Employer Address: _____

Marital Status: _____ Years married to this spouse: _____

# of marriages: _____ Religious preference: _____

Insurance Co: _____ Policy #: _____

ID#: _____ Phone #: _____

Primary Care Physician: _____

Gynecologist: _____

Referring Physician or person: _____

Male: Name: _____ Age: _____

Birth date: _____ SS#: _____

Employer: _____ Occupation: _____

Employer Address: _____

Work Phone: _____

# of marriages: _____ Religious preference: _____

Primary Care Physician: _____

Urologist: _____

Emergency Name & Phone #: _____

Relation: _____

Please complete and return this form to:

Cohen Center
7777 Forest Lane, Suite C-625
Dallas, TX 75230
(972) 566-8506

Also, please arrange to have a copy of your previous medical records and **the films of your Hysterosalpingogram (HSG**), if applicable, sent to Cohen Center. No appointment will be made unless the records and films are available for the physician. You may call approximately one week after having this information sent to confirm our receipt of your records and to see if an appointment can be scheduled.

FOR OFFICE USE ONLY

Name: _____

Reason for Visit: _____

_____

_____

_____

Social History:

Level of Education: ☐ High School ☐ Bachelors Degree ☐ Masters Degree ☐ Doctorate Degree

Current Occupation/Vocation: _____ Hr./wk. worked _____

yrs. @ current job _____ If retired, when _____

Excessive exposure at home or work to ☐ fumes ☐ dust ☐ solvents ☐ airborne particles ☐ noise

Current Weight: _____ Has there been any major weight loss or gain recently: ☐ Yes ☐ No

Reason why: _____

Weight at age 16 _____ Since the age of 16 your **highest** _____ and **lowest** _____ weight

Have you ever been diagnosed with ☐ anorexia ☐ bulemia If yes, please describe _____

_____

Height: _____ Current Exercise: _____ # hours per week

From the age of 16 to the present, have you participated in any of the following activities:

☐ drill team ☐ dance ☐ running/jogging ☐ aerobic dance ☐ other _____

Please give a brief description of the type and level of exercise you have participated in _____

_____

Are you now or have you been in the last year on a special diet? ☐ low carb ☐ reduced calorie ☐ vegetarian

☐ other _____

If yes, for how long _____ # lbs. lost _____ Maintained weight loss ☐ Yes ☐ No

Smoking: ☐ Yes ☐ No Number per day: _____

Alcohol: ☐ Yes ☐ No Number per week: _____

per month: _____

per day: _____

Recreational Drugs: ☐ Yes ☐ No Name of Drug or Substance _____

_____

Medication(s) you currently take and dosage(s) per day: _____

_____

Name: _____

List any herbs you currently take and dosage(s) per day: _____

_____

List any vitamins, enzymes and/or supplements you currently take and dosage(s) per day: _____

_____

Skin problems: acne ☐ Yes ☐ No Treatment: _____

blotchiness ☐ Yes ☐ No Diagnosis & Treatment: _____

Excessive hair: ☐ Facial ☐ Abdominal ☐ Inner thighs

Any milky discharge from breasts: ☐ Yes ☐ No

Any problems with headaches: ☐ Yes ☐ No

Are you frequently hot or cold (circle one) when people around you are comfortable.

Do you have cold: ☐ Hands ☐ Feet

Do you ever have blueness in your ☐ Hands ☐ Feet

Visual problems: ☐ Eyeglasses ☐ Contacts

Difficulties in peripheral vision: ☐ Yes ☐ No

Any heart palpitations: ☐ Yes ☐ No

Any known drug allergies: _____

Any known drug reactions: _____

Gynecologic History:

Age at onset of menstruation: _____

Menstrual cycle: ☐ Regular ☐ Irregular

Days bleeding/days between cycles: _____ Days bleeding_____ Days between_____

(For example: 5 days bleeding/28 days between → 5/28)

Pain with periods: ☐ Yes ☐ No

Treatment for this pain: _____

Bleeding between periods: ☐ Yes ☐ No

Bleeding after intercourse: ☐ Yes ☐ No

Increased Bleeding: ☐ Yes ☐ No # tampons_____ # pads_____

Decreased Bleeding: ☐ Yes ☐ No # tampons_____ # pads_____

Clots: ☐ Present ☐ Absent

Name: _____

Prior Surgery for irregular bleeding or pain associated with menses: ☐ Yes ☐ No

If yes, please list surgery, date and outcome and forward records to Cohen Center

_____

_____

_____

Prior history of birth control method (please list all types used):

Type: _____

Duration: _____

History of pelvic infection: ☐ Yes ☐ No

Any vaginal discharges: ☐ Yes ☐ No

Treatment: _____

History of vaginal infection (yeast, Herpes, etc.): ☐ Yes ☐ No

Treatment: _____

Last pap smear: _____ Result: _____

History of any abnormal pap smears: ☐ Yes ☐ No

Treatment: _____

Urinary Difficulties: ☐ Burning ☐ Increased frequency

☐ Stress Incontinence ☐ Urgency

☐ Prior urinary infections, treatment: _____

Regular bowel habits: ☐ Yes ☐ No

☐ Constipation ☐ Diarrhea ☐ Black stools

☐ Blood on stools ☐ Fissures ☐ (Piles) Hemorrhoids

Treatment: _____

Pain accompanying bowel movements: ☐ Yes ☐ No

Related to menses: ☐ Yes ☐ No

Breasts: tenderness ☐ Yes ☐ No

current masses ☐ Yes ☐ No

past masses ☐ Yes ☐ No

Treatment for breast masses _____

_____

_____

Name: _____

Frequency of sexual intercourse: _____# times per week

_____# times per month

Painful intercourse: ☐ Yes ☐ No

Superficial pain Deep (inside lower abdomen)

Libido: ☐ Increased ☐ Decreased ☐ Unchanged ☐ Concerns_____

Interest: ☐ Increased ☐ Decreased ☐ Unchanged ☐ Concerns_____

Fantasies: ☐ Yes ☐ No

Satisfaction: ☐ Yes ☐ No

Orgasmic: ☐ Yes ☐ No

% of experiences ☐ < 25% ☐ 25%-50% ☐ 50%-75% ☐ >75%

Responsive: ☐ Excitement ☐ Boredom ☐ Spontaneous ☐ Arranged

Partner's Satisfaction: ☐ Somewhat ☐ Usually ☐ Never ☐ Concerns_____

Use of vaginal lubricants: ☐ Yes ☐ No

Use of douche: ☐ Yes ☐ No; frequency: _____

Obstetric History:

Number of pregnancies: _____

Live births: _____

Still births: _____

Miscarriages: _____

Tubal pregnancies: _____

Date: Right tube: _____

Left tube: _____

Terminations: _____

Pregnancy **induced/related** conditions: ☐ Antiphospholipid antibodies ☐ Antinuclear antibodies

☐ Lupus Anticoagulant ☐ Gestational Diabetes

☐ Hypertension ☐ Other_____

Method of: ☐ forceps ☐ vacuum ☐ episiotomy ☐ C Section ☐ normal vaginal delivery

Previous sterilization: ☐ Yes ☐ No

Request for sterilization reversal: ☐Yes ☐ No

Reason for seeking reversal: _____

Need for sterilization: _____

(We offer transuterine intratubal clips if patient meets appropriate criteria. There are no abdominal cuts using this technique.)

Name: _____

Personal Medical History:

			Comment
Heart disease	☐ Yes	☐ No	_____
High blood pressure	☐ Yes	☐ No	_____
Blood clotting disorders	☐ Yes	☐ No	_____
Phospholipid syndrome	☐ Yes	☐ No	_____
Anemia	☐ Yes	☐ No	_____
Asthma	☐ Yes	☐ No	_____
Bronchitis	☐ Yes	☐ No	_____
Winter bronchitis	☐ Yes	☐ No	_____
Pneumonia	☐ Yes	☐ No	_____
Chron's	☐ Yes	☐ No	_____
Malabsorbtion	☐ Yes	☐ No	_____
Gallstones	☐ Yes	☐ No	_____
Ulcers	☐ Yes	☐ No	_____
Ulcerative colitis	☐ Yes	☐ No	_____
Eating disorder	☐ Yes	☐ No	_____
Diabetes	☐ Yes	☐ No	_____
Insulin resistance	☐ Yes	☐ No	_____
PCOD	☐ Yes	☐ No	_____
Cushing's	☐ Yes	☐ No	_____
Thyroid disorder	☐ Yes	☐ No	_____
Prolactin	☐ Yes	☐ No	_____
Pituitary	☐ Yes	☐ No	_____
Kidney disease	☐ Yes	☐ No	_____
Renal infection	☐ Yes	☐ No	_____
Hepatitis	☐ Yes	☐ No	_____
Other liver disease	☐ Yes	☐ No	_____
Sexually transmitted disease	☐ Yes	☐ No	_____
Breast cancer	☐ Yes	☐ No	_____
Cervical cancer	☐ Yes	☐ No	_____
Ovarian cancer	☐ Yes	☐ No	_____
Other cancers	☐ Yes	☐ No	_____

Name: _____

Personal Medical History, continued:

			Comment
Arthritis	☐ Yes	☐ No	_____
Rheumatoid arthritis	☐ Yes	☐ No	_____
Sjogrens	☐ Yes	☐ No	_____
Other autoimmune disorders	☐ Yes	☐ No	_____
Depression	☐ Yes	☐ No	_____
Bipolar disorder	☐ Yes	☐ No	_____
Anxiety	☐ Yes	☐ No	_____
Other psychiatric disorders	☐ Yes	☐ No	_____
Neurological disorders	☐ Yes	☐ No	_____
Birth defects	☐ Yes	☐ No	_____
Other health problems	☐ Yes	☐ No	_____

If you feel you are experiencing Menopausal Symptoms, please fill out the following questions, if not skip to the Family Medical History.

Hot flashes	☐ Yes	☐ No	_____
Insomnia	☐ Yes	☐ No	_____
Irritability	☐ Yes	☐ No	_____
Loss of memory	☐ Yes	☐ No	_____
Slow Cerebration	☐ Yes	☐ No	_____
Premenstrual:			
Dysphoria	☐ Yes	☐ No	_____
Tension	☐ Yes	☐ No	_____
Emotional	☐ Yes	☐ No	_____
Vaginal dryness	☐ Yes	☐ No	_____
Stress incontinence (when laughing or coughing)	☐ Yes	☐ No	_____
Increase urinary frequency	☐ Yes	☐ No	_____
Urinary urgency	☐ Yes	☐ No	_____
Other symptoms	☐ Yes	☐ No	_____

Name: _____

Family history:

			Comment
Mother's age at menopause	_____		_____
High Blood Pressure	☐ Yes	☐ No	_____
Heart Disease	☐ Yes	☐ No	_____
High cholesterol	☐ Yes	☐ No	_____
Hypertension	☐ Yes	☐ No	_____
Diabetes	☐ Yes	☐ No	_____
Thyroid Problems	☐ Yes	☐ No	_____
Kidney disease	☐ Yes	☐ No	_____
Breast Cancer	☐ Yes	☐ No	_____
Other reproductive or genital cancers	☐ Yes	☐ No	_____
Osteoporosis	☐ Yes	☐ No	_____
Autoimmune Disease	☐ Yes	☐ No	_____
Alzheimer's	☐ Yes	☐ No	_____
Premature degeneration	☐ Yes	☐ No	_____
Parkinson's	☐ Yes	☐ No	_____
Psychiatric disorders	☐ Yes	☐ No	_____
Downs Syndrome	☐ Yes	☐ No	_____
Mental Retardation	☐ Yes	☐ No	_____
Birth Defects	☐ Yes	☐ No	_____
Other	☐ Yes	☐ No	_____

Have you ever had: Hysterosalpingogram (x-ray) ☐ Yes ☐ No

Date: _____ Results: _____

(Please send the actual film to the Cohen Center)

Have you ever had: Laparoscopy ☐ Yes ☐ No

Date: _____ Results: _____

Date: _____ Results: _____

Hysteroscopy ☐ Yes ☐ No

Date: _____ Results: _____

Name: _____

Please list **any/all** previous surgeries or hospital admissions (date, procedure and outcome):

Please give a personal summary (treatment goals and objectives):