CAMRAN NEZHAT
INSTITUTE

1775 Woodside Road, Suite #202
Woodside, CA 94061
Phone: 650-327-8778
Fax: 650-878-6869
office@camrannezhatinstitute.com
www.nezhat.org

New Patient Assessment Packet

Contact Information

Name: ____ Birth Date: _____ /_____ / _____
Phone #: Home: (_____) _____-______ Cell: (_____) _____-______ Work: (_____) _____-______
Home Address: _____________________________________ City: ___________ State: _____ Zip:______
Emergency Contact and Phone Number: ____
Referring Provider's Name and Address: ____

Who is your primary care provider? ____
Address: ______________________________ Phone #: (_____) _____-______ Fax #: (_____) _____-______

What pharmacy do you use? ____
Address: _____________________________ Phone #: (_____) _____-______ Fax #: (_____) _____-______

Basic Admission/Consultation Evaluation

Age: _______ Height: _______ Weight: ________

Reason for Visit: □ Endometriosis Evaluation □Pain Evaluation □ Infertility Evaluation □Other (specify):
____

Please briefly describe your reason for visit:
____
____
____

What questions do you want answered at this visit?
____
____
____

What are your goals/expectations for your health/fertility/endometriosis treatment/for today's visit?
____
____

Demographic Information

Check all that apply for the following:
Status: □Married □Widowed □Separated □ Committed Relationship □Single □Divorced
Education: □Less than 12 years □High School Graduate □College Degree □Postgraduate Degree

What is your sexual preference (i.e. heterosexual, homosexual, bisexual, etc.)? ______________________________
Whom do you live with?: ____
Current Job/Line of work: ____

Medical and Surgical History

Allergies (Please list **all**: ie. latex allergies, and the reactions you have):
____
____

Please list any medical problems and diagnoses:
____
____
____

Please list **all** surgical procedures you have had *(use a separate page if needed)*:
For any surgeries related to the reason for your visit, please include operative reports and pathology reports.

Year	Procedure	Surgeon	Findings

Please list **all medications** (including herbs and supplements) you are presently taking:

Medication/Dosage	Prescribing Provider	Medical Condition

Menstrual History

1. Age when you had your first period: _____ years old
2. Are you still having menstrual periods ? □ No □ Yes
3. If you are no longer having menstrual periods, at what age did you go through menopause? ______ years old
4. Have you had any vaginal bleeding after menopause? □ No □ Yes
5. How many days of menstrual flow? ________ days
6. Number of days between the start of one period to the start of the next period: _____ days
7. Dates of the 1st day of your last 2 menstrual periods: _____/_____/_____; _____/_____/_____
8. Do you need medication to bring on a period (ie. provera)? □ No □ Yes - what type? ____________________
9. How many periods do you have per year? _____
10. How many periods do you have per year? _____
11. Do you have pelvic pain with ovulation? □ No □ Yes

Answer the following only if you are still having menstrual periods ***(check all that apply)***:

□ Regular periods
□ Spotting before periods
□ No periods
□ Light periods
□ Irregular periods
□ Heavy periods

Do you have severe cramping or pelvic pain with your periods?
□ No □ Yes: ____Always ____Sometimes ____ Recently ____In the past

Do you have changes in bladder habits with your periods, such as bleeding or urgency? □ No □ Yes
If yes, please explain: ____

Do you have changes in bowel habits with your periods, such as constipation or diarrhea? □ No □ Yes
If yes, please explain: ____

Birth control method or Hormonal Medication:

□ Pill
□ Vasectomy
□ Diaphragm
□ IUD
□ Vaginal ring
□ None
□ Tubal Sterilization
□ Hysterectomy
□ Other: ___________
□ Depo provera
□ Condom

When was your last Pap smear? Do you have a history of abnormal Pap? □ No □ Yes

When/Date: __________________ Result/Treatment: ____

When was your last mammogram? Do you have a history of abnormal mammogram? □ No □ Yes

When/Date: __________________ Result/Treatment: ____

Have you ever had an endometrial biopsy? □ No □ Yes

When/Date: __________________ Result/Treatment: ____

Have you ever had a colonoscopy? □ No □ Yes

When/Date: __________________ Result/Treatment: ____

Have you ever had:	Yes	No	When	Result/Treatment
Chlamydia				
Gonorrhea				
Herpes				
Trichomonas				
Condyloma (warts)				
Exposure to HIV				

Pelvic Pain

Please describe your pain problem *(use a separate sheet of paper if needed)*:
____
____
____

Is there an event that you associate with the onset of your pain? ◻ No ◻ Yes
If so, what?____
How long have you had this pain? ____ years ____ months

For each of the symptoms listed, place an ✓ to indicate your level of pain using a 10 point scale:

Symptoms:	0	1	2	3	4	5	6	7	8	9	10
Pain at ovulation (mid-cycle)											
Pain just before period											
Pain (not cramps) before period											
Pain with intercourse											
Pain in groin when lifting											
Pelvic pain lasting hours or days after intercourse											
Pain when bladder is full											
Muscle/Joint pain											
Level of cramps with period											
Pain after period is over											
Burning vaginal pain after sex											
Pain with urination											
Backache											
Migraine headache											
Pain with sitting											

Information About Your Pain

What types of treatments / providers have you tried in the past for your pain? ***(check all that apply)***

□ Acupuncture	□ Anesthesiologist	□ Anti-seizure medications
□ Antidepressants	□ Biofeedback	□ Botox injection
□ Contraceptive pills/patch/ring	□ Danazol (Danocrine)	□ Depo-provera
□ Gastroenterologist	□ Gynecologist	□ Family Practitioner
□ Herbal Medicine	□ Homeopathic medicine	□ Lupron, Synarel, Zoladex
□ Massage	□ Meditation	□ Narcotics
□ Naturopathic medication	□ Nerve blocks	□ Neurosurgeon
□ Nonprescription medicine	□ Nutrition / diet	□ Physical Therapy
□ Psychotherapy	□ Psychiatrist	□ Rheumatologist
□ Skin magnets	□ Surgery	□ TENS units
□ Trigger point injections	□ Urologist	□ Other:________________

Please comment on what has worked and has not worked for you in the past:
____
____
____
____

Pelvic Varicosity Pain Syndrome Questions

1. Is your pelvic pain aggravated by prolonged physical activity?
   □ No □ Yes
2. Does your pelvic pain improve when you lie down?
3. □ No □ Yes
4. Do you have pain that is deep in the vagina or pelvis *during* sex?
5. □ No □ Yes
6. Do you have pelvic throbbing or aching *after* sex?
   □ No □ Yes
7. Do you have pelvic pain that moves from side to side?
   □ No □ Yes
8. Do you have sudden episodes of severe pelvic pain that come and go?
   □ No □ Yes

Infertility Assessment

Fertility Questionnaire

1. Do you plan on trying to get pregnant now or in the future? □ No □ Yes
2. Are you currently trying to get pregnant? □ No □ Yes
3. How long have you been trying? ____
4. Have you had any fertility treatment, such as IVF?
5. Does your partner have a normal semen analysis? □ No □ Yes
6. Do you have any personal, ethical, or religious objections to any tests or treatments, such as insemination, in vitro fertilization, egg donation, sperm donation, masturbation to collect a semen sample, etc? □ No □ Yes
   If yes, please explain:____
7. Have you been treated for infertility previously? □ No □ Yes
   If yes, where and when?
   ____

Fertility Treatment History

Which tests have been performed? ***(Please attach results of any tests)***

□ Basal body temperature □ Infection test (ureaplasma,mycoplasma) □ Estradiol
□ Postcoital test □ Endometrial biopsy □ FSH
□ Clomid challenge test □ Hysterosalpingogram □ DHEAS
□ Sonohysterogram □ Antibody tests □ Thyroid tests
□ Testosterone □ Ultrasound □ Estrogen

Have you ever taken any of the following medications?

□Clomid □ Letrozole □HCG (Ovidrel) □ Estrogen
□Injectable Gonadotropins □ Progesterone □Progestin □ Testosterone

Have you ever attempted intrauterine insemination? □ No □ Yes
If yes, please list dates and semen donor (partner or anonymous):

____
____

Have you ever attempted in vitro fertilization? □ No □ Yes
If yes, please list dates and results:

____
____

Do you currently have any frozen embryos? □ No □ Yes
If yes, how many? ______

Obstetrical History

How many pregnancies have you had? ________
Resulting in (#): Full 9 months ____ Premature ____ Miscarriage/Abortion ____ Living children ____

1. Number of Miscarriages (less than 20 weeks): __________
2. Number of Ectopic/Tubal Pregnancies: __________
3. Number of Elective Terminations/Abortions: __________

Were there any complications during pregnancy, labor, delivery, or postpartum?

□ 4° Episiotomy □ C-Section □ Vacuum
□ Vaginal laceration □ Postpartum hemorrhaging □ Medication for bleeding

Please list **all** of your pregnancies and their outcomes:

Date	Treatments to Conceive	Delivery Type (Vaginal, Cesarean, D&C, etc)	Complications	Weight	Sex	Current Partner?
					□M □F	□Y □N
					□M □F	□Y □N
					□M □F	□Y □N
					□M □F	□Y □N
					□M □F	□Y □N
					□M □F	□Y □N

Gastrointestinal/Eating

1. Do you have nausea?
   □No □With pain □Taking medications □With eating □Other
2. Do you have vomiting?
   □No □With pain □Taking medications □With eating □Other
3. Have you ever had an eating disorder such as anorexia or bulimia?
   □No □With pain □Taking medications □With eating □Other
4. Are you experiencing rectal bleeding or blood in your stool?
   □No □With pain □Taking medications □With eating □Other
5. Do you have increased pain with bowel movements?
   □No □With pain □Taking medications □With eating □Other

The following questions help to diagnose irritable bowel syndrome, a gastrointestinal condition, which may be a cause of pelvic pain. **Do you have pain or discomfort that is associated with the following:**
Change in frequency of bowel movement □ No □ Yes
Change in appearance of stool or bowel movement? □ No □ Yes
Does your pain improve after completing a bowel movement? □ No □ Yes

Urinary Symptoms

1. Do you experience any of the following?
   □ No □ Yes
2. Loss of urine when coughing, sneezing, or laughing? Difficulty passing urine?
   □ No □ Yes
3. Frequent bladder infections?
   □ No □ Yes
4. Blood in your urine?
   □ No □ Yes
5. Still feeling full after urination?
   □ No □ Yes
6. Having to void again within minutes of voiding?
   □ No □ Yes

Coping Mechanisms

1. Who are the people you talk with concerning your pain, or during stressful times?
   □Spouse/Partner □Clergy □Doctor/Nurse □Mental Health provider
   □Relative □Support group □Friend □I take care of myself
2. How does your partner deal with your pain?
   □Doesn't notice □Takes care of me □Gets angry □Withdraws
   □Feels helpless □Helps distract me □Not applicable
3. What helps your pain?
   □Meditation □Relaxation □Lying down □Music
   □Massage □Ice □Heating pad □Hot bath
   □Pain medication □Laxatives/Enema □Injection □TENS unit
   □Bowel movement □Emptying bladder □Nothing □Other ___________
4. What makes your pain worse?
   □Intercourse □Bowel movement □Standing □Full bladder
   □Urination □Orgasm □Exercise □Weather
   □Stress □Full meal □Walking □Time of Day
   □Contact w/ Clothing □Coughing/Sneezing □Unrelated to anything □Other ___________
5. Of all the problems or stresses or your life, how does your pain compare in importance?
   □The most important problem □Just one of many problems

Sexual and Physical Abuse History

1. Check an answer for both as a child and as an adult:	13 & younger	14 & older
Has anyone ever exposed the sex organs of their body to you when you did not want it?	□Y □N	□Y □N
Has anyone ever threatened to have sex with you when you did not want it?	□Y □N	□Y □N
Has anyone ever touched the sex organs of your body when you did not want this?	□Y □N	□Y □N
Has anyone forced you to have sex when you did not want this?	□Y □N	□Y □N
Have you had any other unwanted sexual experiences not mentioned above?	□Y □N	□Y □N

1.Have you ever been the victim of emotional abuse? This can include being humiliated or insulted
□No □Yes □No Answer

2. When you were a child (13 or younger), did an older person do the following?
a. Hit, kick, or beat you?
□Never
□Seldom
□Occasionally
□Often
b. Seriously threaten your life?
□Never
□Seldom
□Occasionally
□Often

3. Now that you are an adult (14 or older), has any other adult done the following?
a. Hit, kick, or beat you?
□Never
□Seldom
□Occasionally
□Often
b. Seriously threaten your life?
□Never
□Seldom
□Occasionally
□Often

Family History

Please list all family members with diagnoses such as fibromyalgia, chronic pelvic pain, irritable bowel syndrome, depression, interstitial cystitis, endometriosis, cancer, and any other chronic conditions:

Family Member	Condition

Health Habits

1. How often do you exercise?
   □ Rarely □1-2 times weekly □3-5 times weekly □Daily

2. What is your caffeine intake (number cups per day, include coffee, tea, soft drinks, etc)?
   □0 □1-3 □4-6 □>6

3. How many cigarettes do you smoke per day? _____
   If yes, for how many years? _____

4. Do you drink alcohol?
   □ No □ Yes
   Number of drinks per week ______

5. Have you ever received treatment for substanceabuse?
   □ No □ Yes

6. What is your use of recreational drugs?
   □Never used □Used in the past, but not now □Presently using
   □No answer □Heroin □Amphetamines
   □Marijuana □Barbiturates □Cocaine

7. How would you describe your diet? (check all that apply)
   □Well balanced □Vegan □Fried Food □Vegetarian
   □Special diet ______________________ Other ____

8. Have you ever been hospitalized for anything other than childbirth?
   □ No □ Yes
   If yes, please explain: ____

9. Have you had major accidents such as falls or a back injury?
   □ No □ Yes

10. Have you ever been treated for depression?
    □ No □ Yes
    If yes, treatments: □ Medication □Hospitalization □Psychotherapy

Thank you for completing our consultation intake packet. We look forward to seeing you soon!

-Camran Nezhat Institute