FEMALE PATIENT HISTORY

I. IDENTIFYING INFORMATION

Date____

Name____ Partner's Name_________________________________

Address____

Telephone Number - Day: (   ) ______________________ Evening: (   ) ______________________________

Date of Birth________ Partner's Date of Birth________ Duration of Relationship________ Duration of Infertility_______

Insurance Company__________________________________ Insurance I.D. #_________________________________

Nature of present employment (title, brief description)____

____

II. MEDICAL HISTORY

	YES	NO
Weight__________ Height__________ Blood Type (if known)______________________________		
Have you lost greater than 20 pounds of weight in the last year?	☐	☐
Do you follow a particular food diet or have any special dietary habits?	☐	☐
If yes, specify:____		
List the forms and frequency of regular vigorous exercise (swimming, cycling, running) and the age you began:		
Exercise:_________ Hrs/Week_________ Age_________ Exercise:_________ Hrs/Week_________ Age________ __		
Have you ever had pelvic surgery?	☐	☐
If yes, specify date and type:____		

Do you have or have you ever had (check all that apply):

☐ Anemia 0 Epilepsy 0 Parasitic Infection

☐ Appendicitis
☐ Arthritis
☐ Blood Transfusions
☐ Breast Milky Discharge
☐ Breast Soreness
☐ Breast Tenderness
☐ Cancer? Specify__________________
____
☐ Chlamydia
☐ Chronic Bronchitis
☐ Chronic Headaches
☐ Colitis
☐ Color Blind
☐ Diabetes
☐ Dizziness
☐ Endometriosis

☐ Gallbladder Problems
☐ Gonorrhea
☐ Heart Disease
☐ Hepatitis
☐ Herpes
☐ Hirsutism (Excess Hair Growth)
☐ High Blood Pressure
☐ Immunization: German Measles
☐ Kidney Infection
☐ Liver Problems
☐ Loss of Balance
☐ Measles: German
☐ Measles: Regular
☐ Neurological Problems
☐ Nongonococcal Urethritis
☐ Ovarian Cysts

☐ Pelvic Infection
☐ Pneumonia
☐ Poor Sense of Smell
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Seizures
☐ Syphilis
☐ Thyroid Problems
☐ Tuberculosis
☐ Ulcers
☐ Vaginitis (Trichomoniasis, yeast)
# of episodes____________
☐ Visual Disturbances
☐ Any Allergies: List________
____
____

	YES	NO
Have you ever been treated for cancer?	☐	☐
If yes, explain therapy:____		
Have you ever received X-rays to the pelvic area for therapy or diagnosis?	☐	☐
If yes, specify:____		
Within the last year, have you taken any prescription medications?	☐	☐
If yes, list all prescriptions and problems for which you were taking them:______________________________		
Are you taking any over-the-counter medications on a regular basis?	☐	☐
If yes, list all medications and diagnoses:____		

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Do you use or have you ever used (check all that apply):

☐ Alcohol - How many glasses per week do you usually drink? Wine_______ Beer_______ Cocktails_______

☐ Cigarettes - Number of packs per day_______

☐ Illicit or Recreational Drugs (Marijuana, Cocaine, etc.) If you would feel more comfortable not writing anything down, please discuss this directly with your physician. Specify:____

____

III. MENSTRUAL AND PREGNANCY HISTORY — YES / NO

Age at first period?____ When was your last period?________________________________

Are your periods regular?. . . . . ☐ YES ☐ NO

If yes, what is the usual number of days between periods?________________________

If no, how many times per year do you menstruate?________________________

What is the usual duration of your period?_______________________ Use: ☐ Tampons? ☐Pads?

Are cramps present before, during, or after your period?________________________

Are cramps: ☐ Mild ☐ Moderate ☐ Severe

Do you have to take pain medication for cramps?. . . . . ☐ YES ☐ NO

If yes, specify medication:________________________________

Do you bleed or spot between periods?. . . . . ☐ YES ☐ NO

How many pregnancies (including abortions) have you had?________________________

	When? (year)	End in Abortion?	End in Marriage?	Ectopic Pregnancy?	Infertility therapy required to conceive?	How Long to conceive?	Baby born alive?	Is Current partner the father
1st Pregnancy								
2nd Pregnancy								
3rd Pregnancy								
4th Pregnancy								
5th Pregnancy								

Were there any complications during or after your pregnancies?. . . . . ☐ YES ☐ NO

If yes, explain:________________________________

Did your mother have any difficulty with conception or pregnancy?. . . . . ☐ YES ☐ NO

If yes, explain:________________________________

How long have you now been trying to get pregnant?________________________

Did your mother take diethylstilbestrol (DES) when she was pregnant with you?. . . . . . ☐ YES ☐ NO

IV. CONTRACEPTIVE/SEXUAL HISTORY — YES / NO

What form of contraception do you use now or have you used in the past? Check all that apply:

☐ Pills Name:_______________ ☐ IUD Name:______________ ☐ Diaphragm ☐ Withdrawal ☐ Foams/Jellies

☐ Condom ☐ Rhythm ☐ None ☐ Other:________________________________

For each contraceptive method used, specify length of use and reason for discontinuation:

Method	Length of Use	Reason for Discontinuation

If you've ever been on oral contraceptives (pills), were your periods regular after stopping the pills?. . . . . . ☐ YES ☐ NO

How many times per week do you and your partner have sexual intercourse?________________________

How many times do you have intercourse around ovulation?________________________

Is intercourse painful or difficult for you?. . . . . ☐ YES ☐ NO

	YES	NO
Do you use lubricants for intercourse?	☐	☐
If yes, which one?______		
Do you douche before or after intercourse?	☐	☐

V. FAMILY HISTORY

	YES	NO
Is there a family history of infertility?	☐	☐
If yes, who (list all members and relationship to you):______		
Is there a history of hormonal disorders in your family?	☐	☐
If yes, list who (relationship to you) and what type:______		

VI. HISTORY OF FERTILITY THERAPY

	YES	NO
Have you been treated for infertility before?	☐	☐
If yes, who was your physician?______		

What cause of infertility was diagnosed?______

What drugs have you taken for infertility? Check all that apply:

☐ clomiphene citrate (Serophene®, Clomid®)
☐ hMG (Pergonal®)
☐ estrogens
☐ progesterone
☐ prednisone (or cortisone-like drugs)
☐ antibiotics
☐ GnRH or LHRH (Factrel®)
☐ hCG (Profasi®, A.P.L.®)
☐ bromocriptine (Parlodel®)
☐ danazol (Danocrine®)
☐ urofollitropin or FSH (Metrodin®)
☐ Other - Specify______
☐ None

Which of the following tests have you had performed? Check all that apply and the results if known:

Test	When?	Results:
☐ BBT	When?______	Results:______
☐ Postcoital Test	When?______	Results:______
☐ Hormonal Assays (FSH, LH, prolactin, estrogen DHEA-S, testosterone, progesterone)	When?______	Results:______
☐ Endometrial Biopsy	When?______	Results:______
☐ Hysterosalpingogram	When?______	Results:______
☐ Ultrasound	When?______	Results:______
☐ Antibodies	When?______	Results:______
☐ Laparoscopy, Hysteroscopy	When?______	Results:______
☐ MycoplasmaKhlamydia Cultures	When?______	Results:______
☐ Thyroid Tests	When?______	Results:______
☐ Other - Specify ______	When?______	Results:______

	YES	NO
Have you ever had surgery for tubal reversal?	☐	☐
If yes, specify dates:______		
Have you ever had surgery for lysis of adhesions?	☐	☐
Have you ever had cervical conization or cautery?	☐	☐
Have you ever had any other surgery (D&C, ovarian, appendectomy, thyroid)? .0 0		
If yes, please specify:______		
Have you ever undergone artificial insemination or in vitro fertilization?	☐	☐
If yes, using partner or donor sperm?______		
Is your partner seeing a doctor for evaluation of infertility?	☐	☐
If yes, specify physician name and location:______		
Does the doctor feel that your partner has an infertility problem?	☐	☐
If yes, what is the diagnosis and how is he being treated?______		
Has he ever fathered a child with another woman?	☐	☐
If yes, when?______		