

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 ID # _____

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 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):

- | | | |
|-------------------------------------------------|---------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Parasitic Infection |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Gallbladder Problems | <input type="checkbox"/> Pelvic Infection |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Poor Sense of Smell |
| <input type="checkbox"/> Breast Milky Discharge | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Breast Soreness | <input type="checkbox"/> Herpes | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Breast Tenderness | <input type="checkbox"/> Hirsutism (Excess Hair Growth) | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cancer? Specify _____ | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Syphilis |
| | <input type="checkbox"/> Immunization: German Measles | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chronic Headaches | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Vaginitis (Trichomoniasis, yeast) |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Measles: German | # of episodes _____ |
| <input type="checkbox"/> Color Blind | <input type="checkbox"/> Measles: Regular | <input type="checkbox"/> Visual Disturbances |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neurological Problems | <input type="checkbox"/> Any Allergies: List _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Nongonococcal Urethritis | _____ |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Ovarian Cysts | _____ |

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: _____

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 Miscarriage?	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

Do you use lubricants for intercourse? YES NO
 If yes, which one? _____

Do you douche before or after intercourse? YES NO

V. FAMILY HISTORY

Is there a family history of infertility? YES NO
 If yes, who (list all members and relationship to you): _____

Is there a history of hormonal disorders in your family? YES NO
 If yes, who and what type: _____

VI. HISTORY OF FERTILITY THERAPY

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

What cause of infertility was diagnosed? _____

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

<input type="checkbox"/> clomiphene citrate (Serophene®, Clomid®)	<input type="checkbox"/> hCG (Profasi®, A.P.L.®)
<input type="checkbox"/> hMG (Pergonal®)	<input type="checkbox"/> bromocriptine (Parlodel®)
<input type="checkbox"/> estrogens	<input type="checkbox"/> danazol (Danocrine®)
<input type="checkbox"/> progesterone	<input type="checkbox"/> urofollitropin or FSH (Metrodin®)
<input type="checkbox"/> prednisone (or cortisone-like drugs)	<input type="checkbox"/> Other • Specify _____
<input type="checkbox"/> antibiotics	<input type="checkbox"/> None
<input type="checkbox"/> GnRH or LHRH (Factrel®)	

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

<input type="checkbox"/> BBT	When? _____ Results: _____
<input type="checkbox"/> Postcoital Test	When? _____ Results: _____
<input type="checkbox"/> Hormonal Assays (FSH, LH, prolactin, estrogen DHEA-S, testosterone, progesterone)	When? _____ Results: _____
<input type="checkbox"/> Endometrial Biopsy	When? _____ Results: _____
<input type="checkbox"/> Hysterosalpingogram	When? _____ Results: _____
<input type="checkbox"/> Ultrasound	When? _____ Results: _____
<input type="checkbox"/> Antibodies	When? _____ Results: _____
<input type="checkbox"/> Laparoscopy, Hysteroscopy	When? _____ Results: _____
<input type="checkbox"/> Mycoplasma/Chlamydia Cultures	When? _____ Results: _____
<input type="checkbox"/> Thyroid Tests	When? _____ Results: _____
<input type="checkbox"/> Other • Specify _____	When? _____ Results: _____

Have you ever had surgery for tubal reversal? YES NO
 If yes, specify dates: _____

Have you ever had surgery for lysis of adhesions? YES NO

Have you ever had cervical conization or cautery? YES NO

Have you ever had any other surgery (D&C, ovarian, appendectomy, thyroid)? YES NO
 If yes, please specify: _____

Have you ever undergone artificial insemination or in vitro fertilization? YES NO
 If yes, using partner or donor sperm? _____

Is your partner seeing a doctor for evaluation of infertility? YES NO
 If yes, specify physician name and location: _____

Does the doctor feel that your partner has an infertility problem? YES NO
 If yes, what is the diagnosis and how is he being treated? _____

Has he ever fathered a child with another woman? YES NO
 If yes, when? _____