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) ____

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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):

- □ Anemia
- □ Appendicitis
- □ Arthritis
- □ Blood Transfusions
- □ Breast Milky Discharge
- □ Breast Soreness
- □ Breast Tenderness
- □ Cancer? Specify ___________________ __________________________________
- □ Chlamydia
- □ Chronic Bronchitis
- □ Chronic Headache
- □ Colitis
- □ Color Blind
- □ Diabetes
- □ Dizziness
- □ Endometriosis
- □ Epilepsy
- □ 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
- □ Parasitic Infection
- □ 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: ____		

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?…………………………………………………………………… □ □

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

If no, how many times per year do your menstruate? ______________________________________

What is the usual duration of your period? ______________________________Use: □ Tampons? □ Pads?

Are cramps: □ Mild □ Moderate □ Severe

Do you have to take pain medication for cramps?…………………………………………………… □ □

If yes, specify medication: ____

Do you bleed or spot between periods? ……………………………………………………………….. □ □

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

	When? (Year)	End in Abortion?	End in Miscarriage?	Ectopic Pregnancy?	Infertility therapy req'd 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?…………………………………… □ □

If yes, explain? ____

Did your mother have any difficulty with conception or pregnancy?………………………………… □ □

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?……………………… □ □

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? ……………………….. □ □

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? ……………………………………………………………….. □ □

Do you use lubricants for intercourse? ……………………………………………………………………………………………. □ □

If yes, which one? ____

Do you douche before or after intercourse?……………………………………………………………………………………. □ □

V. FAMILY HISTORY YES NO

Is there are family history of infertility? ……………………………………………………………………………………………. □ □

If yes, who (list all members and relationship to you): ____

____

Is there are history or hormonal disorders in your family? ………………………………………………………………...………. □ □

If yes, who and what type: ____

____

VI. HISTORY OF INFERTILITY 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 appy:

□ 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: ______________________
□ Mycoplasma/ Chlamydia Cultures	When? ______	Results: ______________________
□ Thyroid Tests	When? ______	Results: ______________________
□ Other – Specify ______________________	When? ______	Results: ______________________

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)? ………………………………………………. □ □

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? ____