FEMALE PATIENT HISTORY

IDENTIFYING INFORMATION

Name_____ Date_____
Partner's Name_____
Address_____
Telephone (Day)_____ (cell)_____(evening)_____
e-mail address_____ Duration of Infertility_____
Date of Birth_____ Partner's Date of Birth_____ Duration of Relationship_____
Insurance Company_____ ID#_____
Nature of present employment (title, brief description)_____
_____

MEDICAL HISTORY

Weight _____ Height_____ Blood Type (if known)_____
Have you lost greater than 20 pounds of weight in the last year?..... Y N
Do you have a particular food diet or have any special dietary habits?..... Y N
If yes, specify_____
List the forms and frequency of regular vigorous exercise (swimming, cycling, running) and the age you began.
Exercise_____Hrs/week_____ Exercise_____ Hrs/week_____
Have you ever had pelvic surgery?..... Y N
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 Headaches
___ 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 Problems
___ 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
_____
_____

Have you ever been treated for cancer?..... Y N
If yes, explain therapy:_____
Have you ever received X-rays to the pelvic area for therapy or diagnosis..... Y N
If yes, specify:_____
Within the last year, have you taken any prescription medication..... Y N
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..... Y N
If yes, list all medication and diagnosis_____
_____

Do you use or have you ever used (check all the 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 down, please discuss this directly with your physician. Specify:_____

_____

MENSTRUAL AND PREGNANCY HISTORY

Age at first period?_____ When was your last period_____

Are your periods regular?..... Y N

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?..... Y N

Are cramps: ___ Mild ___ Moderate ___ Severe

Do you have to take pain medication for cramps..... Y N

If yes, specify medication:_____

Do you bleed or spot between periods?..... Y N

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

PREGNANCY

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?

Were there any complications during or after your pregnancies?..... Y N

If yes, explain_____

Did your mother have any difficulty with conception or pregnancy?..... Y N

If yes, explain_____

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

Did you mother take diethylstilbestrol (DES) when she was pregnant with you?..... Y N

CONTRACEPTIVE/SEXUAL HISTORY

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 contraceptive (pills) were your periods regular after stopping the pill? Y N

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?..... Y N

Do you use lubricants for intercourse?..... Y N

If yes, which ones?_____

Do you douche before or after intercourse?..... Y N

FAMILY HISTORY

Is there a family history of infertility?..... Y N

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

_____

Is there a family history of hormonal disorders in your family..... Y N

If yes, who and what type_____

_____

HISTORY OF FERTILITY THERAPY

Have you been treated for infertility before?..... Y N

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
___ Antibotics
___ GnRH or LHRH (Factrel)
___ Gonal f
___ 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 results if known:

___ 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?..... Y N

If yes, specify dates_____

Have you ever had surgery for lysis of adhesions?..... Y N

Have you ever had cervical conization or cautery?..... Y N

Have you ever had any other surgery (D&C, Ovarian, appendectomy, thyroid)?..... Y N

If yes, please specify:_____

Have you ever undergone artificial insemination or in vitro fertilization?..... Y N

If yes, using partner or donor sperm?_____

Is you partner seeing a doctor for evaluation if infertility?..... Y N

If yes, specify physician name and location_____

Does the doctor feel that your partner has an infertility problem..... Y N

If yes, what is the diagnosis and how is he being treated?_____

_____

Has your partner ever fathered a child with another woman?..... Y N

If yes, when:_____