

# FEMALE PATIENT HISTORY

## I. IDENTIFYING INFORMATION

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

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? \_\_\_\_\_

Pregnancy	When? (Year)	End in Abortion?	End in Miscarriage?	Ectopic Pregnancy?	Infertility therapy required to conceive?	Baby born alive?	Is current partner the father?
1 <sup>st</sup>							
2 <sup>nd</sup>							
3 <sup>rd</sup>							
4 <sup>th</sup>							
5 <sup>th</sup>							

Were there any complications during or after you 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 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 have 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

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, who 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:

- 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 cauterization? .....

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? \_\_\_\_\_

FOR PHYSICIAN USE ONLY

VII. PHYSICAL FINDINGS

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VIII. SURGERY

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IX. OTHER COMMENTS

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X. COURSE OF ACTION

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