

# 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 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 Blindness        | <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                  | _____  |



**MENSTRUAL AND PREGNANCY HISTORY (CONT.)**

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

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**

What form of contraception do you use now or have you used in the past? (check all that apply) YES NO

( ) 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**

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? ..... ( ) ( )

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:

- |  |  |
|--|--|
| <input type="checkbox"/> clomiphene citrate (Clomid) | <input type="checkbox"/> hCG (Pregnyl, Profasi)            |
| <input type="checkbox"/> recFSH (Follistim, Gonal-f) | <input type="checkbox"/> hMG (Repronex, Humegon, Pergonal) |
| <input type="checkbox"/> hpFSH (Fertinex, Bravelle)  | <input type="checkbox"/> bromocriptine (Parlodel)          |
| <input type="checkbox"/> estrogens                   | <input type="checkbox"/> danazol (Danocrine)               |
| <input type="checkbox"/> progesterone                | <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  | When? _____ | Results: _____ |
| <input type="checkbox"/> Hormonal Assays (FSH, LH, prolactin, estrogen<br>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 in blood   | 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? ..... ( ) ( )

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? \_\_\_\_\_