

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?	<input type="checkbox"/>	<input type="checkbox"/>
Do you follow a particular food diet or have any special dietary habits?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify: _____		
List the forms and frequency of regular vigorous exercise (swimming, cycling, running) and the age you began:		
Exercise: _____ Hrs/Week _____ Age _____ Exercise: _____ Hrs/Week _____ Age _____		
Have you ever had surgery in the pelvic area?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify date and type of surgery: _____		
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) # of episodes _____
<input type="checkbox"/> Colitis	<input type="checkbox"/> Measles: German	<input type="checkbox"/> Visual Disturbances
<input type="checkbox"/> Color Blind	<input type="checkbox"/> Measles: Regular	<input type="checkbox"/> Any Allergies? List _____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Neurological Problems	_____
<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?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, explain therapy: _____		
Have you ever received X-rays to the pelvic area for therapy or diagnosis?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify: _____		
Within the last year, have you taken any prescription medications?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, list all medications and diagnoses: _____		

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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: _____

Tattoo - if yes date _____ Body Piercing - if yes date _____

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 pregnancy? 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 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?

If yes, which one: _____

Do you douche before or after intercourse?

V. FAMILY HISTORY

Is there a family history of infertility?

If yes, list who (relationship to you) and what type: _____

Is there a history of hormonal disorders in your family?

If yes, who and what type: _____

VI. HISTORY OF FERTILITY THERAPY

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®)
- hCG (Profasi®, A.P.L.®)
- hMG (Pergonal®)
- bromocriptine (Paridel®)
- estrogens
- danazol (Danocrine®)
- progesterone
- urofollutropin or FSH (Metrodin®)
- prednisone (or cortisone-like drugs)
- Other – Specify _____
- antibiotics
- None
- GnRH or LHRH (Factrel®) 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 surgery for 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 donor or partner 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 was the diagnosis and how is he being treated? _____

Has he ever fathered a child with another woman?

If yes, when? _____

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VII. PHYSICAL FINDINGS

VIII. SURGERY

IX. OTHER COMMENTS

X. COURSE OF ACTION
