

FEMALE PATIENT HISTORY: INFERTILITY

I. Identifying Information

Date: _____
 Name: _____ Partner's Name _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Telephone Number: Day () _____ Evening () _____
 Referring Physician: Name _____
 Address _____
 Age: _____ Date of Birth: _____ Partner's Age: _____ Date of Birth _____

II. Pregnancy History

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

	When (Year)	How Long to Conceive (Months)	Fertility Therapy Used (Yes / No)	Is Current Partner the Father (Yes / No)	Duration of Pregnancy (Months)	Outcome*	Complications
1 st Pregnancy							
2 nd Pregnancy							
3 rd Pregnancy							
4 th Pregnancy							
5 th Pregnancy							

*Outcomes: Vaginal Deliver = VD; Cesarean Section = CS; Abortion = AB; Miscarriage = MS; Ectopic = EC

III. Fertility History

How long have you and your present partner been trying to conceive: _____

Have you ever been infertile with a past partner: YES NO If so, how long: _____

Have you had any of the following tests performed: (Check all that apply and the results)

	Date	Results
<input type="checkbox"/> Basal Body Temperature	_____	_____
<input type="checkbox"/> Urinary LH (Ovulation) Predictor Kits	_____	_____
<input type="checkbox"/> Post-coital Test	_____	_____
<input type="checkbox"/> Hormone Tests	_____	_____
<input type="checkbox"/> Endometrial Biopsy	_____	_____
<input type="checkbox"/> Hysterosalpingogram (HSG)	_____	_____
<input type="checkbox"/> Sonohysterogram	_____	_____
<input type="checkbox"/> Ultrasound	_____	_____
<input type="checkbox"/> Anti-sperm Antibodies	_____	_____
<input type="checkbox"/> Laparoscopy	_____	_____
<input type="checkbox"/> Hysteroscopy	_____	_____
<input type="checkbox"/> Gonorrhea/Chlamydia Cultures	_____	_____
<input type="checkbox"/> Rubella (German Measles)	_____	_____
<input type="checkbox"/> Hepatitis B or C	_____	_____
<input type="checkbox"/> HIV	_____	_____
<input type="checkbox"/> RPR (Syphilis)	_____	_____
<input type="checkbox"/> Blood type and Rh	_____	_____

Fertility Center of the Carolinas



Antibody Screen _____

What types of fertility therapy have you received in the past?

Drug / Treatment	Dosage	How Long or How Many Cycles	When
Clomiphene Citrate (Clomid) Letrozole (Femara)			
Gonadotropins (Pergonal, Repronex, Gonal-F, Follistim, Menopur)			
HCG (Profasi, Pregnyl, Ovidrel)			
Progesterone			
Prednisone or Dexamethasone			
Bromocriptine (Parlodel, Dostinex)			
Artificial Insemination			
Donor Insemination			
In Vitro Fertilization/ICSI			

IV. Gynecological History

How old were you when you started having periods? ____ Date your last period started? _____

Are your periods regular Yes No

If yes, how many days between periods (start until start)? _____

If no, how many periods per year do you have? _____

How many days do your periods last? _____

Have you ever had bleeding between periods? _____

If yes, are they: Mild Moderate Severe

Have you every missed work due to pain? Yes No

Do you have pain with intercourse?

Do you have pain between periods?

Were you ever diagnosed with endometriosis?

Have you ever been told you had fibroid tumors in your uterus?

How often do you and your partner have intercourse? _____

Have you had any of the following tests performed on you? Check all that apply and the results.

	Date	Results
<input type="checkbox"/> Hormone Tests	_____	_____
<input type="checkbox"/> Gonorrhea/Chlamydia Cultures	_____	_____
<input type="checkbox"/> Endometrial Biopsy	_____	_____
<input type="checkbox"/> Hysterosalpingogram (HSG)	_____	_____
<input type="checkbox"/> Sonohysterogram	_____	_____
<input type="checkbox"/> Ultrasound	_____	_____

What type of contraception have you used in the past or are using now?

- | | | |
|--|---|--|
| <input type="checkbox"/> Birth control pills | <input type="checkbox"/> IUD | <input type="checkbox"/> Depo Provera (birth control shot) |
| <input type="checkbox"/> Diaphragm | <input type="checkbox"/> Foams/jellies | <input type="checkbox"/> Withdrawal |
| <input type="checkbox"/> Rhythm | <input type="checkbox"/> Tubal Ligation | <input type="checkbox"/> Condoms |
| <input type="checkbox"/> Essure | | |



History of contraceptive complications? _____

When did you last use contraception? _____

Have you ever had an abnormal Pap smear? _____ If so, when? _____

What was done about it? _____

When was your last Pap smear? _____

Have you ever had any of the following (check all that apply):

- | | | |
|------------------------------------|---|--|
| <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Venereal Warts | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Pelvic Inflammatory Disease (PID) |

V. Medical History

Do you have or have you ever had: (Check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ovarian Cysts |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Gallbladder Problems | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rubella (German Measles) |
| <input type="checkbox"/> Breast Discharge | <input type="checkbox"/> Hirsutism (excess facial hair) | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Breast Pain | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Kidney Infections | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Chronic Headaches | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Neurological Problems | <input type="checkbox"/> Vision Problems |

Current Medications: _____

Are you allergic to any medications: YES NO What: _____

Have you ever had surgery before: YES NO Date and type _____

VI. Social History

Current or Recent Employer/Position _____

- | | Yes | No | |
|----------------------------|--------------------------|--------------------------|-------------------------------------|
| Do you drink alcohol? | <input type="checkbox"/> | <input type="checkbox"/> | Number of drinks per week? _____ |
| Do you smoke? | <input type="checkbox"/> | <input type="checkbox"/> | Number of cigarettes per day? _____ |
| Ever used illicit drugs? | <input type="checkbox"/> | <input type="checkbox"/> | Specify _____ |
| Do you exercise? | <input type="checkbox"/> | <input type="checkbox"/> | Type _____ |
| Are you on a special diet? | <input type="checkbox"/> | <input type="checkbox"/> | Type _____ |



VII. Family History

Do any members have significant health problems or inherited diseases? _____

Check all that apply

- | | | |
|---|--|--|
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Brain/Spinal Defects | <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Down Syndrome |
| <input type="checkbox"/> Fragile X Syndrome | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tay-Sachs Disease |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Thalassemia |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Thyroid Disease |

Who? _____

VIII. Review of Systems

What is your usual height? _____ Current weight _____ Ideal weight _____

Have you had more than a 10-pound weight gain/loss this past year? _____

If so, how much? _____ Was this intentional? _____

Please check the following that apply to you:

Constitutional	<input type="checkbox"/> Fever <input type="checkbox"/> Fatigue <input type="checkbox"/> Sleep problems <input type="checkbox"/> Other
Eyes	<input type="checkbox"/> Vision Changes <input type="checkbox"/> Glasses/Contacts <input type="checkbox"/> Other
Ear, Nose, Throat	<input type="checkbox"/> Headache <input type="checkbox"/> Ulcers <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Sinusitis <input type="checkbox"/> Other
Cardiovascular	<input type="checkbox"/> Swelling <input type="checkbox"/> Chest Pain <input type="checkbox"/> Difficulty Breathing on Exertion <input type="checkbox"/> Palpitations <input type="checkbox"/> Other
Respiratory	<input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Cough <input type="checkbox"/> Asthma <input type="checkbox"/> Other
Gastrointestinal	<input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Pain <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Bloody Stool <input type="checkbox"/> Other
Genitourinary	<input type="checkbox"/> Urinary Frequency/Burning <input type="checkbox"/> Incontinence <input type="checkbox"/> Blood in urine <input type="checkbox"/> Other
Musculoskeletal	<input type="checkbox"/> Muscle or Joint Pain <input type="checkbox"/> Muscle Swelling <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Other
Skin	<input type="checkbox"/> Rash <input type="checkbox"/> Moles <input type="checkbox"/> Dry Skin <input type="checkbox"/> Ulcers <input type="checkbox"/> Other
Breast	<input type="checkbox"/> Discharge <input type="checkbox"/> Pain <input type="checkbox"/> Masses <input type="checkbox"/> Other
Neurologic	<input type="checkbox"/> Fainting Spells <input type="checkbox"/> Memory Loss <input type="checkbox"/> Seizures <input type="checkbox"/> Numbness <input type="checkbox"/> Other
Psychiatric	<input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Crying Spells <input type="checkbox"/> Other
Endocrine	<input type="checkbox"/> Diabetes <input type="checkbox"/> Hair Loss <input type="checkbox"/> Abnormal Hair Growth <input type="checkbox"/> Heat/Cold Intolerance <input type="checkbox"/> Other
Hematologic/Lymph	<input type="checkbox"/> Bleeding <input type="checkbox"/> Bruising <input type="checkbox"/> Swollen Lymph Nodes <input type="checkbox"/> Blood Clots <input type="checkbox"/> Other

Please complete and bring this form with you to your first appointment. Ensure that records from your current or past physician have been sent or faxed to the address or fax number below at least one week in advance of your visit. We look forward to meeting you.

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