

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

## Gynecological and Fertility Histories

### Menstrual History

- Menstrual cycle pattern (check all that apply):  Regular periods  Irregular periods  Spotting before periods
- Age of first period \_\_\_\_\_  Light flow  Heavy flow  Bleeding between cycles
- Number of days between the start of one period to the start of another: \_\_\_\_\_
- How many days of bleeding do you have? \_\_\_\_\_
- When was your last period? \_\_\_\_\_
- Do you pass clots?  No  Yes -- every cycle?  No  Yes
- Do you have cramps?  No  Yes -- every cycle?  No  Yes
- Can you tell when you ovulate?  No  Yes How?  BBT  LH Kits  Other
- What medications do you use for pain relief? \_\_\_\_\_
- Did your mother take DES when she was pregnant with you?  No  Yes  Don't know

### Sexual History

- How many times per month do you have intercourse? \_\_\_\_\_  None  Not applicable
- Do you have pain with intercourse?  No  Yes  
If yes, describe the pain \_\_\_\_\_
- Do you use lubricants?  No  Yes If yes, which type? \_\_\_\_\_
- Have you had any of the following sexually transmitted or pelvic infection? (Check all that apply)  
 Chlamydia  Gonorrhea  Herpes  Genital warts  Syphilis  HIV/AIDS  Hepatitis

### Contraceptive History

- None  Skin patch
- Condoms  Injectable contraception
- IUD  Complications? \_\_\_\_\_
- Birth Control Pills  Tubal sterilization ("tubes tied") When? \_\_\_\_\_

### Pap Smear History

- When was your last PAP Smear? (month and year) \_\_\_\_\_  Normal  Abnormal
- When was your last abnormal PAP Smear? (month and year) \_\_\_\_\_  Not applicable
- Have you undergone any of the following procedures as a result of an abnormal PAP Smear? (Check all that apply)  
 Colposcopy  Cryosurgery (freezing)  Conization  Laser  LEEP

### Breast Screening History

Have you ever had a mammogram?  No  Yes Date: \_\_\_\_\_ Result:  Normal  Abnormal  
Do you perform breast self-exams?  No  Yes

### Pregnancy Summary

- Total Number of ALL pregnancies: \_\_\_\_\_ ● Number of Elective Terminations: \_\_\_\_\_
- Number of Full Term Deliveries: \_\_\_\_\_ ● Number of Ectopic/Tubal pregnancies: \_\_\_\_\_
- Number of Miscarriages: \_\_\_\_\_ ● Number of Preterm Deliveries: (less than 37 weeks): \_\_\_\_\_
- Any pregnancies with birth defects?  No  Yes Please explain:  
\_\_\_\_\_

### Previous Infertility Testing and Treatment:

Have you had prior infertility testing or treatment elsewhere?  Yes  No

### Previous Infertility Testing:

Length of time currently attempting pregnancy \_\_\_\_\_ Years \_\_\_\_\_ Months  
Length of time not using contraceptives \_\_\_\_\_

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**Prior Testing:**

	Yes	No	Year	Normal	Abnormal
Temperature charts	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Hysterosalpingogram (x-ray of tubes and uterus)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Hysteroscopy (looking inside uterus)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Endometrial biopsy (taking tissue from inside uterus)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Post-coital test (to test sperm in cervical mucus)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Semen Analysis	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Laparoscopy (looking inside the abdomen)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Hormone Tests</b>					
Day 3 FSH _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Day 3 Estradiol	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Clomid Challenge Test	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid tests	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Chromosome tests	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>

**Prior Treatment:**

Ovulation Induction	With Intrauterine Inseminations?	# of cycles	Month/Year	Outcome
Clomiphene citrate (Clomid) Maximum number of tablets per day _____				
Daily fertility Injections Maximum # of vials per day _____ Name of drug used _____				
Other (describe) _____ _____				

**Prior IVF Cycles (Please include frozen embryo transfers and cancelled cycles):**

DATES	Medications Used and Total Dose (IU)	Peak Estradiol	# Oocytes Obtained	# Mature Oocytes	# Fertilized (2 PN)	ICSI? Yes or No	# Embryos Transferred	Embryo Grades	Outcome (Biochemical, Miscarriage, Delivery)
1.									
2.									
3.									
4.									

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### Past Medical History

Do you have any medical problems?  No  Yes (please list type, dates and treatment)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

### Surgical History

Have you had any surgeries?  No  Yes (Please list in chronological order)

Year	Reason and Type of Surgery
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Did you have any anesthesia problems?  No  Yes

### Review of Systems

**General:**

- Weight loss or gain
- Anorexia/ Bulimia
- Lack of energy
- Fever/ Chills

**Skin/Extremities:**

- Acne
- Skin cancer
- Burn injuries
- Excess hair growth

**Head/Eyes/Ears/Nose/Throat:**

- Dizziness
- Headaches
- Blurred vision
- Hearing loss
- Loss of sense of smell
- Chronic nasal congestion
- Ringing ears

**Respiratory:**

- Shortness of breath
- Asthma
- Pneumonia
- Bloody cough

**Breast:**

- Discharge (clear, bloody or milky?)
- Lumps  Pain  Cancer
- Abnormal mammogram
- Reduction
- Augmentation (saline or silicone)

**Cardiovascular:**

- Palpitations
- Chest pain
- Stroke
- High blood pressure
- Mitral valve prolapse

**Gastrointestinal:**

- Nausea/vomiting
- Hepatitis
- Blood in your stools
- Diarrhea/ constipation
- Irritable bowel syndrome
- Ulcers

**Genito/Urinary:**

- Bladder infections
- Kidney infections
- Vaginal infections
- Frequent urination
- Blood in urine

**Musculoskeletal:**

- Unusual muscle weakness
- Rheumatoid arthritis
- Lupus erythematosus
- Myasthenia gravis

**Neurological:**

- Weakness
- Seizures
- Headaches
- Numbness
- Memory loss

**Psychiatric:**

- Depression
- Anxiety disorder

**Endocrine/Hormonal:**

- Diabetes
- Thyroid gland problems
- Rapid weight gain or loss
- Excessive hunger/thirst
- Temperature intolerance
- Hair loss

**Hematologic:**

- Blood clotting disorder
- Sickle cell anemia
- Easy bruising
- Swollen glands/lymph nodes

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### Occupation/Habits/Leisure History

		Dates/Comments
Exposed to chemical or x-rays in work or hobby	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
<b>Please list</b>		<b>Amount per day or week</b>
Caffeine	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Smoking	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Alcohol	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Marijuana	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Nutritional supplements, herbs, etc.	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Drugs	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____

Please describe recreation/sports activities (frequency, length of time, etc.) \_\_\_\_\_

### Family History

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Breast cancer        | <input type="checkbox"/> Endometriosis           | <input type="checkbox"/> Neimann-Pick disease      | <input type="checkbox"/> Heart defect from birth    |
| <input type="checkbox"/> Ovarian cancer       | <input type="checkbox"/> Infertility             | <input type="checkbox"/> Fanconi anemia            | <input type="checkbox"/> Down syndrome              |
| <input type="checkbox"/> Colon cancer         | <input type="checkbox"/> Menopause before age 40 | <input type="checkbox"/> Familia Dysautonia        | <input type="checkbox"/> Other chromosomal problems |
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Birth defects           | <input type="checkbox"/> Neurologic (brain/spine)  | <input type="checkbox"/> Marfan syndrome            |
| <input type="checkbox"/> Thyroid problems     | <input type="checkbox"/> Cystic fibrosis         | <input type="checkbox"/> Neural tube defect        | <input type="checkbox"/> Hemophilia                 |
| <input type="checkbox"/> Heart disease        | <input type="checkbox"/> Tay-Sachs disease       | <input type="checkbox"/> Bone/skeletal defects     | <input type="checkbox"/> Sickle cell anemia         |
| <input type="checkbox"/> Blood clots          | <input type="checkbox"/> Canavan disease         | <input type="checkbox"/> Dwarfism                  | <input type="checkbox"/> Thalassemia                |
| <input type="checkbox"/> Obesity              | <input type="checkbox"/> Bloom syndrome          | <input type="checkbox"/> Developmental delay       | <input type="checkbox"/> Galactosemia               |
| <input type="checkbox"/> Psychiatric problems | <input type="checkbox"/> Gaucher disease         | <input type="checkbox"/> Learning problems         | <input type="checkbox"/> Deafness/Blindness         |
| <input type="checkbox"/> Tuberculosis         | <input type="checkbox"/> Hemochromatosis         | <input type="checkbox"/> Polycystic kidney disease | <input type="checkbox"/> Color blindness            |

#### What is Your Ancestry?

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> African American  | <input type="checkbox"/> American Indian    | <input type="checkbox"/> Ashkenazi         |
| <input type="checkbox"/> Asian American    | <input type="checkbox"/> Cajun/French       | <input type="checkbox"/> Caucasian         |
| <input type="checkbox"/> Eastern European  | <input type="checkbox"/> Hispanic/Caribbean | <input type="checkbox"/> Northern European |
| <input type="checkbox"/> Southern European | <input type="checkbox"/> Other Specify      |  |