

Patient's Name: _____ Date: _____

Female History:

Family History: Has anyone in your immediate family (mother, father, siblings) had (who and what kind):

Cancer _____	Heart Disease _____
High Blood Pressure _____	Diabetes (on insulin) _____
Breast Disease _____	Infertility/miscarriages _____
Birth Defect _____	Alcoholism _____

Have you ever experienced any of the following? (Please give detailed information on when, what was done, and whether this condition still exists. Use other side if necessary):

Headaches _____	Breast discharge _____
Chronic cough _____	Asthma _____
Breast pain/lumps _____	Shortness of breath _____
Thyroid Disease _____	Depression _____
Migraines _____	Abnormal hair growth _____
Constipation/diarrhea _____	Cancer _____
Surgeries _____	Pelvic pain _____
Anemia _____	Diabetes _____
Elevated Cholesterol _____	Blurred vision _____
Hemorrhoids _____	Urinary tract infections _____
Back Pain _____	Heart Disease _____
Gallbladder Disease _____	High Blood Pressure _____
Liver Problems _____	Kidney Disease _____
Anxiety _____	Drug Abuse _____
Other _____	

Have you ever had any abnormal lab test results? _____

Have you had any other serious medical illness not listed? _____

Height _____ Weight _____

Has your weight changed in the past year? _____ Increase or decrease? _____

Female's Reproductive History: List all pregnancies, specifying under outcome whether liveborn, stillborn, ectopic, miscarriage or abortion.

Pregnancy #	Outcome	Preg. Length (months)	Mo./Yr. Preg. Ended	Father (check one) Present / Previous
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

Patient's Name: _____ Date: _____

Menstrual History

How old were you when your period began? _____ Are you regular? _____

What is the usual interval between the start of one period and the start of the next? _____

How many days do they last? _____

Do you bleed between them? _____ Do you ever pass clots? _____

Every cycle? _____ Cramps? _____ Every cycle? _____

When do your cramps occur in relation to your period? _____

When was your last period? _____ Can you tell when you ovulate? _____

Do you ever feel moody, depressed or bloated before your period? _____

Have you ever had any abdominal or pelvic infections? An infection of your tubes or ovaries? _____

How often do you have intercourse? _____ Do you use lubricants? _____

If so, what kind of lubricant? _____ Do you douche? _____

Is intercourse painful? _____ Describe the pain (deep, external, beginning, during, after)

When was your last Pap smear? _____ Have you ever had an abnormal Pap smear? _____

Have you ever had a mammogram? _____ When was your last one? _____
(X-ray of your breast)

List any surgical procedures you have had:

<u>Date</u>	<u>Procedure</u>	<u>Hospital</u>	<u>City</u>	<u>Surgeon</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Have you ever had a blood transfusion? _____ If so, when: _____

Do you smoke? _____ Number of cigarettes per day _____

How many alcoholic beverages do you drink in one week? _____

Do you use any recreational drugs (marijuana, cocaine)? _____

Male Reproductive History: List all pregnancies, specifying under outcome whether liveborn, stillborn, ectopic, miscarriage or abortion.

<u>Pregnancy #</u>	<u>Outcome</u>	<u>Preg. Length</u> <small>(months)</small>	<u>Mo./Yr. Preg.</u> <small>Ended</small>	<u>Mother (check one)</u> <small>Present / Previous</small>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

Patient's Name: _____ Date: _____

Male's History:

Have you ever had any serious medical illnesses? _____

Surgeries? _____

Have you ever had an infection of your genital organs? (Please detail) _____

At what age did you start to shave? _____

Do you smoke? _____ Number of cigarettes per day _____

How many alcoholic beverages do you drink in one week? _____

Do you use any recreational drugs (marijuana, cocaine)? _____

Are you taking any medications? _____ Please list: _____

Do you have any problems with erection and or ejaculation? _____

Are there any birth defects in your family? _____

Have you been exposed to pesticides or toxic substances in your work? _____

(Please detail) _____

Infertility Evaluation:

Female: Have you ever had any of the following tests? (Please detail when and results)

1. Keep Basal Body Temperature (BBT) Charts? _____
2. Used ovulation (LH) detection kits or monitors? _____
3. Had an x-ray of your uterus and fallopian tubes (Hysterosalpingogram – HSG) or a “fluid” ultrasound of the uterus? _____
4. A Post Coital Tests? _____
5. An endometrial Biopsy? _____
6. Antisperm antibody testing? _____
7. Infertility or reproductive surgery? _____
8. Any hormonal evaluation? _____

Male: Have you ever had any of the following tests? (Please detail when and results)

1. A sperm count (semen analysis)? _____
2. Antisperm antibody testing? _____
3. Urologic Evaluation? _____
4. Any other information that could be helpful? _____