

# REPRODUCTIVE HEALTH CENTER

## Female Patient History

Date:

### I. Identifying Information

Name	Partner's Name
Address	
Telephone	Home
	Mobile
	Work
Date of Birth	Partner's Date of Birth
Duration of Relationship	Duration of Infertility
Nature of present employment (title, brief description)	
Insurance Company	
Insurance ID	Group #
Responsible Party	

### II. Medical History

Weight                                  Height                                  Blood Type (if known)

Have you lost greater than 20 pounds in the last year?

Do you follow a particular food plan or have any special dietary habits?

If **yes**, specify:

List the forms and frequency of regular vigorous exercise (cycling, running, swimming, etc.) and age at which you began the activity:

Activity	Hours per week	Age
----------	----------------	-----

Have you ever had surgery?

If **yes**, specify date and type:

Have you ever been treated for cancer?

If **yes**, explain therapy:

Have you ever received X-rays to the pelvic area for therapy or diagnosis?

If **yes**, specify:

Within the last year have you taken any prescription medications?

If **yes**, list all prescriptions and problems for which you were taking them.

*Ex. lisinopril – high blood pressure*

Are you taking any over-the-counter medications on a regular basis?

*Ex. Low dose aspirin – high blood pressure*

Anemia	Epilepsy	Endometriosis	Nongonococcal Urethritis
Anorexia		Gallbladder Problems	Ovarian Cysts
Appendicitis		Gonorrhea	Pelvic Infection
Arthritis		Heart Disease	Pneumonia
Bladder Infections		Hepatitis	Poor Sense of Smell
Blood Transfusions		Type?	Problems with Skin
Breast Milky Discharge		Herpes	Pigmentation
Breast Soreness		Hirsutism	Rheumatic Fever
Breast Tenderness		Excess hair growth	Scarlet Fever
Cancer		High Blood Pressure	Seizures
Specify:		Immunizations	Spastic Colon
Chest Pain		for German Measles	Syphilis
Chlamydia		Kidney Infection	Thyroid Problems
Chronic Bronchitis		Liver Problems	Type?
Chronic Headaches		Loss of Balance	Tuberculosis
Colitis		Lupus	Vaginitis: Trichomoniasis/Yeast,
Color Blind		Measles, German	# of Episodes?
Diabetes		Measles, Regular	Visual Disturbances
Dizziness		Neurological Problems	Vitiligo

Allergies *list any allergies:*

Do you or have you have you ever used (*check all that apply*)

Alcohol

About how many ounces per week?

Cigarettes

Number of packs per day?

Recreational Drugs (*marijuana, cocaine, etc.*)

### III. Menstrual and Pregnancy History

Age at first period?

Date of last period?

Are your periods regular?

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:

Are cramps present before, during or after your period?

Cramps are

Do you have to take pain medication for cramps?

If yes, specify medication:

Do you bleed or spot between periods?

How many pregnancies (including abortions) have you had?

When?	Outcome?	Infertility treatment?	How long to conceive?	Is current partner the father?
-------	----------	------------------------	-----------------------	--------------------------------

1

2

3

4

5

6

7

Were there any complications during or after your pregnancies?

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 forms of contraception do you use now or have you used in the past?

Pills

IUD

Other

For each contraceptive method use, 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 brand?

Do you douche before or after intercourse?

#### V. History of Fertility Therapy (if applicable)

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.*

hMG

Estrogens

Progesterone

Prednisone (or cortisone like drugs)

Antibiotics

GnRH or LHRH (Factrel)

Clomiphene citrate (Clomid)	hCG (Ovidrel.)
Bromocriptine (Parlodel)	Letrozole (femara)
Follistim/Gonal-F or FSH	Other, specify:

Which of the following tests have you had performed:

	<b>When</b>	<b>Results</b>
BBT		
Postcoital Test		
Hormonal Assays (AMH, FSH, LH, prolactin, estrogen, DHEA, testosterone, progesterone)		
Endometrial Biopsy		
Hysterosalpingogram (HSG)		
Ultrasound		
Antibodies		
Laparoscopy/Hysteroscopy		
Mycoplasma/Chlamydia/ Gonococcus cultures		
Prolactin		
Thyroid Tests		
Other, specify:		

**VI. Family History**

	Age(s)	Health Problems	Age at Menopause*	N/A
Mother*				
Father				
Sister(s)*				
Brother(s)				

Check all of the following disorders for which you have a family history. Next to each item state which blood relative (mother, father, sister, brother, maternal/paternal grandmother, maternal/paternal grandfather, maternal/paternal aunt or maternal/paternal uncle, cousin) had the disorder.

<b>Disorder</b>	<b>Blood Relative(s)</b>
Cancer	
Thyroid Problems (including goiter)	
Hypertension (high blood pressure)	
Hirsutism (excessive hair growth)	
Diabetes	
Kidney Disease	

Tuberculosis (TB)  
Heart Disease  
Obesity  
Neurologic (nerve) Disorders  
Others, specify:

Are there any genetic disorders in your family?

If yes, specify:

## VII. Review of Symptoms

Check all of the following disorders that you currently have or have experienced in the past. Please explain as completely as possible, including when you have had symptoms or are currently experiencing symptoms.

### Central Nervous System

Seizures  
Migraine headaches  
Other:

Comments

### Eyes, Ears, Nose and Throat

Wear contact lenses  
Eye disorders  
Problem with sense of smell  
Other:

Comments

### Skin

Rash  
Vitiligo  
Problems with skin  
pigmentation  
Acne  
Other:

Comments

### Cardiovascular

Chest pain  
Palpitations  
Diagnosed with rheumatic fever

Comments

Heart valve disease  
High blood pressure  
Mitral valve prolapse  
Given prophylactic antibiotics  
before dental work or surgery  
Other:

**Respiratory**

Shortness of breath  
Asthma (date of last attack)  
Bronchitis  
Pneumonia  
Blood in sputum  
Other:

**Comments**

**Gastrointestinal**

Nausea/vomiting  
Blood in stool  
Ulcers  
Hepatitis  
Constipation/spastic colon  
Poor appetite/anorexia  
Celiac disease  
Other:

**Comments**

**Genitourinary**

Bladder infections (cystitis)  
Kidney infection  
Gonorrhea/Syphilis/Herpes  
Vaginal infections  
Pelvic inflammatory disease  
(PID)  
Pelvic pain  
Other:

**Comments**

**Musculoskeletal****Comments**

Unusual muscle weakness  
Decreased energy/stamina  
Rheumatoid arthritis  
Lupus erythematosus (SLE)  
Other:

**Hematologic****Comments**

Blood clotting disorder  
Sickle cell anemia or trait  
Other:

**Endocrine****Comments**

Diabetes  
Hypoglycemia  
Thyroid disease  
Hirsutism (excessive hair growth  
on various parts of the body)  
Rapid weight gain  
Rapid weight loss  
Other:

Do you have any sexual problems that you would like to discuss?

Have you been screened for immunity to rubella (German measles)?

Have you been vaccinated against hepatitis B?

**ARE YOU ALLERGIC TO ANY MEDICATION?**

If **yes**, please list medications to which you are allergic and describe the reaction you have to each.

*Example: Benadryl*

*Hives*



**If you are currently trying to become pregnant, please answer the following questions:**

Do you and your partner have cats as pets, take care of cats, or consume raw meat in your diet?

Are you or your partner a health care worker, school teacher, or day care worker?

If you or your partner is of Jewish or French Canadian extraction have you been screened for Tay-Sachs disease?

If you or your partner is of African ancestry have you been screened for sickle cell trait?

If you or your partner is of Indian, Spanish, Italian, Greek, Southeast Asian, African, or Chinese ancestry, have you been screened for thalassemia?