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

	When	Results
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.

Disorder		Blood Relative(s)
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		**Comments**
Seizures	___	
Migraine headaches	___	
Other:	___	_____

Eyes, Ears, Nose and Throat		**Comments**
Wear contact lenses	___	
Eye disorders	___	
Problem with sense of smell	___	
Other:	___	_____

Skin		**Comments**
Rash	___	
Vitiligo	___	
Problems with skin pigmentation	___	
Acne	___	
Other:	___	_____

Cardiovascular		**Comments**
Chest pain	___	
Palpitations	___	
Diagnosed with rheumatic fever	___	_____

Heart valve disease ___

High blood pressure ___

Mitral valve prolapse ___

Given prophylactic antibiotics before dental work or surgery ___

Other: ___

Respiratory **Comments**

Shortness of breath ___

Asthma (date of last attack) ___

Bronchitis ___

Pneumonia ___

Blood in sputum ___

Other: ___

Gastrointestinal **Comments**

Nausea/vomiting ___

Blood in stool ___

Ulcers ___

Hepatitis ___

Constipation/spastic colon ___

Poor appetite/anorexia ___

Celiac disease ___

Other: ___

Genitourinary **Comments**

Bladder infections (cystitis) ___

Kidney infection ___

Gonorrhea/Syphilis/Herpes ___

Vaginal infections ___

Pelvic inflammatory disease (PID) ___

Pelvic pain ___

Other: ___

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? _____