



FEMALE PATIENT HISTORY

Name \_\_\_\_\_ Partner's Name \_\_\_\_\_ Date \_\_\_\_\_

Age \_\_\_\_\_ Birth date \_\_\_\_\_ Partner's Age \_\_\_\_\_ Birth date \_\_\_\_\_

What is your primary problem today? \_\_\_\_\_

Who is your primary care physician? \_\_\_\_\_ Who sent you to us? \_\_\_\_\_

MEDICAL HISTORY

Weight \_\_\_\_\_ Height \_\_\_\_\_ Blood Type \_\_\_\_\_ Any recent changes in your weight? \_\_\_\_\_

Are you or have you ever been exposed to environmental toxins in the past?:

Heat Toxic Fumes Chemicals Nuclear Radiation Other Specify:

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

- Anemia, Anesthesia reaction, Appendicitis, Arthritis, Asthma, Bladder Infections, Blood Clot, Blood Transfusions, Breast Lump, Breast Milky Discharge, Breast Soreness, Breast Tenderness, Cancer (Specify), Chronic Bronchitis, Chronic Headaches, Colitis, Color Blindness, Depression, Diabetes, Dizziness, Epilepsy, False teeth, Gallbladder Problems, Heart Disease, Heart murmur, Hepatitis, Hirsutism (Excess Hair), High Blood Pressure, Immunizations: German Measles, Hepatitis, Influenza, Kidney Disease, Liver Problems, Loss of Balance, Low Blood Pressure, Measles: German, Measles: (Age?), Mental Problems, Migraine, Mitral Valve Prolapse, Neurological Problems, Parasitic Infection, Pneumonia, Poor Sense of Smell, Rheumatic Fever, Scarlet Fever, Seizures, Serious Injury, Syphilis, Thyroid Problems, Tuberculosis, Ulcers, Visual Disturbances, Weight Loss, Weight Gain

Any Allergies: List \_\_\_\_\_

- Have you ever had surgery? Yes No
Have you ever been hospitalized? Yes No
Are you currently taking prescription medications? Yes No
Are you currently taking over-the-counter medications? Yes No
Are you currently using any vitamin or herbal therapies? Yes No

GYNECOLOGIC HISTORY

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

- Abnormal Pap Smear (Dysplasia), Adhesions (scar tissue), Blocked tubes, Chlamydia, Endometriosis, Ectopic Pregnancy, Fibroids, Gonorrhea, Herpes, HIV (AIDS virus), Mycoplasma, Nongonococcal Urethritis (NGU), Ovarian Cysts, Pelvic Infection (PID), Polyps, Syphilis, Tipped (retroverted) Uterus, Trichomonas, Ureaplasma, Vaginitis, Vaginal ulcers, Yeast



**CONTRACEPTIVE HISTORY**

What form of contraception do you use now or have you used in the past? Circle all that apply and specify durations:

Pills      IUD      Diaphragm      Foams/Jellies      Condom      Rhythm      None      Other:

**SEXUAL HISTORY**

How many times do you and your partner have sex? \_\_\_\_\_

How often do you have sex around ovulation? \_\_\_\_\_

How many months have you been trying to conceive? \_\_\_\_\_

Is sex painful or difficult for you? Always    Never    Sometimes \_\_\_\_\_

Does your partner have any difficulty with sex? \_\_\_\_\_

Do you have any other problems with sex?      Yes      No \_\_\_\_\_

Do you use lubricants for intercourse? Yes    No    Specify \_\_\_\_\_

**FAMILY HISTORY**

Number of brothers \_\_\_\_\_ sisters \_\_\_\_\_ Is there a family history of infertility?      Yes      No

Explain: \_\_\_\_\_

**HISTORY OF FERTILITY EVALUATION AND THERAPY**

Which of the following tests have you had performed? Check all that apply and the results if known:

Test	Date	Results	Test	Date	Results
FSH/Estradiol			Hysterosalpingogram		
Progesterone			Ultrasound		
Prolactin			Laparoscopy		
Thyroid Tests			Hysteroscopy		
LH			Semen Analysis		

**Please obtain copies of these test results from your physician.**

What treatments have you tried for infertility? If yes Specify:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_