

FEMALE HISTORY

Height: _____

Weight: _____

Have you been treated for infertility before: ___ No ___ Yes Name of Physician: _____

How long have you been having intercourse without any form of birth control? _____ months/years

INFERTILITY DIAGNOSIS (check all that apply)

- ___ Male Infertility
- ___ History of Endometriosis
- ___ Ovulation Disorders (PCO)
- ___ Diminished Ovarian Reserve
- TUBAL Sterilization Date: ___/___/___
- ___ Tubal Ligation (not reversed)
- ___ Hydrosalpinx (in place)
- ___ Other tubal disease (no hydrosalpinx)
- Date Tubes Untied: ___/___/___
- ___ Uterine
- ___ Other
- ___ Unexplained

MENSTRUAL HISTORY

Age at first period: _____ Number of days between start of period to start of next period: _____

days bleeding: _____ How many periods do you have a year: _____

Date of 1st day of your last 2 menstrual periods: ___/___/20___ ; ___/___/20___

MENSTRUAL PATTERN (check all that apply)

- ___ Regular periods
- ___ Irregular periods
- ___ Heavy periods
- ___ Light periods
- ___ No periods
- ___ Bleeding between periods
- ___ Spotting between periods
- ___ Breast tenderness
- ___ Bloating
- ___ Do you need medication to bring on a period? ___ Yes ___ No
- ___ Fatigue
- ___ Personality/Mood Changes
- ___ Headaches
- What medication: _____

Do you have cramping or pelvic pain with your periods? ___ Never ___ Sometimes ___ Always ___ Recently ___ In the past

Are cramps present ___ Before ___ During ___ After your period. Cramps are: ___ Mild ___ Moderate ___ Severe

What pain medication do you take for cramps: _____

When was your last pap smear: ___/___/___ ___ Normal ___ Abnormal Physician: _____

When was the abnormal pap smear: ___/___/___ ___ Not applicable

Have you undergone any procedures as a result of an abnormal pap smear? ___ No ___ Yes (check all that apply)

- ___ Coloscopy
- ___ Laser Treatment
- ___ Cryosurgery (Freezing)
- ___ Conization
- ___ LEEP Procedure

Have you ever had a mammogram? ___ Yes ___ No Date of last exam: ___/___/___

___ Normal ___ Abnormal

PREGNANCY HISTORY

Total # of ALL Pregnancies	# Full Term Births (>37 weeks)	# Pre-Term Births (<37 weeks)	# Stillborn	# Miscarriages (>20 weeks)	# Elective Termination (abortion)	# Ectopic or Tubal Pregnancies	Date of Last Pregnancy	# Pregnancies w/ current partner

CONTRACEPTION HISTORY

- ___ None
- ___ Condoms Dates of use: _____
- ___ Diaphragm Dates of use: _____
- ___ IUD Dates of use: _____
- ___ Injectable Dates of use: _____ Complications? _____
- ___ Skin Patch Dates of use: _____ Complications? _____
- ___ Foam or Jelly Dates of use: _____ Complications? _____
- ___ Oral Contraceptive Dates of use: _____ Complications? _____
- Brand: _____

MEDICAL HISTORY

Do you have any medical problem(s)? No Yes (list dates and treatments)

Type: _____ Date: ____/____/____ Treatment: _____

Type: _____ Date: ____/____/____ Treatment: _____

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

- | | | |
|---|--|--|
| <input type="checkbox"/> Blood Transfusions (date ____/____/____) | <input type="checkbox"/> Pelvic Infection | <input type="checkbox"/> Ovarian cysts |
| <input type="checkbox"/> Hepatitis (date ____/____/____) | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Herpes (date ____/____/____) | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Infection |
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Chickenpox (date ____/____/____) | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Problems |
| <input type="checkbox"/> Chlamydia (date ____/____/____) | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Genital Warts/HPV |
| <input type="checkbox"/> Syphilis (date ____/____/____) | <input type="checkbox"/> Neurological Problems | <input type="checkbox"/> TB |
| <input type="checkbox"/> Measles/Rubella (date ____/____/____) | <input type="checkbox"/> Vaginitis (Trichomoniasis/yeast infections) | |
| <input type="checkbox"/> Gonorrhea (date ____/____/____) | <input type="checkbox"/> Other: _____ | |

Have you ever been treated for Cancer? No Yes - explain therapy _____

Are you allergic to any MEDICATIONS? No Yes - list all and describe reaction:

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Are you allergic to any FOODS? No Yes - list all and describe reaction:

Food: _____ Reaction: _____

Food: _____ Reaction: _____

Within the last year, have you taken any PRESCRIPTION MEDICATIONS? No Yes - list all:

Prescription: _____ For: _____

Prescription: _____ For: _____

Are you taking any OVER-THE-COUNTER MEDICATION? No Yes - list all:

Medication: _____ For: _____

Medication: _____ For: _____

Do you take any HERBAL MEDICINES/VITAMINS or health food supplements? No Yes - list all:

Medication: _____ For: _____

Medication: _____ For: _____

SOCIAL HISTORY

How many caffeinated beverages (coffee, tea, soda) do you drink a day? _____ None

Do you smoke cigarettes? No Yes How many/day: _____ How many years: _____

Age started: _____ Quitting? _____

Do you drink alcohol? No Yes #Beer/week _____ #Wine per week _____ #Liquor/week _____

Do you use marijuana, cocaine or other simular drugs? No Yes - describe _____

Do you exercise? No Yes Type: _____ Freq hrs/week: _____

