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?