NORTH HOUSTON CENTER FOR REPRODUCTIVE MEDICINE

FEMALE PATIENT HISTORY

I. IDENTIFYING INFORMATION **Date**____________________

Name____Partner's Name____

Address____

Telephone: Home_______________________________Work________________________________Cell_______________________________

Date of Birth_________________Partner's Date of Birth________________Duration of Relationship___________Duration of Infertility_________

Nature of present employment (Title, brief description)____

II. MEDICAL HISTORY

Weight__________Height__________Blood type (if known)____ YES NO

Have you lost greater than 20 pounds of weight in the last year?…………………………………………………………………………… ☐ ☐

Do you follow a particular food diet or have any special dietary habits?……………………………………………………………… ☐ ☐

If yes, specify:____

List the form and frequency of regular vigorous exercise (swimming, cycling, running) and age you began:

Exercise:_______________Hrs/Week__________Age__________ Exercise: _______________Hrs/Week__________Age_________ _

Have you ever had pelvic surgery? ……… ☐ ☐

If yes, specify date and type: ____

____

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

- ☐ Anemia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Blood Transfusion
- ☐ Breast Milky Discharge
- ☐ Cancer? Specify_______________ _____________________________
- ☐ Chlamydia
- ☐ Diabetes
- ☐ Endometriosis
- ☐ Epilepsy
- ☐ Gonorrhea
- ☐ Heart Disease
- ☐ Any medication Allergies? List: ____
- ☐ Other Diagnoses: ____
- ☐ Hepatitis
- ☐ Herpes
- ☐ Hirsutism (Excess Hair Growth)
- ☐ High Blood Pressure
- ☐ Liver Problems
- ☐ Neurological Problems
- ☐ Ovarian Cysts
- ☐ Pelvic Infection
- ☐ Syphilis
- ☐ Thyroid Problems
- ☐ Ulcers

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

If yes, specify: ____

List all current medications, both prescription and non prescription____

____

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

- ☐ Alcohol – How many servings per week do you usually drink? ____
- ☐ Cigarettes – Number of packs per day _______________ Number of years ____________________________________
- ☐ Marijuana, Cocaine, etc. ____

III. MENSTRUAL AND PREGNANCY HISTORY

Age at first period?________________ When did your last period begin? ____ **YES** **NO**

Are your periods regular?…….. ☐ ☐

What is the usual number of days between periods?____

What is the usual duration of your period? ____

Are cramps: ☐ Mild ☐ Moderate ☐ Severe ☐ Absent

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? (Year)	End in Abortion?	End in Miscarriage?	Ectopic Pregnancy?	Infertility Therapy Required to Conceive	How Long to Conceive?	Baby Born Alive?	Is Current Partner Father?
1st Pregnancy								
2nd Pregnancy								
3rd Pregnancy								
4th Pregnancy								
5th Pregnancy								

Were there any complications during or after your pregnancies? ………………………………………………………………………. ☐ ☐

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 form of contraception do you use now or have you used in the past? Check all that apply:

☐ Pills Name: ____________________ ☐ IUD Name: ____________________ ☐ Diaphragm ☐ Withdrawal ☐ Condom

☐ Other: ____

When did you discontinue contraception? (Approximate date) ____

Is intercourse painful or difficult for you? ……………………………………………………………………………………………. ☐ ☐

Do you use lubricants for intercourse? ……………………………………………………………………………………………….. ☐ ☐

If yes, which one? ____

V. FAMILY HISTORY

Is there a family history of: (if yes, specify)

☐ Diabetes____ ☐ ☐

☐ Birth Defects____ ☐ ☐

☐ Cancer____ ☐ ☐

☐ Heart Disease / Strokes ____ ☐ ☐

☐ Blood clots or bleeding problems____ ☐ ☐

☐ Hepatitis or liver disease____ ☐ ☐

☐ Infertility____ ☐ ☐

☐ Inherited or genetic diseases____________________ ☐ ☐

VI. HISTORY OF FERTILITY THERAPY

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”

☐ Clomiphene citrate (Serophene®, Clomid®)

☐ hMG or FSH injections

☐ Estrogens

☐ Progesterone

☐ Antibiotics

☐ None

☐ hCG injections

☐ Bromocriptine

☐ Metformin

☐ Lupron

☐ Other – Specify____________________

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

☐ Postcoital Test? When__________Results:____________________

☐ Hormonal Assays ? When__________Results:____________________

(FSH, LH, Prolactin, Estrogen, DHEA-S, testosterone, progesterone)

☐ Hysterosalpingogram? When__________Results:____________________

☐ Laparoscopy? When __________Results: ____________________

☐ Hysteroscopy? When__________Results:____________________

☐ Thyroid Tests ? When__________Results:____________________

Have you ever had surgery for tubal reversal?………… . ☐ ☐

If yes, specify dates____________________

Have you ever had surgery for infertility?………… ☐ ☐

Have you ever had cervical conization, cryo or leep?………… ☐ ☐

Have you ever had any other surgery? ………… ☐ ☐

If yes, please specify:____________________

Have you ever undergone artificial insemination or in vitro fertilization?………… ☐ ☐

If yes, using partner or donor sperm?____________________

Is your partner seeing a doctor evaluation of infertility? ………… ☐ ☐

If yes, specify physician name and location:____________________

Has he ever fathered a child with another woman?………… ☐ ☐

If yes, when? ____________________