

FEMALE PATIENT HISTORY

- I. IDENTIFYING INFORMATION Date _____
 Name _____ Age _____ Birthday _____
 Reason for visit _____
 Language Preference: _____
 Allergy to medications? YES NO
 If YES, please specify name and reaction _____
- II. HISTORY OF FERTILITY THERAPY Duration of fertility problem _____
 Have you or your partner been treated for infertility? YES NO IVF? YES NO
 Hysterosalpingogram Endometrial Biopsy Artificial insemination Fertility meds _____
- III. MENSTRUAL AND PREGNANCY HISTORY
 Age at first period? _____ First day of last period? _____ First day of prior period? _____
 Are your cycles monthly? YES NO Duration of period? _____ Days between cycles? _____
 Do you have pain or cramps with your periods? _____ Mild Moderate Severe
 Do you bleed or spot between periods? YES NO If so, when during your cycle _____
 Last Pap smear? Date _____ Results _____
 Do you have a history of abnormal paps? YES NO If yes, treatment? _____

Please check all boxes that apply

Pregnancy	Year	End In Termination	End in Miscarriage	Ectopic Pregnancy	Infertility Treatment	Duration of pregnancy	Vaginal or C-section	Baby born alive?	Current partner the father?
1 st									
2 nd									
3 rd									
4 th									

Were there any complications during or after your pregnancies? YES NO
 If yes, please specify _____
 Did your mother take diethylstilbestrol (DES) when she was pregnant with you? YES NO

- IV. MEDICAL HISTORY
 Weight _____ Height _____ Blood Type _____
 Current medications _____

Do you have a history of the following? **Also include family (e.g. M=Mother, F=Father) for diseases only**

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Liver/Gall Bladder Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizure/Epilepsy |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Recent Loss of Balance | <input type="checkbox"/> Uterine Fibroids/Abnormality | <input type="checkbox"/> Adrenal problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Recent Abdominal Pain | <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> Weight loss/gain |
| <input type="checkbox"/> Bone Fracture | <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Gyn or other cancer |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Chronic Headaches | <input type="checkbox"/> Recurrent miscarriage | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Breast Milky Discharge/Pain | <input type="checkbox"/> Intestinal Disease | <input type="checkbox"/> Recent change with urinating or moving bowels | <input type="checkbox"/> Vaginal Dryness |
| <input type="checkbox"/> Heat or Cold Intolerance | <input type="checkbox"/> Congenital/Genetic disorders | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Excess Fatigue | <input type="checkbox"/> Visual Disturbances |
| <input type="checkbox"/> Herpes/Chlamydia | <input type="checkbox"/> Polycystic Ovary Syndrome | <input type="checkbox"/> Gonorrhea/Syphilis | <input type="checkbox"/> Unexplained fever |
| <input type="checkbox"/> Excess facial/body hair | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease/Stroke | <input type="checkbox"/> Recent Chest Pain or shortness of breath |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Dizziness/Light headed | <input type="checkbox"/> New skin marks | |
| <input type="checkbox"/> Bacterial Vaginosis | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Hepatitis | |
| <input type="checkbox"/> Recent Muscle/Joint Pain | <input type="checkbox"/> Recent Nausea/Vomiting | | |

CONTINUED ON BACK (9/07)

Have you ever had the chicken pox? YES NO
 Do you have allergies to iodine, contrast dye, or shellfish? YES NO
 If YES, please explain the reaction _____
 Do you follow a particular food diet or have any special dietary habits? YES NO
 Have you ever had surgery? If yes, please specify:
 Type of Surgery _____ Year _____
 Type of Surgery _____ Year _____
 Type of Surgery _____ Year _____

V. CONTRACEPTIVE/SEXUAL HISTORY

Have you used the following: PILLS & name _____ IUD & name _____
 Tubal ligation YES NO Do you have pain with intercourse? YES NO
 Do you use lubricants for intercourse? YES NO If YES, please specify type _____
 How many times per week do you and your partner have sexual intercourse? _____ Around ovulation? _____

VI. GENETIC HISTORY

Are you or your partner of the following decent?	Yes(self)	No(self)	Yes(partner)	No(partner)
Eastern European	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
African American	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ashkenzi Jewish, Cajun, or French-Canadian	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Italian, Greek, Mediterranean	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Philippine or Southeast Asian	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Are you a carrier of a genetic disease, (e.g. cystic fibrosis, sickle cell, thalassemia, tay-sachs)? YES NO

VII. SOCIAL HISTORY

Do you drink alcoholic beverages? YES type and number per week _____ NO
 Do you smoke cigarettes (or use other forms of tobacco)? YES packs per day _____ NO
 Do you use other drugs (illicit or recreational)? YES type and amount of usage _____ NO
 Do you exercise on a regular basis: YES type and frequency _____ NO
 Do you have any religious or spiritual beliefs that might interfere or conflict with your medical care? If so, please explain.

- Do you have any impairments: Physical [] Auditory [] Visual []

VIII. **FOR FERTILITY PATIENTS:** Partner Name _____ Age _____ Birthday _____
 Last semen analysis date and results _____
 Previous Surgery _____ Date of genital exam? _____ Result _____
 Medical Problems: _____
 Medications _____ Medication Allergies _____
 Previous Marriage? YES NO Number of Children & Ages _____
 Frequent Sauna or Hot tub: YES NO
 Do you smoke? YES packs per day _____ NO
 Do you drink alcoholic beverages? YES type and number per week _____ NO
 Recreational Drugs? YES type and amount of usage _____ NO
 Problems with erection or ejaculation: YES NO Genital infections or injury: YES NO

IX. AMERICAN COLLEGE OF OB/GYN VIOLENCE SCREEN

The American College of OB/GYN recommends that physicians routinely screen all women for domestic violence, not just patients with suspicious symptoms. Because research shows that abuse may begin or escalate during pregnancy or after delivery, it is important to screen women before pregnancy is achieved. Please answer the following important questions. (Please feel free to share additional information with your physician or nurse)

These three screening questions can save your life:

- Within the past year have you been bit, slapped, kicked, or otherwise physically hurt by someone? YES NO
- Are you in a relationship with a person who threatens or physically hurts you? YES NO
- Has anyone forced you to have sexual activities that made you feel uncomfortable? YES NO

THIS FORM MUST BE SIGNED TO BE COMPLETE

Thank you for your time in completing this form. All the valuable information you supplied will assist us toward helping you. We are committed to providing you the highest quality service and our goal is to work closely with you and include you in your care so we encourage your education and input.

On behalf of the entire staff, Welcome to Fertility C.A.R.E.!

 Patient Signature Date

 Physician's Signature Date