

## REPRODUCTIVE AND MEDICAL HISTORY

**Date filled out:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Date of appt:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
month/day/year month/day/year

**Patient's Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Partner's Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**REFERRING PHYSICIAN or HEALTH CARE PROVIDER:**

**Did someone refer you?**       Yes       No (self-referred)

Last name: \_\_\_\_\_ First name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (    ) \_\_\_\_\_ - \_\_\_\_\_ FAX: (    ) \_\_\_\_\_ - \_\_\_\_\_

**Why are you coming to see us?** \_\_\_\_\_

## FERTILITY

**(Please complete this section if you are being seen for fertility. If being seen for something other than fertility, skip to next section and do not complete the male history)**

How long have you been trying to conceive? \_\_\_\_\_

Time since contraception last used? \_\_\_\_\_

If you previously have been pregnant, how long has it been since the most recent pregnancy? \_\_\_\_\_

Do you have any theories as to why you and your partner have been unable to conceive? \_\_\_\_\_

Have you been infertile (sexually active without contraception) for a year or more with any man other than your current partner?  Yes  No

How Often Do You Have Intercourse (number of times per week) \_\_\_\_\_

**PREVIOUS FERTILITY WORK-UP:**

Have you had any of the following tests performed?

<u>Fertility Test</u>	<u>Yes</u>	<u>No</u>	<u>Date</u>	<u>Result (normal or abnormal)</u>
Day 3 FSH level	<input type="radio"/>	<input type="radio"/>	_____	_____
Post Coital Test	<input type="radio"/>	<input type="radio"/>	_____	_____
Basal Body Temperatures	<input type="radio"/>	<input type="radio"/>	_____	_____
Progesterone Level(s)	<input type="radio"/>	<input type="radio"/>	_____	_____
Hysterosalpingogram (HSG)	<input type="radio"/>	<input type="radio"/>	_____	_____
Sonohysterogram (SHG)	<input type="radio"/>	<input type="radio"/>	_____	_____
Laparoscopy	<input type="radio"/>	<input type="radio"/>	_____	_____
Other Surgery:	<input type="radio"/>	<input type="radio"/>	_____	_____

**PRIOR TREATMENTS:** (check all that apply)

	# of cycles	Dates: (mo./year) to (mo./year)	Pregnant:
<input type="checkbox"/> Intrauterine insemination:		from: ___/___/___ to: ___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Clomiphene citrate with timed intercourse: maximum # tablets per day? _____		from: ___/___/___ to: ___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Clomiphene citrate with insemination: maximum # tablets per day? _____		from: ___/___/___ to: ___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Daily fertility drug injections with insemination: maximum # vials per day? _____		from: ___/___/___ to: ___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Complete in vitro fertilization cycle(s):			
1. #eggs _____ #embryos transferred _____ #frozen _____		from: ___/___/___ to: ___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. #eggs _____ #embryos transferred _____ #frozen _____		from: ___/___/___ to: ___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. #eggs _____ #embryos transferred _____ #frozen _____		from: ___/___/___ to: ___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. #eggs _____ #embryos transferred _____ #frozen _____		from: ___/___/___ to: ___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Frozen embryo transfers:			
1. #embryos transferred _____		from: ___/___/___ to: ___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. #embryos transferred _____		from: ___/___/___ to: ___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. #embryos transferred _____		from: ___/___/___ to: ___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. #embryos transferred _____		from: ___/___/___ to: ___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Canceled in vitro fertilization attempt(s)			

**Additional Information/Complications:** \_\_\_\_\_  
 \_\_\_\_\_

**GYNECOLOGICAL HISTORY**

The first day of your last menstrual period: \_\_\_ / \_\_\_ / \_\_\_

Age when you had your first menstrual period: \_\_\_ years old

**Menstrual cycle pattern** (check all that apply):

- Regular periods                       Irregular periods                       No periods  
 Spotting between periods               Heavy periods                       Light periods

How many days of bleeding do you usually have? \_\_\_ days

How many days from the first day of one period to the first day of the next? \_\_\_ days

Do you need medication to bring on a period?  Yes  No

Do you have severe cramping or pelvic pain with your periods? (check one)

- Always       Sometimes       Recently       In the past       No

Do you experience pain during intercourse?  Yes  No

**Have you ever had these tests?**

Test	Yes	No	Date	Result (normal or abnormal)
Progesterone blood test	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____
Endometrial Biopsy	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____
FSH blood test	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____
Thyroid blood test	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____

Prolactin                            \_\_\_/\_\_\_/\_\_\_                    \_\_\_\_\_  
 Blood glucose                    \_\_\_/\_\_\_/\_\_\_                    \_\_\_\_\_  
 Insulin test                        \_\_\_/\_\_\_/\_\_\_                    \_\_\_\_\_  
 Testosterone                      \_\_\_/\_\_\_/\_\_\_                    \_\_\_\_\_

**Contraceptive History:** Please check if you have ever used.

Birth Control Pill / Patch                     IUD                     Condoms     Tubal Sterilization  
 Depo Provera, Lunelle                     Norplant                     Diaphragm     Other \_\_\_\_\_  
 List number of years each method used: \_\_\_\_\_

**Have you ever had any sexually transmitted diseases?** (please check all that apply)

Chlamydia                     Gonorrhea                     Herpes                     HIV                     Hepatitis  
 Syphilis                     Genital Warts                     Trichomonas                     Pelvic Inflammatory Disease

**Last Pap smear?** \_\_\_/\_\_\_/\_\_\_ Was it normal?  Yes  No Ever had an abnormal pap smear?  Yes  No

**Have you ever had a mammogram?**  Yes  No                    Date: \_\_\_/\_\_\_/\_\_\_

**OBSTETRIC HISTORY:**

List all pregnancies, specifying under outcome whether liveborn, stillborn, ectopic, miscarriage or abortion.

Pregnancy #	Preg. Ended (mo./yr.)	Preg. Length (weeks, months)	Outcome	FATHER ( check one )	
				Present partner	Previous partner

**GENERAL MEDICAL HISTORY**

Please circle any of the following that have been a problem for you during the last 6 months.

<p><b>Condition</b> _____</p> <p>Eye problems</p> <p>Stuffy nose, sinus trouble, hay fever</p> <p>Frequent nosebleeds</p> <p>Anemia</p> <p>Bleeding/bruising from minor injury</p> <p>Headaches</p> <p>Enlarged or painful breasts</p> <p>Discharge from nipples</p> <p>Breast lumps</p> <p>Shortness of breath</p> <p>Fast or irregular heartbeat</p> <p>Hot flashes</p> <p>Excessive face or body hair</p>	<p><b>Condition</b> _____</p> <p>Anxiety</p> <p>Shaking, tremor</p> <p>Dizziness, fainting</p> <p>Fevers, sweats, chills</p> <p>Depression</p> <p>Poor circulation</p> <p>Fatigue</p> <p>Low energy</p> <p>Heart burn, indigestion</p> <p>Gas, cramps, pains</p> <p>Blood in stool or black stool</p> <p>Darker skin areas on your neck, inner thighs or underarms</p> <p>Acne or pimples</p>	<p><b>Condition</b> _____</p> <p>Nausea, vomiting</p> <p>Constipation, diarrhea</p> <p>Hemorrhoids</p> <p>Hernia</p> <p>Gall bladder problems</p> <p>Frequent urination at night</p> <p>Vaginal discharge, itching, or burning</p> <p>Pelvic Pain</p> <p>Sexual problems</p> <p>Excessive thirst</p> <p>Temperature intolerance</p> <p>Hair thinning or loss</p>
--	---	--

**Please describe any positive answers:** \_\_\_\_\_

**Please circle any of the following that apply to you now or in the past:**

<b>Condition</b>	<b>Condition</b>	<b>Condition</b>
Breast disease	Liver disease	Psychiatric illness
High blood pressure	Hepatitis	Endometriosis
Heart disease	Hernia	Ovarian Tumor
Heart murmur	Bladder/kidney disease	Cancer
Mitral valve prolapse	Thyroid problems	Antibiotics during reproductive years
Lung disease	Elevated prolactin	Herpes (oral)
Asthma	Congenital Adrenal Hyperplasia	Tuberculosis
Blood clots	Diabetes	Rubella (German Measles)
Blood transfusions	Neurologic disease	Birth defects
Bleeding disorder	Seizures	Past history of IV drug use

Other:

**Please describe any positive answer:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Please list any major surgeries or hospitalizations in the table below. Include abortions, ectopic pregnancy, tubal surgery or any other surgeries:**

	<b>Mo. / Year</b>	<b>Reason</b>	<b>Location (City, State)</b>
<b>1</b>			
<b>2</b>			
<b>3</b>			
<b>4</b>			
<b>5</b>			

**Please list all medications or treatments you are currently taking:** *(please include any over-the-counter or herbal drug).*

<b>Medication</b>	<b>Dosage</b>	<b>Frequency</b>	<b>Reason</b>

**ALLERGIES:** *(medicines, foods, pollens, other)*  Yes  No

If "yes," please specify: \_\_\_\_\_

## SOCIAL HISTORY

Current Occupation: \_\_\_\_\_

**Have you or do you use any of the following?**

	<b>Never</b>	<b>Not in the last 3 month</b>	<b>Yes</b>	<b>List amount, type and frequency (how often-per day / per week)</b>
Tobacco	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Social drugs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

# FAMILY & GENETIC HISTORY

Are you adopted?    Yes  No      If yes, do you know your biologic family history?    Yes  No

**Ethnic Background:** \_\_\_\_\_

**Ancestry:** Are any of your blood relatives:

Increased Risk For:

- |                                |                           |                          |                                 |
|--------------------------------|---------------------------|--------------------------|---------------------------------|
| Caucasian                      | <input type="radio"/> Yes | <input type="radio"/> No | Cystic Fibrosis                 |
| English, Irish                 | <input type="radio"/> Yes | <input type="radio"/> No | Neural Tube Defects             |
| Mediterranean (Greek, Italian) | <input type="radio"/> Yes | <input type="radio"/> No | Thalassemia                     |
| Ashkenazi Jewish               | <input type="radio"/> Yes | <input type="radio"/> No | Tay Sachs, Canavan              |
| French Canadian                | <input type="radio"/> Yes | <input type="radio"/> No | Tay Sachs                       |
| Southeast Asian                | <input type="radio"/> Yes | <input type="radio"/> No | Thalassemia                     |
| African descent                | <input type="radio"/> Yes | <input type="radio"/> No | Sickle Cell Anemia, Thalassemia |

**Please read the following list of medical problems and indicate by a check which ones any of your blood relatives has had. Please include the age at which the condition appeared:**

MEDICAL PROBLEM	PARENTS		SIBLINGS		GRANDPARENTS				YOUR Children	OTHER Relatives
					MATERNAL		PATERNAL			
	Mother	Father	Sisters	Brothers	GF	GM	GF	GM		
Diabetes										
Cancer (specify)										
Heart Disease										
High Blood Pressure										
High Cholesterol										
Thyroid Disease										
Birth Defect										
Mental Retardation										
Down Syndrome										
Open Spine Defect										
Cystic Fibrosis (CF)										
Sickle Cell Anemia										
Thalassemia										

**Please explain any positive answers:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## REPRODUCTIVE HISTORY - PARTNER

**MALE REPRODUCTIVE HISTORY:**

Have you previously conceived with another woman?       Yes     No  
 Have you been infertile (sexually active without contraception) for a year or more with any woman other than your current partner?  Yes     No  
 Have you ever had a serious overexposure to radiation or toxins (e.g. pesticides, toxic chemicals, poisons, herbicides, plastics, organic chemicals, lead, cadmium, industrial by-products, etc.)?  Yes     No  
 Ever had a serious genital or groin injury?     Yes     No  
 Were you exposed to DES before your birth?       Yes     No       Unsure  
 Have you ever consulted a urologist or male infertility specialist?     Yes     No

If yes, explain: \_\_\_\_\_

**Have you had any of the following tests performed?**

Fertility Test	Yes	No	Date	Result (normal or abnormal)
Semen Analysis	<input type="radio"/>	<input type="radio"/>	___/___/___	_____
Antibody Testing	<input type="radio"/>	<input type="radio"/>	___/___/___	_____
Hormone Blood tests	<input type="radio"/>	<input type="radio"/>	___/___/___	_____

**Please list any major medical problems and/ or surgeries or hospitalizations in the table below. Include vasectomy, vasectomy reversal, varicocele repair, or any other surgeries:**

	Mo. / Year	Reason	Location (City, State)
<b>1</b>			
<b>2</b>			
<b>3</b>			
<b>4</b>			
<b>5</b>			

**Please list all medications or treatments you are currently taking:** *(please include any over-the-counter or herbal drugs)*

Medication	Dosage	Frequency	Reason

**ALLERGIES:** *(medicines, foods, pollens, other)*     Yes     No

If "yes," please specify: \_\_\_\_\_

Current Occupation: \_\_\_\_\_

**Have you or do you use any of the following?**

	Never	Not in the last 3 month	Yes	List amount, type and frequency (how often-per day / per week)
Tobacco	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Social drugs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Hot tub/sauna	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

**FAMILY AND GENETIC HISTORY:**

Are you adopted?  Yes  No      If yes, do you know your biologic family history?  Yes  No

**Ethnic Background:** \_\_\_\_\_

**Ancestry:** Are any of your blood relatives:

Increased Risk For:

- |                                |                           |                          |                                 |
|--------------------------------|---------------------------|--------------------------|---------------------------------|
| Caucasian                      | <input type="radio"/> Yes | <input type="radio"/> No | Cystic Fibrosis                 |
| English, Irish                 | <input type="radio"/> Yes | <input type="radio"/> No | Neural Tube Defects             |
| Mediterranean (Greek, Italian) | <input type="radio"/> Yes | <input type="radio"/> No | Thalassemia                     |
| Ashkenazi Jewish               | <input type="radio"/> Yes | <input type="radio"/> No | Tay Sachs, Canavan              |
| French Canadian                | <input type="radio"/> Yes | <input type="radio"/> No | Tay Sachs                       |
| Southeast Asian                | <input type="radio"/> Yes | <input type="radio"/> No | Thalassemia                     |
| African descent                | <input type="radio"/> Yes | <input type="radio"/> No | Sickle Cell Anemia, Thalassemia |

**Please read the following list of medical problems and indicate by a check which ones any of your blood relatives has had. Please include the age at which the condition appeared:**

MEDICAL PROBLEM	PARENTS		SIBLINGS		GRANDPARENTS				YOUR Children	OTHER Relatives
	Mother	Father	Sisters	Brothers	MATERNAL		PATERNAL			
					GF	GM	GF	GM		
Diabetes										
Cancer (specify)										
Heart Disease										
High Blood Pressure										
High Cholesterol										
Thyroid Disease										
Birth Defect										
Mental Retardation										
Down Syndrome										
Open Spine Defect										
Cystic Fibrosis (CF)										
Sickle Cell Anemia										
Thalassemia										

**Please explain any positive answers:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_