

UC Center for Reproductive Health

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Female Patient History Form

1. IDENTIFYING INFORMATION

Name _____ DOB ____/____/____ Age _____

Significant Other Name _____ DOB ____/____/____ Age _____

Primary Language spoken: English Spanish Other: _____

Date this form completed ____/____/____ Referred by: _____

Primary Ob/Gyn _____ Address _____

Primary Care MD _____ Address _____

How long have you been attempting conception? _____ Number of years married/together _____

Reasons you are coming to see us: _____

What questions do you want answered at this visit? _____

2. PREGNANCY HISTORY

Total number of ALL pregnancies ____ Full term births ____ Premature births (less than 37 weeks) ____

Miscarriages (less than 20 weeks) ____ Elective abortions ____ Ectopic/Tubal Pregnancies ____ Adopted children ____

| Date | Miscarriage? | Elective Abortion? | Ectopic? | Months to conceive? | Infertility Treatment? | Weight and sex? | C-section? | Complications? | Is current partner the father? |
|----------|--------------|--------------------|----------|---------------------|------------------------|-----------------|------------|----------------|--------------------------------|
| 1. _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 2. _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 3. _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 4. _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 5. _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |

3. CONTRACEPTIVE USE

| | Type | From when to when | Reason discontinued |
|----------|-------|-------------------|---------------------|
| 1. _____ | _____ | _____ | _____ |
| 2. _____ | _____ | _____ | _____ |



4. SURGERIES AND HOSPITALIZATIONS

| Date | Reason and type of surgery | Where | Physician |
|----------|----------------------------|-------|-----------|
| 1. _____ | _____ | _____ | _____ |
| 2. _____ | _____ | _____ | _____ |
| 3. _____ | _____ | _____ | _____ |
| 4. _____ | _____ | _____ | _____ |

5. MEDICAL HISTORY

Do you have or have you had?

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney disorder | <input type="checkbox"/> Psychiatric disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Rubella | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Anesthetic complication | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Hepatitis / liver disorder | <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Gall bladder problems | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Bleeding disorder |
| <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Serious injury / accident | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Colitis / enteritis | <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Recent immunization |
| <input type="checkbox"/> Heart murmur | | | |

Any medical problem not listed above (please list type, dates, treatments)

- _____
- _____
- _____
- _____

List all prescriptions and over-the-counter drugs used during the past year

| Date | Dose and frequency | From when to when | Reason |
|----------|--------------------|-------------------|--------|
| 1. _____ | _____ | _____ | _____ |
| 2. _____ | _____ | _____ | _____ |
| 3. _____ | _____ | _____ | _____ |
| 4. _____ | _____ | _____ | _____ |

6. ALLERGIES

| Drug or substance | Reaction |
|-------------------|----------|
| 1. _____ | _____ |
| 2. _____ | _____ |

7. MENSTRUAL/HORMONAL

Menstrual cycle pattern (check all that apply):

| | | | |
|--|--|---|-------------------------------------|
| <input type="checkbox"/> Regular periods | <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Spotting before periods | <input type="checkbox"/> No periods |
| <input type="checkbox"/> Heavy periods | <input type="checkbox"/> Light periods | <input type="checkbox"/> Bleeding between periods | |

Age at first period First day of last two menstrual periods ____/____/____ and ____/____/____

How many days from start of one period to start of the next period? How many days of bleeding do you have?days

Pelvic pain/cramps: none during period before period after period at mid cycle

during intercourse with bowel movements with urination cause you to miss work cause you to miss usual activities

Pelvic pain/cramps are: mild moderate severe

worsening improving no change in midline on right side on left side

Do you have or have you had? (Check all that apply)

- Hot flashes Increased facial or body hair Breast discharge Increased acne

Please explain a "Yes" answer: _____

8. GYNECOLOGIC / INFECTION

Last pap smear ____/____/____ Last mammogram ____/____/____

Do you have or have you had?

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Pelvic infection | <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Ovarian cysts |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Colitis or enteritis | <input type="checkbox"/> Syphilis | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Uterine fibroids or myomas | <input type="checkbox"/> Mycoplasma | <input type="checkbox"/> Cytomegalovirus (CMV) |
| <input type="checkbox"/> Pelvic adhesions | <input type="checkbox"/> Abnormal shape of uterus | <input type="checkbox"/> Ureaplasma | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Cervicitis | <input type="checkbox"/> Recurrent vaginitis | <input type="checkbox"/> Genital warts / condyloma | <input type="checkbox"/> Trichomonas |
| <input type="checkbox"/> Genital herpes | <input type="checkbox"/> Abnormal Pap smears | <input type="checkbox"/> Cryo (freezing) or surgery of the cervix | <input type="checkbox"/> Other _____ |

9. SEXUAL HISTORY

- Are you sexually active? Yes No
- How many times do you have intercourse per week? _____
- Do you have pain with intercourse? Yes No
- Is your partner Male Female
- Have you used over the counter ovulation kits to time intercourse? Yes No
- Do you use lubricants during intercourse? Yes – what types? _____ No

10. OTHER HISTORY

- Your occupation:..... Alcohol - type and number per week:.....
- Cigarettes – How many per day? How many years? Quit – When?
- Marijuana - amount: Other drugs - type and amount:
- Caffeinated beverages (coffee, tea, soda) per day:
- Ever used intravenous drugs? yes no Radiation exposure: yes no

11. SYSTEMIC REVIEW

Height _____ Weight _____ Maximum Weight _____ Minimum Weight _____ Weight change in last 2 yrs _____

Do/have you participated in any significant dietary changes over the past 3 years?.....

Do/have you participated in any exercise programs over the past 3 years?.....

If so please document exercise: type hrs/week

- The effect of being overweight on fertility therapies have been well documented.
- Please speak with your physician regarding weight loss attempts and ideal weight range for you height.
- Obesity does not usually cause infertility but it may have significant impact on treatment responses & may have multiple negative effects on both you & the fetus

Check all that applies:

General

- Recent weight gain / loss
- Anorexia/bulimia
- Lack of energy
- Fever/Chills
- Other _____

Endocrine/Hormonal

- Diabetes
- Hair loss
- Thyroid gland problems
- Excessive thirst or hunger
- Temperature intolerance – Hot flashes or feeling cold
- Other _____

Gastrointestinal

- Nausea/vomiting
- Ulcers
- Diarrhea
- Constipation
- Irritable Bowel Syndrome
- Change in bowel habits
- Other _____

Musculoskeletal

- Muscle weakness
- Decreased energy/stamina
- Rheumatoid arthritis
- Lupus erythematosus
- Other _____

Mental Health Problems

- Depression Anxiety
- Schizophrenia
- Other _____

Head, Eyes, Nose, & Throat

- Dizziness
- Headaches
- Blurred vision
- Hearing loss/deafness
- Loss of sense of smell
- Chronic nasal congestion
- Other _____

Cardiovascular

- Palpitations Murmurs
- Chest pain Stroke
- Heart attack
- Mitral valve prolapse
- Other _____

Breasts

- Discharge (clear? ___ bloody? ___ milky? ___)
- Lumps Pain
- Cancer Rash
- Abnormal mammogram
- Reduction Augmentation/implants
- Other _____

Genito-Urinary

- Bladder infections
- Kidney infections
- Vaginal infections
- Frequent urination
- Leaking urine
- Blood in the urine
- Other _____

Hematologic

- Blood clotting disorder/blood clot
- Sickle cell anemia
- Easy bruising
- Swollen glands/lymph nodes
- Blood transfusions (dates/reasons _____)
- Other _____

Respiratory

- Shortness of breath
- Asthma Bronchitis
- Pneumonia Asthma
- Bloody cough
- Other _____

Neurological Problems

- Weakness/loss of balance
- Seizures/Epilepsy
- Headaches
- Migraine headaches
- Numbness
- Memory loss
- Other _____

Skin/Extremities

- Unexplained rash
- Acne
- Skin cancer
- Excess hair growth
- Moles changing appearance
- Other _____

12. FAMILY HISTORY / GENETIC HISTORY

| | Mother | Father | Brothers: # | Sisters: # | Children: # | Other |
|-------------------------|--------|--------|-------------|------------|-------------|-------|
| Cancer (type) | | | | | | |
| Diabetes | | | | | | |
| Hypertension | | | | | | |
| High Cholesterol | | | | | | |
| Heart Disease | | | | | | |
| Stroke | | | | | | |
| Uterine fibroids | | | | | | |
| Endometriosis | | | | | | |
| Menopause before age 40 | | | | | | |

13. ETHNICITY *Data will be used for genetic testing recommendation purposes

- Caucasian
 Hispanic
 Asian
 African American
 Other (_____)

Do you or anyone in either family have?

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Neural tube defects/spina bifida/anencephaly | <input type="checkbox"/> Cystic fibrosis | <input type="checkbox"/> Tay-Sachs disease | <input type="checkbox"/> Chromosomal disorder |
| | <input type="checkbox"/> Muscular dystrophy | <input type="checkbox"/> Sickle cell disease or trait | <input type="checkbox"/> Genetic / inherited disorder |
| <input type="checkbox"/> Thalassemia | <input type="checkbox"/> Huntington chorea | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Baby with birth defects |
| <input type="checkbox"/> Down syndrome | <input type="checkbox"/> Mental retardation / fragileX | <input type="checkbox"/> Hormonal disorder | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Hydrocephalus | <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Stillbirth | <input type="checkbox"/> Phenylketonuria | <input type="checkbox"/> Neurofibromatosis | <input type="checkbox"/> Myotonic dystrophy |
| <input type="checkbox"/> 3 or more miscarriages | <input type="checkbox"/> Diabetes | | |
| <input type="checkbox"/> Any birth defects? | <input type="checkbox"/> Any inherited disorders? | | |

Please explain a "Yes" answer to any of the above _____

Genetic Screening:

It is recommended that **all couples** attempting conception be offered cystic fibrosis screening. Cystic Fibrosis is a pulmonary disease affecting children and the most common genetic disease. The effectiveness of the test varies dependent on your ethnic background. You may be offered additional screening based on your ethnicity. Are you: African-American Yes No
 Ashkenazi Jewish Yes No Mediterranean/Asian/French Canadian Yes No

If you answered YES to any of these, please let your physician know at the visit, so that the additional genetic screening can be offered to you. If you have any specific genetic concerns and desire to see a geneticist, please let the physician know.

14. HISTORY OF FERTILITY THERAPY (Fill out if applicable)

Have you been treated for infertility previously? YES NO

If yes, who was your physician?

What cause of infertility was diagnosed?

What drugs have you taken for infertility? Please check all that apply:

- | | | |
|---|---|--|
| <input type="checkbox"/> Clomid (Serophene) | <input type="checkbox"/> hCG Profasi | <input type="checkbox"/> Antibiotics |
| <input type="checkbox"/> Gonal F | <input type="checkbox"/> Progesterone | <input type="checkbox"/> Baby aspirin |
| <input type="checkbox"/> Follistim | <input type="checkbox"/> Lupron | <input type="checkbox"/> Heparin |
| <input type="checkbox"/> Repronex | <input type="checkbox"/> Microdose Lupron | <input type="checkbox"/> Steroids |
| <input type="checkbox"/> Pergonal | <input type="checkbox"/> Antagon | <input type="checkbox"/> Oral Contraceptives |
| <input type="checkbox"/> Fertinex | <input type="checkbox"/> Parlodel | <input type="checkbox"/> Other |

Which of the following tests have you or your partner had performed? Please check all that apply and results, if known:

- Hysterosalpingogram When ____/____/____ Results
- Sonohystogram When ____/____/____ Results
- Laparoscopy, Hysteroscopy When ____/____/____ Results
- Thyroid tests When ____/____/____ Results
- Chromosomes When ____/____/____ Results
- Genetic screening When ____/____/____ Results
- OTHER _____

Have you ever undergone Artificial Insemination (IUI) or In Vitro Fertilization (IVF)? YES NO
If yes, partner donor sperm #IUI's ____ #IVF cycles _____

At the UC Center for Reproductive Health, we understand that infertility can place a significant burden on the respective couple. This stress can have a profound impact on the reproductive system. Given these facts and our emphasis on treating the whole person, we would like to know your experience with / willingness to try alternative therapies. These include, but are not limited to:

- Acupuncture (if so, which acupuncturist) _____
Dates: Current Previous _____
- Herbal treatment _____
Dates: Current Previous _____
- Massage _____
Dates: Current Previous _____
- Psychological/group therapy _____
Dates: Current Previous _____
- Yoga / biofeedback / stress reduction techniques _____
Dates: Current Previous _____

PATIENT'S SIGNATURE

DATE

I confirm that I have reviewed the above information.

PHYSICIAN'S SIGNATURE

DATE

**Welcome and we look forward to working with you.
Please write down any specific concerns you want to review at your visit.**

Thank you - The UC Center for Reproductive Health Team