WC AK
Women's Care of Alaska 2741 DeBarr Rd, Suite C-205 • Anchorage, AK 99508 • (907) 279-2273 • Fax (907) 258-7705

MEDICAL AND REPRODUCTIVE HISTORY – INFERTILITY

Reason for visit: _____

Female Patient:
(LEGAL) Last name: _____ **(LEGAL)** First name: _____ Middle initial: _____

Age: _____ Date of birth: _____/_____/_____

Marital status: _____ single _____ married _____ domestic partner Length of relationship: _____years

Partner:
(LEGAL) Last name: _____ **(LEGAL)** First name: _____ Middle initial: _____

Age: _____ Date of birth: _____/_____/_____

FERTILITY HISTORY – FEMALE PATIENT

How long have you been attempting to conceive? _____

Do you have any theories as to why you have been unable to conceive? _____

Pregnancy History: List all pregnancies, specifying under outcome whether liveborn, stillborn, ectopic, miscarriage or elective termination (abortion).

Pregnancy #	Pregnancy ended (mo. / yr.)	Pregnancy length (weeks, months)	Outcome	Father (check one)	
				Present partner	Previous partner

Previous Fertility Evaluation: List any previous testing or procedures you have had done. _____

_____

Do you need medication to bring on a period? ☐ Yes ☐ No If Yes, what type? _____

SEXUAL HISTORY

How many times per week do you have intercourse? _____

How many times do you have intercourse mid-cycle? _____

Do you experience any pain with intercourse? ☐ Yes ☐ No

Do you regularly use lubricant with intercourse? ☐ Yes ☐ No If yes, what type? _____

Have you ever had pelvic inflammatory disease? ☐ Yes ☐ No If yes, when? _____

Were you hospitalized? ☐ Yes ☐ No

GENERAL MEDICAL HISTORY – FEMALE PATIENT

What is your current weight? _____ Height? _____ Usual weight? _____

Have you had recent weight loss or gain in the past 6 months? ☐ Yes ☐ No

Are you currently being treated or being seen for any medical condition(s)? ☐ Yes ☐ No

If yes, describe: _____

_____

FAMILY AND GENETIC HEALTH HISTORY – FEMALE PATIENT

Are there any known genetic diseases or conditions that run in your family? ☐ Yes ☐ No

If yes, describe: _____

Are you adopted? ☐ Yes ☐ No

Are you of any of the following ethnic backgrounds? (check all that apply)

☐ Ashkenazi Jewish ☐ Mediterranean ☐ Middle Eastern ☐ Asian
☐ African ☐ Hispanic or Caribbean ☐ French Canadian of Cajun ☐ Caucasian

Have you had a blood test to see if you were a genetic carrier for:

Condition	Tested?	Result
α (alpha) thalassemia	☐ Yes ☐ No	
β (beta) thalassemia	☐ Yes ☐ No	
Sickle Cell Anemia	☐ Yes ☐ No	
Tay Sach's Disease	☐ Yes ☐ No	
Cystic Fibrosis	☐ Yes ☐ No	
Spinal Muscular Atrophy	☐ Yes ☐ No	

****If you are of Eastern European Jewish (Ashkenazi) ancestry****
Have you had a blood test to see if you were a genetic carrier for:

Condition	Tested?	Result
Canavan Disease	☐ Yes ☐ No	
Familial Dysautonomia	☐ Yes ☐ No	
Fanconi Anemia	☐ Yes ☐ No	
Neimann-Pick Disease	☐ Yes ☐ No	
Mucolipodisis Type IV	☐ Yes ☐ No	
Bloom Syndrome	☐ Yes ☐ No	
Gaucher Disease	☐ Yes ☐ No	

Indicate which of the following conditions may be found in your family:

Medical Condition	Self	Parents		Siblings		Maternal Grandparents		Paternal Grandparents		Your children	Other relatives
		M	F	S	B	GM	GF	GM	GF		
Autoimmune disorder, such as lupus or rheumatoid arthritis											
Birth defects requiring surgery (cleft lip, etc.)											
Bleeding disorders (hemophilia, etc.)											
Blindness											
Bone Disorder											
Cancer before age 50 (Specify)											
Chromosome disorders (Down syndrome, Klinefelter syndrome)											
Clotting disorders (Factor V Leiden, etc.)											
Deafness											
Diabetes (insulin dependent)											
Endocrine disorders (thyroid disorders, adrenal hyperplasia, etc.)											
Epilepsy											
Heart defects ("hole in the heart", etc.)											
Heart Disease											
High blood pressure											
High cholesterol											
Hydrocephaly ("water on the brain")											
Kidney disease											
Limb defects (missing or extra fingers or toes, shorten arms or legs)											
Marfan syndrome											
Mental illness (schizophrenia, bipolar, etc.)											
Mental retardation, autism or learning disabilities											
Muscular dystrophy											
Neurofibromatosis											
Neurologic or neurodegenerative disease (Alzheimer, Huntington, etc.)											
Neuromuscular diseases (muscular dystrophies, etc.)											
Phenylketonuria (PKU)											
Polycystic kidney disease											
Skin diseases (eczema, melanoma)											
Stillbirth of children who have died as infants											
Stroke											
Thalassemia (Cooley's anemia)											
Unusual genitals in boys or girls											
Urinary tract abnormalities											
Women who have had multiple miscarriage											
Other serious health issues											

Explain any positive responses: _____

_____

FERTILITY HISTORY – PARTNER

Do you have any theories as to why you have been unable to conceive? _____

_____

Pregnancy History: List all pregnancies you have fathered, specifying under outcome whether liveborn, stillborn, ectopic, miscarriage or elective termination (abortion).

Pregnancy #	Pregnancy ended (mo. / yr.)	Pregnancy length (weeks, months)	Outcome	Father (check one)	
				Present partner	Previous partner

Have you ever been unable to conceive with anyone other than your current partner? ☐ Yes ☐ No

Have you ever consulted a urologist or male infertility specialist? ☐ Yes ☐ No If yes, when? _____/_____

Reason: _____

Findings / Recommendations: _____

_____

Previous Fertility Evaluation: List any previous testing or procedures you have had done. _____

_____

GENERAL MEDICAL HISTORY – PARTNER

Surgical History: List any major illnesses, surgeries or hospitalizations in the table below. Include vasectomy, vasectomy reversal, varicocele repair, or any other surgeries:

Date (month / year)	Procedure	Reason

<u>Current Medications:</u> List all medications (including vitamins, herbs and over the counter medications) or treatments you are currently taking:

Medication	Dosage	Frequency	Reason

SOCIAL HISTORY – PARTNER

Current occupation: _____

Have you or do you partake in any of the following?

	Never	Not in the last 3 months	Yes	List type, amount and frequency (how often / per day or week)
Tobacco	☐	☐	☐	
Alcohol	☐	☐	☐	
Social Drugs	☐	☐	☐	
Exercise	☐	☐	☐	

Have you ever had a serious exposure to radiation or toxins (e.g. pesticides, toxic chemicals, poisons, herbicides, plastics, organic chemicals, lead, cadmium, industrial by-products, etc.)? ☐ Yes ☐ No

FAMILY AND GENETIC HEALTH HISTORY – PARTNER

Are there any known genetic diseases or conditions that run in your family? ☐ Yes ☐ No

If yes, describe: _____

Do any of your blood relatives (siblings, children, aunts, uncles, etc.) have a birth defect (e.g. mental retardation, spina bifida, heart abnormalities, etc.)? ☐ Yes ☐ No

If yes, describe: _____

_____

Are you adopted? ☐ Yes ☐ No

Are you of any of the following ethnic backgrounds? (check all that apply)

☐ Ashkenazi Jewish ☐ Mediterranean ☐ Middle Eastern ☐ Asian
☐ African ☐ Hispanic or Caribbean ☐ French Canadian of Cajun ☐ Caucasian

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