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Medical and Reproductive History – Infertility

Today's date: _____/_____/_____

***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: _____/_____/_____

Reason for visit: _____

Fertility History – Female Patient

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

How long have you been trying 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. _____

_____

_____

_____

Reproductive Health History – Female Patient

***Menstrual History*:**
Age when you had your first menstrual period: _____ years old

The first day of your most recent menstrual period: _____/_____/_____

Menstrual cycle pattern without hormone or oral contraceptive pills (OCP's) – (check all that apply):

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

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

How many days of bleeding do you usually have? _____ days

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

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

☐ Always ☐ Sometimes ☐ Recently ☐ In the past
☐ No

Degree of pain (1 to 10, with 10 being most severe): _____

Over the past few years, is the pain: ☐ Getting better ☐ Getting worse ☐ Staying the same

If you do not have periods, at what age did you stop having them? _____ years old

When was your last Pap smear? _____/_____ Was it normal? ☐ Yes ☐ No

Have you ever had an abnormal Pap smear? ☐ Yes ☐ No

If yes, date and treatment: _____/_____ _____

Contraceptive Method History:

Type	Years used
☐ Birth control pills / Patch	
☐ Depo Provera, Lunelle	
☐ Nuva Ring	
☐ Norplant / Implanon / Nexplanon	
☐ Diaphragm	
☐ IUD	
☐ Condoms	
☐ Tubal sterilization	
☐ Vasectomy	
☐ Rhythm method	
☐ Other	

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 any sexually transmitted infections? (check all that apply)

☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ Syphilis
☐ Genital Warts ☐ Trichomonas ☐ HIV ☐ HPV
☐ Hepatitis ☐ Other _____

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

Were you hospitalized? ☐ Yes ☐ No

Has anyone close to you, ever threatened to, or physically hurt you? ☐ Yes ☐ No

Has anyone, including your partner, ever forced you to have sex? ☐ Yes ☐ No

Do you fear harm from anyone at home, or school, or anywhere else? ☐ 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: _____

_____

***Review of systems*:** Check any of the following that you are presently having or have had in the past:

Eye problems ☐	Gall bladder problems ☐	Excessive thirst ☐
Stuffy nose or hay fever ☐	Liver disease ☐	Temperature intolerance ☐
Frequent nose bleeds ☐	Frequent urination at night ☐	Headaches ☐
Fast or irregular heartbeat ☐	Vaginal discharge, itching, pain ☐	Shaking or tremor ☐
Heart murmur ☐	Pelvic pain ☐	Anxiety ☐
Mitral valve prolapse ☐	Sexual problems ☐	Depression ☐
Dizziness or fainting ☐	Endometriosis ☐	Bulimia or anorexia ☐
Shortness of breath ☐	Ovarian tumor ☐	Anemia ☐
Lung disease ☐	Dark skin on neck or armpits ☐	Easy bleeding or bruising ☐
Asthma ☐	Acne or pimples ☐	Poor circulation ☐
Tuberculosis ☐	Enlarged or painful breast ☐	Blood transfusion ☐
Heartburn or indigestion ☐	Discharge from nipples ☐	Fatigue ☐
Gas, cramps or pain ☐	Breast lumps ☐	Low energy ☐
Blood in stool or black stool ☐	Breast disease ☐	Past history of IV drug use ☐
Nausea or vomiting ☐	Hot flashes ☐	Rubella (German measles) ☐
Constipation ☐	Excessive face or body hair ☐	Other ☐
Diarrhea ☐	Hair thinning or loss ☐	_____ ☐
Hernia ☐	Fever, sweats or chills ☐	_____ ☐

Explain any positive responses: _____

_____

_____

Surgical History: List any major illnesses, surgeries or hospitalizations in the table below. Include elective termination (abortion), ectopic pregnancy, tubal surgery or any other surgeries:

Date (month / year)	Procedure	Reason

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

Medication	Dosage	Frequency	Reason

***Allergies*:** List all drug, environmental and food allergies:

Allergy	Reaction

Social History – Female Patient

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	☐	☐	☐	
Caffeine	☐	☐	☐	
Social Drugs	☐	☐	☐	
Exercise	☐	☐	☐	

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	
Mucolipidosis 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											

Medical Condition	Self	Parents		Siblings		Maternal Grandparents		Paternal Grandparents		Your children	Other Relatives
		M	F	S	B	GM	GF	GM	GF		
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

***Current Medications*:** 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	☐	☐	☐	
Caffeine	☐	☐	☐	
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

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

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Spinal Muscular Atrophy	☐ Yes ☐ No	

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