



FERTILITY CENTER OF THE CAROLINAS

FEMALE PATIENT HISTORY: INFERTILITY

I. Identifying Information

Date: _____
 Name: _____ Partner's Name: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Telephone Number: Day (____) _____ Evening (____) _____
 Referring Physician: Name _____
 Address _____
 Age: _____ Date of Birth: _____ Partner's Age: _____ Date of Birth: _____

II. Pregnancy History

How many pregnancies (including abortions) have you had: _____

	When (Year)	How Long to Conceive (Months)	Fertility Therapy Used (Yes / No)	Is Current Partner the Father (Yes / No)	Duration of Pregnancy (Months)	Outcome*	Complications
1 st Pregnancy							
2 nd Pregnancy							
3 rd Pregnancy							
4 th Pregnancy							
5 th Pregnancy							

*Outcomes: Vaginal Deliver = VD; Cesarean Section = CS; Abortion = AB; Miscarriage = MS; Ectopic = EP

III. Fertility History

How long have you and your present partner been trying to conceive: _____

Have you ever been infertile with a past partner: YES NO If so, how long: _____

Have you had any of the following tests performed: (Check all that apply and the results)

	Date	Results
<input type="checkbox"/> Anti-Sperm Antibodies	_____	_____
<input type="checkbox"/> Blood type / Antibody Screen	_____	_____
<input type="checkbox"/> Basal Body Temperature	_____	_____
<input type="checkbox"/> Blood type and Rh	_____	_____
<input type="checkbox"/> Endometrial Biopsy	_____	_____
<input type="checkbox"/> Gonorrhea/Chlamydia Cultures	_____	_____
<input type="checkbox"/> Hepatitis B or C	_____	_____
<input type="checkbox"/> HIV	_____	_____
<input type="checkbox"/> Hormone Tests	_____	_____
<input type="checkbox"/> Hysterosalpingogram (HSG)	_____	_____

- Post-coital Test _____
- RPR (Syphilis) _____
- Rubella (German Measles) _____
- Sonohysterogram _____
- Ultrasound _____
- Urinary LH (Ovulation) Predictor Kits _____
- Hysteroscopy _____
- Laparoscopy _____

What types of fertility therapy have you previously received:

Drug / Treatment	Dosage	How Long or How Many Cycles	When
Clomiphene Citrate (Clomid, Seraphene) Letrozole (Femara)			
Gonadotropins (Pergonal, Repronex, Gonal-F, Follistim, Menopur)			
HCG (Profasi, Pregnyl, Ovidrel)			
Progesterone			
Prednisone or Dexamethasone			
Bromocriptine (Parlodel) or Cabergoline (Dostinex)			
Artificial Insemination			
Donor Insemination			
In Vitro Fertilization (IVF) or Intracytoplasmic Sperm Injection (ICSI)			

IV. Gynecological History

How old were you when you started having periods: _____ Date your last period started: _____

Are your periods regular: YES NO

If yes, how many days between periods (start until start): _____

If no, how many periods per year do you have: _____

How many days do your periods last: _____ Do you have cramps with your periods: YES NO

If yes, are they: Mild Moderate Severe

Have you ever missed work or school due to menstrual pain: YES NO

Do you have pain with intercourse: YES NO

Were you ever diagnosed with endometriosis: YES NO

Have you ever been told you have/had fibroid tumors in your uterus: YES NO

How often do you and your partner have intercourse: _____

What type of contraception have you used in the past or are using now: (Check all that apply)

- Birth Control IUD Depo Provera (birth control shots)
- Condoms Diaphragm Foams/Jellies
- Withdrawal Rhythm Tubal Ligation

History of contraceptive complications: _____

When did you last use contraception: _____

Have you ever had an abnormal Pap smear: YES NO If so, when: _____
What was done about it: _____
When was your last Pap smear: _____

Have you ever had any of the following: (Check all that apply)

- | | | |
|------------------------------------|---|--|
| <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Venereal Warts | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Pelvic Inflammatory Disease (PID) |

V. Medical History

Do you have or have you ever had: (Check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ovarian Cysts |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Gallbladder Problems | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rubella (German Measles) |
| <input type="checkbox"/> Breast Discharge | <input type="checkbox"/> Hirsutism (excess facial hair) | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Breast Pain | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Kidney Infections | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Chronic Headaches | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Neurological Problems | <input type="checkbox"/> Vision Problems |

Current Medications: _____

Are you allergic to any medications: YES NO What: _____

Have you ever had surgery before: YES NO

Date and type: _____

VI. Social History

Current or Recent Employer/Position: _____

Do you drink alcohol: YES NO Number of drinks per week: _____

Do you smoke: YES NO

Number of cigarettes per day: _____ Number of years smoking: _____

Do you now, or have you ever, used illicit drugs (marijuana, cocaine, etc.): YES NO

If yes, please specify: _____

Do you have a special exercise program: YES NO

If yes, type: _____ Number of hours per week: _____

Are you on a special diet: YES NO If yes, type: _____

VII. Family History

Do any family members have significant health problems or inherited diseases: (Check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> Brain/Spinal Defects | <input type="checkbox"/> Fragile X Syndrome | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Tay-Sachs Disease |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Thalassemia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disease |

Who: _____

VIII. Review of Systems

What is your usual height: _____ Current weight: _____ Ideal weight: _____
 Have you had more than a 10-pound weight gain or loss in the past 12 months: YES NO
 If yes, how much: _____ Was this intentional: YES NO

Please check the following that apply to you:

Breast	<input type="checkbox"/> Discharge <input type="checkbox"/> Masses <input type="checkbox"/> Pain <input type="checkbox"/> Other
Cardiovascular	<input type="checkbox"/> Chest pain <input type="checkbox"/> Difficulty breathing on exertion <input type="checkbox"/> Palpitations <input type="checkbox"/> Swelling <input type="checkbox"/> Other
Constitutional	<input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Sleep problems <input type="checkbox"/> Other
Ear, Nose, Throat	<input type="checkbox"/> Headache <input type="checkbox"/> Hearing loss <input type="checkbox"/> Sinusitis <input type="checkbox"/> Ulcers
Endocrine	<input type="checkbox"/> Abnormal hair growth <input type="checkbox"/> Diabetes <input type="checkbox"/> Hair loss <input type="checkbox"/> Heat/cold intolerance <input type="checkbox"/> Other
Eyes	<input type="checkbox"/> Glasses/contacts <input type="checkbox"/> Vision changes <input type="checkbox"/> Other
Gastrointestinal	<input type="checkbox"/> Bloody stool <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Pain <input type="checkbox"/> Other
Genitourinary	<input type="checkbox"/> Blood in urine <input type="checkbox"/> Incontinence <input type="checkbox"/> Urinary frequency/burning <input type="checkbox"/> Other
Hematologic/Lymph	<input type="checkbox"/> Bleeding <input type="checkbox"/> Blood clots <input type="checkbox"/> Bruising <input type="checkbox"/> Swollen lymph nodes <input type="checkbox"/> Other
Musculoskeletal	<input type="checkbox"/> Muscle or joint pain <input type="checkbox"/> Muscle swelling <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Other
Neurologic	<input type="checkbox"/> Fainting spells <input type="checkbox"/> Memory loss <input type="checkbox"/> Numbness <input type="checkbox"/> Seizures <input type="checkbox"/> Other
Psychiatric	<input type="checkbox"/> Anxiety <input type="checkbox"/> Crying spells <input type="checkbox"/> Depression <input type="checkbox"/> Other
Respiratory	<input type="checkbox"/> Asthma <input type="checkbox"/> Cough <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Other
Skin	<input type="checkbox"/> Dry skin <input type="checkbox"/> Moles <input type="checkbox"/> Rash <input type="checkbox"/> Ulcers <input type="checkbox"/> Other

Please bring this form with you to your first appointment. Ensure that records from your current or previous physician have been sent or faxed to the address below at least one week in advance of your visit. We look forward to meeting you.

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