STILLWATER
MEDICAL GROUP
*A member of Lakeview Health*
**Women's Center**

# Infertility Female History Form

**Complete the form to the best of your knowledge.**

I.IDENTIFYING INFORMATION Date_____

Name_____ Partner's Name_____

Date of Birth_____ Duration of Relationship _____

Duration of attempting pregnancy_____ Nature of present employment_____

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II. MEDICAL HISTORY Height_____ Weight_____

Do you have or have you ever been diagnosed with or treated for (check all that apply)

| | | |
|---|---|---|
| ____Chronic Headaches | ____Anemia | ____Breast Discharge |
| ____Dizziness | ____Cancer Specify:_____ | ____Chlamydia |
| ____Epilepsy | ____Hirsutism (excessive hair growth) | ____Endometriosis |
| ____Loss of Balance | ____Thyroid Disease/Surgery | ____Gonorrhea |
| ____Neurological Problems | ____Herpes | ____Poor Sense of Smell |
| ____Appendicitis | ____Ovarian-Cysts | ____Seizures |
| ____Colitis | ____Pelvic Infection | ____Visual Disturbances |
| ____Diabetes | ____Syphilis | ____Eating Disorders |
| ____HIV/AIDS | ____Asthma | ____Gall Bladder Disease/Surgery |
| ____Kidney Infection | ____Chronic Bronchitis | ____Hepatitis |
| ____Arthritis | ____Tuberculosis | ____Liver Problems |
| ____Lupus Erythematosus | | |

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CARDIOVASULAR HISTORY

| | | |
|---|---|---|
| Bleeding Disorder | Yes | No |
| Blood Clots | Yes | No |
| High Blood Pressure | Yes | No |
| History of Heart Disease | Yes | No |
| Heart Murmur | Yes | No |
| Antibiotics needed for dental/surgical procedure | Yes | No |

ALLERGIES

| | | | |
|---|---|---|---|
| General Allergies | Yes | No | If yes, list_____ |
| Drug Allergies | Yes | No | If yes, list_____ |
| Latex Allergies | Yes | No | |
| Iodine Allergies | Yes | No | |
| Egg Allergies | Yes | No | |

PRESCRIBED MEDICATIONS

Past Year Yes No If yes, list_____

Current Yes No If yes, list_____

OVER THE COUNTER MEDICATIONS

Current Yes No If yes , list_____

Homeopathic/Herbal Yes No If yes, list_____

CURRENT USE OF THE FOLLOWING

Alcohol Yes No If yes, type_____ amount per week_____

Smoking Yes No If yes, number of cigarettes a day_____

Recreational Drugs Yes No If yes, type_____ frequency_____

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III. CONTRACEPTIVE/SEXUAL HISTORY

Have you ever used in the past (check all that apply)

____Birth Control Pills Name_____

____IUD Name_____

____Depo-Provera

If you 'ev ever been on oral contraceptives (pills), were your periods regular after stopping the pills?

Yes No

Do you use lubricants for intercourse? Yes No If yes, type_____

Is intercourse painful or difficult for you? Yes No

How many times per week do you and your partner have intercourse? _____

How many times do you have intercourse at the time of ovulation? _____

Indicate your sexual orientation by circling one of the following. Heterosexual Homosexual Bisexual

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IV. MENSTRUAL AND PREGNANCY HISTORY

Age of first period? _____

Are your periods regular? Yes No

If yes, what is the usual length (from onset of period to the onset of your next period)? _____

If no, how many times per year do you menstruate? _____

Progesterone or Provera needed to initiate bleeding? Yes No

What is the usual duration of your period? _____

Are cramps: ____ mild ____ moderate ____severe

Do you bleed or spot between periods? Yes No

How many pregnancies (including elective abortions) have you had? _____

| Pregnancy | Year Conceived | How long to conceive | Infertility Therapy Required to Conceive? | Choose one Elective Abortion? Miscarriage ? Ectopic? Pre-term Delivery? Full-term Delivery? | Date Baby Born | Vaginal Delivery Or C-Section? | Complications? | Male Or Female | Is current Partner The Father? |
|---|---|---|---|---|---|---|---|---|---|
| 1st | | | | wks | | | | | Yes no |
| 2nd | | | | wks | | | | | Yes no |
| 3rd | | | | wks | | | | | Yes no |
| 4th | | | | wks | | | | | Yes no |
| 5th | | | | wks | | | | | Yes no |

## V. FAMILY HISTORY

Is there a family history of cancer/malignancy?

____Ovarian Yes No whom_____

____Breast Yes No whom_____

____Other Yes No whom_____

Is there a history of hormonal disorders in your family? Yes No

If yes, who and what type_____

Is there a family history of?

____Cystic Fibrosis Yes No If yes, whom_____

____Tay Sachs Disease Yes No If yes, whom_____

____Sickle Cell Anemia Yes No If yes, whom_____

With which of the following racial/ethnic group do you identify? Check the appropriate racial/ethnic group.

____American Indian/Alaska Native ____Asian ____Black/African American ____Latino/Hispanic

____Native Hawaiian or Pacific Islander ____White/Caucasian ____Unknown/other

## VI. INFERTILITY HISTORY/TREATMENT

Have you been treated for infertility before? Yes No

If yes, who was your physician? _____

Infertility Diagnoses_____

Which of the following tests have you had performed? Check all that apply and the results if known.

____BBT (Basal Body Temperature) When? _____ Results_____

____Postcoital Test When? _____ Results_____

____Hormonal Testing (FSH, LH, Progesterone,
Prolactin, Estrogen, DHEA-S Testosterone) When? _____ Results_____
____Endometrial Biopsy When? _____ Results_____
____Hysterosalpingogram (HSG) When? _____ Results_____
____Mycoplasma/Chlamydia cultures When? _____ Results_____
____Thyroid tests When? _____ Results_____
____Pap Smear (most current) When? _____ Results_____
____Other- Specify When? _____ Results_____

Immunology/ Recurrent Pregnancy Loss Testing (if applicable)

| | | | | |
|---|---|---|---|---|
| Anticardiolipin Antibody | Yes | No | When? _____ | Results_____ |
| Lupus Anticoagulant | Yes | No | When? _____ | Results_____ |
| Anti-Chlamydial Antibody | Yes | No | When? _____ | Results_____ |

Have you ever had any of the following procedures/ surgeries?

| | | | |
|---|---|---|---|
| Appendectomy | Yes | No | Date_____ |
| Cervical Conization or Cautery | Yes | No | Date_____ |
| C-Section | Yes | No | Date_____ |
| D&C | Yes | No | Date_____ |
| Hysteroscopy | Yes | No | Date_____ |
| Laparoscopy | Yes | No | Date_____ |
| Laparotomy | Yes | No | Date_____ |
| Tubal Ligation | Yes | No | Date_____ |
| Tubal Reversal | Yes | No | Date_____ |

Other_____ Date_____

Indicate the following treatment types you have undergone or are currently undergoing
____Clomid Number of Cycles_____
____Superovulation Number of Cycles_____
____Intrauterine Insemination (IUI) Number of Cycles_____
____Husband's Sperm Number of Cycles_____
____Donor Sperm Number of Cycles_____

____In Vitro Fertilization Yes No

Number of Fresh Cycles_____ Number of Frozen Cycles_____

Facility/ location where treatment occurred_____