South Jersey Fertility Center

Female Health History Form – Fertility

9/2018

Name:
Name of Partner:
Date of Birth:
Date of Appointment:
Nickname or Name you like to be called:

Who Referred you?
[ ] OB/GYN Physician [ ] OB/GYN NP/Midwife [ ] Non OB/GYN Physician
Name of OB/GYN (or other referring physician): _____
[ ] Google [ ] Social Media [ ] Friend/Family
[ ] Insurance Company [ ] Former Patient [ ] Other: _____

Reason for Visit:
[ ] Infertility Evaluation/Treatment [ ] Recurrent Pregnancy Loss [ ] Same Sex Relationship [ ] Fertility Preservation/Egg Freezing

Other complaints (check all that apply):
[ ] Fibroids [ ] PCOS [ ] Endometriosis [ ] Tubal Reversal
[ ] Male Factor Infertility [ ] Irregular Menses [ ] Other: _____

Fertility History (if applicable):

When did you begin attempting to conceive? (Unprotected intercourse without contraception)
Please indicate month and year: _____

About how often do you have intercourse during the "fertile week"? _____

Do you use a "personal lubricant" (such as K-Y) with intercourse? [ ] Yes [ ] No

Have you tried to conceive with a previous partner? [ ] Yes [ ] No
Were you successful? [ ] Yes [ ] No

How long have you been with your current sexual partner? (if applicable) _____

Have you done Basal Body Temperature (BBT) charting to assess ovulation status and timing?

If yes, what were the results? (If applicable) _____

Have you done urine Ovulation Predictor Kits to check for ovulation timing? [ ] Yes [ ] No

Did the kits turn positive? [ ] Yes [ ] No
If yes, what day of the cycle?_____

Prior Infertility Testing (If applicable):

Blood test for FSH (ovarian reserve assessment) drawn early in menstrual cycle? [ ] Yes [ ] No
If yes, indicate results (normal/abnormal) and date _____

Blood test for AMH (Ovarian Reserve Assessment) [ ] Yes [ ] No
If yes, indicate results and date _____

Pelvic Ultrasound [ ] Yes [ ] No
If yes, indicate results and date_____

Hysterosalpingogram (HSG/dye test) to check fallopian tubes? [ ] Yes [ ] No
If yes, indicate results and date_____

Semen Analysis [ ] Yes [ ] No
If yes, indicate results and date _____

Blood test for progesterone (about 3 weeks after a period) to assess ovulatory status? [ ] Yes [ ] No
If yes, indicate results and date _____

Laparoscopy (surgical scope near navel to evaluate fertility)? [ ] Yes [ ] No
If yes, indicate results and date: _____

Hysteroscopy (surgical scope in uterus to evaluate fertility)? [ ] Yes [ ] No
If yes, indicate results and date:_____

Prior fertility treatment (Please indicate the number of attempts with each treatment if applicable):
Name of previous fertility care center (if applicable): _____

Clomid pills: [ ] Yes [ ] No Number of attempts:_____
Clomid with intrauterine insemination (IUI): [ ] Yes [ ] No Number of attempts:_____

Letrozole pills: [ ] Yes [ ] No Number of attempts:_____
Letrozole/IUI: [ ] Yes [ ] No Number of attempts:_____

Gonadotropin(daily fertility shots)/IUI: [ ] Yes [ ] No Number of attempts:_____

In Vitro Fertilization (IVF): [ ] Yes [ ] No Number of attempts:_____

Where was the IVF performed (name of Center) and the dates:_____

Were any of the IVF's cycles paid for by any insurance company? [ ] Yes [ ] No If yes, how many: _____

Frozen Embryo Transfer: [ ] Yes [ ] No Number of attempts:_____

Donor egg recipient [ ] Yes [ ] No Number of attempts:_____

Where were the Donor Egg cycles performed (name of Center) and dates: _____

Were any of the Donor egg cycles paid for by any insurance company? [ ] Yes [ ] No If yes, how many: _____

Donor sperm insemination: [ ] Yes [ ] No Number of attempts:_____

Surgical repair of tubes, uterus, or pelvic scarring. [ ] Yes [ ] No

Any other fertility treatments: _____

Have you or your partner had a surgical sterilization procedure done? [ ] Yes [ ] No

When did you last use a contraceptive method? _____

Have you had a pelvic infection called "Pelvic Inflammatory Disease (PID)? [ ] Yes [ ] No

Are you bothered by excessive unwanted hair growth? [ ] Yes [ ] No
If yes, where? _____

Do you have a milky discharge from your nipples? [ ] Yes [ ] No

What is your blood type? _____

Medications:
Please list any present medications including prenatal or other vitamins/herbs. (If more than 5, please list them in the area below):

Medication	Dosage	Directions

Additional Medication(s):_____

Medical History:

Please check all that apply:

[ ] Anxiety [ ] Asthma [ ] Depression [ ] Melanoma [ ] Epilepsy

[ ] Fibroids [ ] Stroke [ ] Heart Murmur [ ] Thyroid Disorder [ ] Diabetes

[ ] Hepatitis [ ] Anemia [ ] High Blood Pressure [ ] Cancer: Location _____

[ ] Other _____

Allergies:

Please list any allergies to medications, seasonal allergies, or allergy to latex and your reaction:

_____

GYN History:

Last Pap Smear (mm/yyyy): _____

Result of last pap: [ ] Normal [ ] Abnormal [ ] No pap ever done

Have you had your cervix treated for an abnormal pap [ ] Yes [ ] No

What Treatment? _____

How often do you perform a self breast exam: [ ] Monthly [ ] Do not perform [ ] Sometimes

Have you had a Gardisil HPV Vaccine: [ ] Yes [ ] No

Last Mammogram Date (mm/yyyy): _____

Result of last Mammogram: [ ] Normal [ ] Abnormal [ ] No mammo ever done

Menstruation:

At what age did your periods start? _____

Date of last menstrual period (dd/mm/yy): _____

How long is it from the beginning of one period to the beginning of the next period (typically 28-30 days)? _____

How long does your period last? [ ] > 7 days [ ] 2 - 7 days [ ] 3 days

Pad / Tampon Use Per Day: [ ] 1-3 [ ] 4-6 [ ] 7+

How would you describe your period?

[ ] with severe pain [ ] with moderate pain

[ ] with mild discomfort [ ] without discomfort/ pain

[ ] heavy [ ] light

Do you take any pain medication for pelvic pain or cramping with her period? [ ] Yes [ ] No

If yes, what Medication helps? _____

Do you experience any ovulatory pain? [ ] Yes [ ] No

Menstruation Symptoms:

Premenstrual Syndrome: [ ] Yes [ ] No

If yes, please mark any symptoms you are experiencing:

[ ] Withdrawal [ ] Weight gain [ ] Tension [ ] Pelvic pain

[ ] Mood swings [ ] Tiredness [ ] Headaches [ ] Depression

[ ] Bowel changes [ ] Bloating [ ] Anxiety [ ] Changes in desire

[ ] Breast swelling/discomfort [ ] Hot Flashes

Past Birth Control:

[ ] Condoms

[ ] Oral contraceptive pills Indicate which pill: _____

[ ] Mirena IUD [ ] Paraguard IUD

[ ] Skyla IUD [ ] Diaphragm

[ ] Nuvaring [ ] Bilateral Tubal Ligation

[ ] Vasectomy [ ] None

[ ] Depo-Provera [ ] Ortho Evra Patch

[ ] Spermicide [ ] Nexplanon

Sexual activity:

Are you currently sexually active? [ ] Yes [ ] No

Past history of sexual abuse: [ ] Yes [ ] No

Have you had a pelvic infection called "Pelvic Inflammatory Disease" (PID)? [ ] Yes [ ] No

Sexually Transmitted Infections (STI's)?

[ ] None

[ ] Human Papilloma Virus (HPV) [ ] Herpes Simplex Virus (HSV)

[ ] Chlamydia [ ] Gonorrhea

[ ] Human Immunodeficiency Virus (HIV) [ ] Trichomoniasis (Trich)

[ ] Hepatitis B [ ] Hepatitis C

[ ] Syphilis

Pregnancy History:

Total pregnancies: _____ Total living children: _____

Total full term pregnancies: _____ Total pre term pregnancies: _____

Total spontaneous miscarriages: _____

Total elective abortions: _____

Total ectopic pregnancies: _____

How many of your pregnancies were fathered with your current partner? _____

Please fill out the following to the best of your recollection regarding prior pregnancies:

Birth Date	# Weeks Pregnant at Birth	Hours in Labor	Birth Weight	Anesthesia	Delivery Method	Delivery Location & Provider
					[ ] vaginal [ ] c-section	
Comments or Complications (i.e. diabetes, blood pressure, etc.)						
					[ ] vaginal [ ] c-section	
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					[ ] vaginal [ ] c-section	

Comments or Complications (i.e. diabetes, blood pressure, etc.)

If you have a history of recurrent pregnancy losses, please answer the following questions:

How long did it take you to conceive your last pregnancy? _____

Do you have a past history of infertility? [ ] Yes [ ] No

Are you currently pregnant? [ ] Yes [ ] No

If yes, how many weeks? _____

Have you had any genetic testing completed? [ ] Yes [ ] No

If yes, results and date: _____

Have you seen a genetic counselor? [ ] Yes [ ] No

If yes, results and date: _____

Have you seen a maternal fetal medicine physician (high risk)? [ ] Yes [ ] No

If yes, when and what were the recommendations: _____

Have you had any blood work specifically for pregnancy loss? [ ] Yes [ ] No

If yes, results and date: _____

Any additional information about your losses that you'd like to provide: _____

_____

Surgical History:

Please list any previous surgeries and c-sections (include minor surgeries like wisdom teeth, appendix, etc.). Please indicate approximate date:

_____

_____

Have you ever had a blood transfusion? [ ] Yes [ ] No

Hospitalizations:

Please list any hospitalizations:

_____

_____

Have you ever had a problem with anesthesia in the past? [ ] Yes [ ] No

Family History:

Please check all that apply for the corresponding family member. Under status, please indicate "alive", "deceased", or "unknown". Please put an "X" in the appropriate boxes below. Example of birth defects would include a history of Down's Syndrome, Sickle Cell Anemia, Mental Retardation, Cystic Fibrosis, etc.

	Status (Deceased or Alive)	Age	Blood Clotting	Hx of Birth Defects**	Breast Cancer	Ovarian Cancer	Colon Cancer

Name:

			Disorder				
Mother							
Father							
Sister #1							
Sister #2							
Brother #1							
Brother #2							
Son #1							
Son #2							
Daughter #1							
Daughter #2							
Maternal Grandmother							
Maternal Grandfather							
Paternal Grandmother							
Paternal Grandfather							
Maternal Aunt							
Maternal Uncle							
Paternal Aunt							
Paternal Uncle							
Cousin							

Social History:

Current smoking status: [ ] Current smoker [ ] Current every day smoker

[ ] Current some day smoker [ ] Smoker [ ] Former smoker

[ ] Current status unknown [ ] Nonsmoker [ ] Unknown if ever smoked

How many cigarettes a day do you smoke? _____

Are you interested in quitting?

Name:

[ ] Ready to quit [ ] Thinking about quitting [ ] Not ready to quit

Alcohol:

How often do you consume alcohol, including beer and wine, in a week:

[ ] Never consumed alcohol (If no, skip other alcohol questions)

[ ] 1-2 times [ ] 3-5 times [ ] >5 times [ ] Socially [ ] Rarely

Did you have a drink containing alcohol in the past year? [ ] Yes [ ] No

How often did you have a drink containing alcohol in the past year?

[ ] Never [ ] Monthly or less [ ] 2-4 times a month [ ] 2-3 times a week

[ ] 4 or more times a week

How many drinks did you have on a typical day when you were drinking in the past year?

[ ] 1-2 drinks [ ] 3-4 drinks [ ] 5-6 drinks [ ] 7-9 drinks [ ] 10 or more drinks

How often did you have 6 or more drinks on one occasion in the past year?

[ ] Never [ ] Less than monthly [ ] Monthly [ ] Weekly [ ] Daily or almost daily

Drugs:

Have you used drugs other than those for medical reasons in the past year? [ ] Y [ ] N

Caffeine Intake: [ ] None [ ] 1-2 cups per day [ ] 2-3 cups per day

[ ] 3-4 cups per day [ ] More than 4 cups per day

Exercise Frequency: [ ] Never [ ] Occasionally [ ] 1-2 times per week

[ ] 2-3 times per week [ ] 3-4 times per week [ ] 4-7 times per week

Any history of domestic violence?

[ ] None [ ] History in the past [ ] Has restraining order

[ ] Feel unsafe at home [ ] Have a safety plan

Any history of verbal abuse?

[ ] None [ ] Occasional [ ] Frequent

[ ] Seeking counseling [ ] Has safety plan

Has your current partner ever threatened you or made you feel afraid? [ ] Yes [ ] No

Does your current partner or someone important to you hurt you physically or emotionally? [ ] Yes [ ] No

Review of Systems: Please check any that apply.

General Health:

[ ] weight gain/loss [ ] decreased energy [ ] fever [ ] chills [ ] sleep disorder

Endocrine:

[ ] excessive hunger or thirst [ ] temperature intolerance [ ] hair loss [ ] tremor

GI:

[ ] nausea [ ] vomiting [ ] diarrhea [ ] constipation [ ] change in bowel habits

Musculoskeletal:
[ ] weakness [ ] joint pains or swelling [ ] back pain

Psych:
[ ] depression [ ] anxiety [ ] difficulty concentrating

Neuro:
[ ] dizziness [ ] headaches [ ] blurred vision [ ] hearing problems

Urinary:
[ ] burning with urination [ ] frequent urination [ ] blood in the urine

Hematologic:
[ ] excessive bleeding [ ] easy bruising [ ] swollen glands

Respiratory:
[ ] shortness of breath [ ] chronic cough or wheezing

Skin:
[ ] acne [ ] unusual rashes [ ] changing moles

Cardiovascular:
[ ] chest pain [ ] palpitations [ ] skipped beats

 Name: