PATIENT NAME: DATE OF BIRTH:

New York Reproductive Wellness
Female Medical History & Information

Please complete this form prior to your meeting with the doctor. Leave blank anything that does not apply to you, that you have questions about or that you wish to speak with the doctor about in private.

PROBLEM

Reason for visit (e.g. infertility testing/evaluation, IVF, other)?

_____

How long have you had this problem? _____
Please discuss the nature and severity of the problem: _____

_____

_____

Do you have any personal, ethical, or religious objections to testing or treatments such as inseminations, IVF, egg donor IVF, masturbation to collect a semen sample? Y N If yes, please explain: _____

PROBLEMS CONCEIVING or KEEPING A PREGNANCY?

How long have you been having unprotected intercourse (in years/months)?

_____

Have any of these tests been done? (please provide medical records, if available; otherwise, testing date and results to the best of your memory)

Hysterosalpingogram or Sonohysterogram/water sonogram: _____

_____

Semen analysis: _____

Hormone testing (e.g. cycle day 3 FSH/estradiol, AMH, progesterone, thyroid, prolactin levels): _____

_____

Laparoscopy: _____

Hysteroscopy: _____

PCOS Work-Up: _____

Pregnancy Loss Work-Up: _____

Premature Ovarian Failure Work-Up: _____

Ovulation test kits (do they indicate LH surges, and if so, what cycle day do LH surges occur?): _____

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PREVIOUS FERTILITY TREATMENTS

Please specify # of cycles, the date(s) of treatment, the dosages of medications, and the outcome(s) (i.e. pregnant or not, ectopic pregnancy, or miscarriage).

intrauterine/artificial insemination: _____
Clomiphene citrate (e.g. Clomid or Serophene) with timed intercourse: _____
_____
Clomiphene citrate with insemination: _____
Injectible medications with insemination: _____
IVF cycles (also specify #eggs, #embryos transferred, #embryos frozen): _____
_____
_____
Frozen embryo transfers (also specify #embryos transferred): _____
_____
Other treatments, or complications experienced (e.g. OHSS, DVT, hospitalization): _____

MEDICAL HISTORY

Please list all medical problems.

Examples: autoimmune disorders (e.g. rheumatoid arthritis, SLE, myasthenia gravis), infections (e.g. chicken pox), thyroid disorder, diabetes, asthma, high blood pressure, heart disease, stroke, liver disease/ infection, kidney disease, blood clots (e.g. in leg or lung), bleeding disorder, cancer, and psychiatric disorders (e.g. depression, schizophrenia, bipolar disorder).

Medical problem	When diagnosed; doctor caring for you; treatment received
1. _____	_____
	_____
2. _____	_____
	_____
3. _____	_____
	_____

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4. _____ _____
_____

SURGICAL HISTORY

Please list all previous operative procedures, including dental work (e.g. dentures and bridges), and if any complications (e.g. anesthesia problems, other):

Date	Procedure	Diagnosis	Doctor/Hospital	Complications

1. _____

2. _____

3. _____

4. _____

OBSTETRICAL HISTORY (Chronologically, from most recent)

1. Date (month/day/year) of delivery or end of pregnancy: _____
Check which applies:

☐ Full term delivery
Vaginal delivery or C-section (circle). If C-section, why? _____
Weight of baby (lbs and oz): _____ Sex of baby: F M

☐ Preterm delivery (less than 37 weeks)
Vaginal delivery or C-section (circle). If C-section, why? _____
Weight of baby (lbs and oz): _____ Sex of baby: F M

☐ Ectopic/tubal pregnancy. If so, left or right? L R
Treatment (please circle): methotrexate/ tube removed/ tube opened

☐ Elective termination (abortion)

☐ Miscarriage less than 20 weeks. If so, was a D&C needed? Y N

Pregnancy ended or delivery occurred at how many weeks? _____
Any complications during pregnancy (e.g. stillbirth, high blood pressure, preeclampsia, diabetes, etc.) or after delivery (e.g. heavy vaginal bleeding, retained placenta, etc.)? Y N Specify: _____

PATIENT NAME: DATE OF BIRTH:

Any fertility treatments required? Y N If yes, please specify: _____
_____
How long did it take to get pregnant?_____
Conceived with current partner? Y N

2. Date (month/day/year) of delivery or end of pregnancy: _____
Check which applies:

☐ Full term delivery
Vaginal delivery or C-section (circle). If C-section, why? _____
Weight of baby (lbs and oz): _____ Sex of baby: F M

☐ Preterm delivery (less than 37 weeks)
Vaginal delivery or C-section (circle). If C-section, why? _____
Weight of baby (lbs and oz): _____ Sex of baby: F M

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Treatment (please circle): methotrexate/ tube removed/ tube opened

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Any fertility treatments required? Y N If yes, please specify: _____
_____
How long did it take to get pregnant?_____
Conceived with current partner? Y N

3. Date (month/day/year) of delivery or end of pregnancy: _____
Check which applies:

☐ Full term delivery
Vaginal delivery or C-section (circle). If C-section, why? _____
Weight of baby (lbs and oz): _____ Sex of baby: F M

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Any complications during pregnancy (e.g. stillbirth, high blood pressure, preeclampsia, diabetes, etc.) or after delivery (e.g. heavy vaginal bleeding, retained placenta, etc.)? Y N Specify: _____
Any fertility treatments required? Y N If yes, please specify: _____
_____
How long did it take to get pregnant?_____
Conceived with current partner? Y N

4. Date (month/day/year) of delivery or end of pregnancy: _____
Check which applies:

☐ Full term delivery
Vaginal delivery or C-section (circle). If C-section, why? _____
Weight of baby (lbs and oz): _____ Sex of baby: F M

☐ Preterm delivery (less than 37 weeks)
Vaginal delivery or C-section (circle). If C-section, why? _____
Weight of baby (lbs and oz): _____ Sex of baby: F M

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Treatment (please circle): methotrexate/ tube removed/ tube opened

☐ Elective termination (abortion)

☐ Miscarriage less than 20 weeks. If so, was a D&C needed? Y N

Pregnancy ended or delivery occurred at how many weeks? _____
Any complications during pregnancy (e.g. stillbirth, high blood pressure, preeclampsia, diabetes, etc.) or after delivery (e.g. heavy vaginal bleeding, retained placenta, etc.)? Y N Specify: _____
Any fertility treatments required? Y N If yes, please specify: _____
_____
How long did it take to get pregnant?_____
Conceived with current partner? Y N

5. Date (month/day/year) of delivery or end of pregnancy: _____
Check which applies:

☐ Full term delivery
Vaginal delivery or C-section (circle). If C-section, why? _____
Weight of baby (lbs and oz): _____ Sex of baby: F M

☐ Preterm delivery (less than 37 weeks)
Vaginal delivery or C-section (circle). If C-section, why? _____
Weight of baby (lbs and oz): _____ Sex of baby: F M

☐ Ectopic/tubal pregnancy. If so, left or right? L R

PATIENT NAME: DATE OF BIRTH:

Treatment (please circle): methotrexate/ tube removed/ tube opened

☐ Elective termination (abortion)

☐ Miscarriage less than 20 weeks. If so, was a D&C needed? Y N

Pregnancy ended or delivery occurred at how many weeks? _____

Any complications during pregnancy (e.g. stillbirth, high blood pressure, preeclampsia, diabetes, etc.) or after delivery (e.g. heavy vaginal bleeding, retained placenta, etc.)? Y N Specify: _____

Any fertility treatments required? Y N If yes, please specify: _____

_____

How long did it take to get pregnant?_____

Conceived with current partner? Y N

(Please provide additional pregnancy information on a separate piece of paper.)

GYNECOLOGICAL HISTORY

When was the first day of your last period? _____

Age when you had your first period: _____

The number of days between the start of one period to the start of the next period? _____

How many days of bleeding do you have? _____

Do you have painful periods, no periods, heavy or light periods, or bleeding or spotting between periods? Y N Please explain: _____

Do you need medication (e.g. Provera) to bring on periods? Y N If yes, which medications? _____

Age when you first noticed: breast development _____; pubic hair _____; underarm hair _____

Do you have a history of any of the following? Please specify treatment (e.g. I.V. antibiotics, hospitalization, other).

Y N infection in the fallopian tubes and uterus (i.e. pelvic inflammatory disease) _____

Y N Chlamydia or gonorrhea infection; or, other STD/ sexually transmitted disease (e.g. syphilis, HIV) _____

Y N Any other infection (e.g. tuberculosis)? _____

_____

Which form of birth control have been used [oral contraceptives/ birth control pills, foam or jelly, injectable contraception (e.g. Depo-Provera), diaphragm,

progestin IUD, contraceptive patch, vaginal ring, withdrawal or rhythm method]? Y N
If so, which one(s), when and for how long?
_____
Have you had you fallopian tubes tied? Y N If yes, when and which method (if known) and indicate whether you have had a tubal reversal? _____

When was you last Pap smear? _____
Have you ever had any abnormal Pap smears? Y N
If yes, did you need colposcopy, LEEP or a cone biopsy? _____
Any history of breast masses or nipple discharge? Y N If yes, what kind of evaluation or treatment did you receive? _____
Last mammogram, breast ultrasound or breast examination: _____

ALLERGIES

Please list all the medications or substances that you have an allergy to (e.g. latex, antibiotics, foods, environmental agents), and the reaction experienced (e.g. rash, hives, throat closure, anaphylaxis).

1. _____
2. _____
3. _____
4. _____

MEDICATIONS (including herbals, vitamins, health food store supplements)

Medication	Dosage of Medication	How many tablets/ day	Doctor
1. _____			
2. _____			
3. _____			

4. _____

SOCIAL HISTORY

How many cups of coffee, tea or caffeinated soda do you drink? _____
Do you or have you ever smoked cigarettes (or used any tobacco product)? Y N
If yes, how many packs/day and for how many years? _____
Do you drink alcoholic drinks? Y N If yes, what type (i.e. beer, wine, liquor), how many glasses per day? _____
Do you, or have you ever used other drugs (e.g. marijuana, cocaine, or any other recreational drugs)? Y N
Please specify: _____

Do you exercise? Y N If yes, what kind and how often? _____

Current occupation: _____
Are you aware of any potentially hazardous environmental exposure at work or home? Y N Please specify: _____

What is your ethnic background (e.g. Ashkenazi Jewish, Cajun/French Canadian, Italian or other Mediterranean, African American)?
_____

FAMILY HISTORY

Do you have a family history of:
Y N breast cancer? If yes, which family members? _____
Y N ovarian cancer? If yes, which family members? _____

Do you have a family or extended family members (include mother, father, sisters, brothers, children, paternal grandparents/ uncles/ aunts, maternal grandparents/ uncles/ aunts) with any of the following?

thyroid disorder, diabetes, asthma, high blood pressure, heart disease, stroke, liver disease/ infection, kidney disease, blood clots (e.g. in leg or lung), bleeding disorder, cancers (e.g. colon) and psychiatric disorders (e.g. depression, schizophrenia, bipolar disorder)?

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Family member	Medical conditions
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

Do you have any family history of any of the following?:
Y N inherited conditions [e.g. Cystic Fibrosis, Muscular Dystrophy, Sickle Cell Anemia, Thalassemia, Huntington's disease, Ashkenazi Jewish diseases (e.g. Tay-Sachs, Gaucher disease, Canavan Disease, Bloom Syndrome, Niemann-Pick disease, Fanconi Anemia, Familial Dysautonomia), Fragile X Syndrome, Spinal Muscular Atrophy, Hemophilia, Hemochromatosis, Dwarfism, Polycystic kidney disease, Marfan Syndrome, Galactosemia, color blindness, deafness/ blindness)
Y N Down Syndrome, or other chromosomal defects
Y N autism
Y N mental retardation
Y N developmental delay
Y N birth malformations
Y N endometriosis
Y N infertility
Y N menopause before age 40

Please specify: _____

SIGNS & SYMPTOMS

Do you have any of the following? Please elaborate:

Y N acne _____
Y N anxiety, stress or depression _____
Y N bladder or kidney problems _____
Y N blood in urine or stool _____
Y N breast discharge, lumps or pain _____

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Y N breathing difficulty _____
Y N chest pain _____
Y N cough _____
Y N constipation _____
Y N diarrhea _____
Y N easy bruising tendency _____
Y N excessive hair growth _____
Y N fainting tendency _____
Y N headaches _____
Y N increased frequency of urination _____
Y N increased weakness _____
Y N irregular heart beat _____
Y N leg or arm swelling, pain or redness _____
Y N nausea or vomiting _____
Y N pain in abdomen, pelvis or elsewhere _____
Y N recent weight gain or loss _____
Y N skin discoloration or lesions _____
Y N vaginal discharge _____
Y N vision, smelling or hearing difficulties _____

I confirm that I have read this form and that the information provided by me is true to the best of my knowledge.

Patient Signature: _____ Date: _____