Patient Past Medical History

A. Identifying Data

Date this form when completed___________

Your name _____________________ Partner's name______________________
Age________ Birth date_____________ Height___________ Weight_________
Length of marriage (or relationship)____________________________________
How long have you been trying unsuccessfully to get pregnant? ___________
____
Have you previously been pregnant? ____________________________________
Have you previously tried to get pregnant? ______________________________
Reason for your visit today? ____
____

B. Pregnancy History

Times pregnant__________ Term births_________ Premature births _________
Miscarriages _________ Elective abortion ________ Adopted children________

	Date	MisCarriage	Elective abortions	Ectopic	Months to Conceive	Infertility Treatment	Weight & Sex	C-Section	Complication	Is current partner the father
1.										
2.										
3.										
4.										
5.										

C. Contraceptive Use

Type | From when to when | Reason discontinued

1.____

2.____

3.____

D. Operations and Hospitalizations

Date	Diagnosis	Operation	Where performed	Physician
1.				
2.				
3.				
4.				
5.				
6.				

E. Medications: List all prescriptions and over the counter drugs used in the past year.

Date	Dosage and frequency	From when to when	Reason for taking
1.			
2.			
3.			
4.			
5.			
6.			

F. Allergies

To what (drug or substance)	When	what type of reaction?

G. Menstrual (hormonal) history

Date your last menstrual period began_______________________________
Your age at your first period____
Are your periods regular? ____
How many days from onset to onset? _______________________________
How many days do your period last? ______________________________
Do you bleed between periods? _____________________________________
Do you always have premenstrual symptoms___always___rarely___never?
Vigorous exercise: Type _______________________hours/week________
Type _______________________hours/week________
If you have a hormonal disorder, please specify type and treatment ______
____

Pelvic pain/cramps: ___none___during your period___before your period ___after your period ___at mid cycle ___during intercourse ___with urination ___ with bowel movements ___cause you to miss usual activities ___cause you to miss work
Pelvic pain/cramps are ___mild ___moderate ___severe ___getting worse ___ improving ___not changing ___ on the right side ___ on the left side ___ in the middle
What medications do you take for pain/cramps? _____________________
Do you have or have you had:

	Yes	No		Yes	No
Hot flashes	___	___	Increased facial or body hair	___	___
Breast discharge	___	___	Increased acne	___	___
Vision problems	___	___	Weight gain (> 10 lb.)	___	___
Poor sense of smell	___	___	Weight loss (>10 lb.)	___	___
Chronic headache	___	___	Special dietary habits	___	___
Head injury	___	___	Vomiting	___	___
Seizures	___	___	Diabetes	___	___
Thyroid disorder	___	___	Autoimmune disease	___	___
Excessive stress	___	___	Psychiatric treatment	___	___

If you answered yes to any question, please explain _________________________
____
____
____

H. Physical Conditions/Infections
Do you have, or have you had:

	Yes	No		Yes	No
Pelvic infection	___	___	Appendicitis	___	___
Chlamydia	___	___	Colitis or enteritis	___	___
Antichlamydial antibodies	___	___	Endometriosis	___	___
Gonorrhea	___	___	Pelvic Adhesions	___	___
Syphilis	___	___	Uterine fibroids or myoma	___	___
Mycoplasma	___	___	Abnormal uterus (shape, ect.)	___	___

Urea plasma	___	___	Ovarian cysts	___	___
Tuberculosis	___	___	Toxoplasmosis	___	___
			Cytomegalovirus	___	___

I. Other GYN issues

Do you have or have you had:

	Yes	No		Yes	No
Cervitis	___	___	Recurring vaginitis	___	___
Genital Herpes	___	___	Abnormal pap smears	___	___
Genital warts/ condyloma	___	___	Cryo (freezing) or		
Trichomonas	___	___	surgery of the cervix	___	___

How many times a week do you have sexual intercourse? _____________________
How many times do you have intercourse around ovulation? _________________
Do you use lubricants for intercourse? ______________________________________
Do you douche before or after intercourse? __________________________________
Have you ever had unwanted sexual experiences? ___________________________
Do you have any sexual problems at this time? ______________________________

J. Partner medical history

Your occupation____
Years of formal education____
Cigarettes--packs smoked/day____
Alcohol--type and number of drinks/week_________________________________
Marijuana--amount____
Other drugs--type and amount____
Ever used intravenous drugs? ____
Caffeine drinks per day____
Radiation exposure____
Toxic Exposure____
Video display terminal--hours/day____
Electric blanket use____
Hot tub or sauna use____
List all serious or chronic illnesses or injuries not already described___________
____
____
Do you or you family members have: ___infertility hormonal disorder___other inherited disorders? If yes, please explain___________________________________
____
____

K. Partner's Medical History

Your partner's age____Occupation____
List all serious or chronic illnesses or injuries________________________________
Medications____
____
Cigarettes--packs smoked/day____
Alcohol--type and number of drinks/week_________________________________
Marijuana--amount____
Other drugs--type and amount____
Ever used intravenous drugs? ____
Caffeine drinks per day____
Radiation exposure____
Toxic exposure____
Video display terminal--hours/day____

Electric blanket use____
Hot tub or sauna use____
Any problems with erection or ejaculation______________________________
Has semen analysis ever been abnormal_________________________________
Has your partner seen a doctor for infertility evaluation? ___________________
Doctor____
Diagnosis____
Treatment____

Has your partner ever fathered a pregnancy with another woman? ____________
Any inherited diseases in your partners' family? ___________________________
Does your partner have or has he had:

	Yes	No		Yes	No
Chlamydia	___	___	Vasectomy	___	___
Antichlamydial antibodies	___	___	Vasectomy reversal	___	___
Gonorrhea	___	___	Varicocele	___	___
Syphilis	___	___	Varicocele surgery	___	___
Genital Herpes	___	___	Biopsy of testicles	___	___
Genital warts/condyloma	___	___	Hernia surgery	___	___
Mycoplasm	___	___	Abdominal surgery	___	___
Urea plasma	___	___	Cancer	___	___
Urethritis/epididymitis	___	___	High blood pressure	___	___
Prostatits	___	___	Diabetes	___	___
Penile discharge or pain	___	___	Colitis	___	___
Undescended testicle	___	___	Seizures	___	___
Injury to the testicle(s)	___	___	Psychiatric treatment	___	___
Mumps with injury to the testicles	___	___	Excessive stress	___	___
Physical abnormality	___	___	Strenuous exercise	___	___
DES exposure in womb	___	___	Tight underwear	___	___

L. Previous Evaluation
Have you had:

	Not Done	Result Normal	Result Abnormal	Approx. date	Values (if known)
Basal Body temperature (BBT)	_____	_____	_____	__________	_________
Urine LH surge	_____	_____	_____	__________	_________
Endometrial biopsy	_____	_____	_____	__________	_________
Blood tests:					
FSH	_____	_____	_____	__________	_________
LH	_____	_____	_____	__________	_________
Prolactin	_____	_____	_____	__________	_________
Thyroid tests (TSH, T4)	_____	_____	_____	__________	_________
DHEAS	___	___	___	_________	________
Testosterone	___	___	___	_________	________
Estradiol	___	___	___	_________	________
Progesterone	___	___	___	_________	________
Postcoital test	___	___	___	_________	________
Cervical Mucus penetration test	___	___	___	_________	________
Mycoplasma culture	___	___	___	_________	________
Chlamydia culture	___	___	___	_________	________
Antichlamydial antibodies	___	___	___	_________	________
Female antisperm antibodies	___	___	___	_________	________
Hysterosalpingogram (HSG)	___	___	___	_________	________
Ultrasound	___	___	___	_________	________

IVP (kidney x-ray)	___	___	___	_________	________
Laparoscopy	___	___	___	_________	________
Hysteroscopy	___	___	___	_________	________
Karyotype	___	___	___	_________	________
Anticardiolipin antibodies	___	___	___	_________	________
Lupus anticoagulant	___	___	___	_________	________
Antinuclear antibodies (ANA)	___	___	___	_________	________
Coagulation screen	___	___	___	_________	________
Biochemistry/hematology panel	___	___	___	_________	________
Blood type	___	___	___	_________	________
Other	___	___	___	_________	________

Has your partner had:

Semen analysis	___	___	___	_________	________
Hamster egg penetration assay	___	___	___	_________	________
Semen antisperm antibodies	___	___	___	_________	________

List all causes of infertility previously diagnosed____________________________
____
____
____

M. Previous Treatment

	How many Months?	Dose (If known)	Approx. dates taken
Antibiotics	___________	___________	___________
Clomiphene (Clomid, Serephene)	___________	___________	___________
hMG (Pergonal)	___________	___________	___________
HCG (Profasi)	___________	___________	___________
Progesterone	___________	___________	___________
Dexamethasone	___________	___________	___________
GnRH agonist (Synarel, Lupron)	___________	___________	___________
Danazol	___________	___________	___________
Intrauterine insemination	___________	___________	___________
Insemination with donor sperm	___________	___________	___________
IVF (in vitro fertilization)	___________	___________	___________
Gift	___________	___________	___________
Other	___________	___________	___________

Please use the remainder of this page to explain any additional information you feel we may need. If you have done IVF please obtain copies of the stimulation flow sheet and embryology lab data.