History and Physical

Family Beginnings

**A. Identifying Data** Date this form when completed_____

Your name_____ Partner's name_____

Age_____ Birth date_____ Height_____ Weight_____

Length of marriage (or relationship)_____

Patient Self-Reported Ethnicity: (circle all that apply) Partner Self-Reported Ethnicity:

| American Indian or Alaska Native | Hispanic or Latino | Black or African American |
|---|---|---|
| Asian | Native Hawaiian or Other Pacific | White |

| American Indian or Alaska Native | Hispanic or Latino | Black or African American |
|---|---|---|
| Asian | Native Hawaiian or Other Pacific | White |

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._____

4._____

5._____

**D. Operations and Hospitalizations**

| | Date | Diagnosis | Operation | Where performed | Physician |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |
| 6. | | | | | |
| 7. | | | | | |

**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. | | | | |
| 7. | | | | |

**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, etc.) | ___ | ___ |
| Urea plasma | ___ | ___ | Ovarian cysts | ___ | ___ |
| Tuberculosis | ___ | ___ | Toxoplasmosis | ___ | ___ |
| | | | Cytomegalovirus | ___ | ___ |

**I. Combined**

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. Other 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 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 | ___ | ___ |
| Gonorrhe | ___ | ___ | 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 | _____ | _____ | _____ | _____ | _____ |
| Lupus anticoagulant | _____ | _____ | _____ | _____ | _____ |
| Antinuclear antibodies (ANA) | _____ | _____ | _____ | _____ | _____ |
| Coagulation screen | _____ | _____ | _____ | _____ | _____ |
| Biochemistry/hematology panel | _____ | _____ | _____ | _____ | _____ |
| Blood type | _____ | _____ | _____ | _____ | _____ |
| Other | _____ | _____ | _____ | _____ | _____ |

**Has your partner had:**

| | | | | | |
|---|---|---|---|---|---|
| Semen analysis | _____ | _____ | _____ | _____ | _____ |
| Hamster egg penetration assay | _____ | _____ | _____ | _____ | _____ |
| Semen anti-sperm antibodies | _____ | _____ | _____ | _____ | _____ |

List all causes of infertility previously diagnosed_____
_____
_____
_____

**Previous Treatment**

| | How many Months? | Dose (If known) | Approx. dates taken |
|---|---|---|---|
| Antibiotics | _____ | _____ | _____ |
| Clomiphene (Clomid, Serephene) | _____ | _____ | _____ |
| hMG (Repronex) | _____ | _____ | _____ |
| FSH (Gonal-F, Follistim) | _____ | _____ | _____ |
| HCG (Profasi, Novarel) | _____ | _____ | _____ |
| Progesterone | _____ | _____ | _____ |
| Dexamethasone | _____ | _____ | _____ |
| GnRH Agonist / Antagonist (Ganarelix, 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.**