

FEMALE MEDICAL HISTORY
REPRODUCTIVE ENDOCRINOLOGY/INFERTILITY

Physician you will be seeing: _____ Date of visit: _____

Physician who referred you: _____

Your Name: _____ Age: ____ Birthdate: _____

Address: _____

Telephone: _____ Your Occupation: _____
(home) (office)

Your Employer: _____ Your Religion: _____

Spouse's Name (if applicable): _____

Spouse's Occupation: _____ Date of Marriage: (if applicable): _____

Reason for your current visit: _____

Describe; as thoroughly as possible the background of your present problem. Include all symptoms, how long you have experienced them and indicate whether they have become worse, lessened or stayed the same in severity overtime (Continue on reverse side if needed).

Physician Notes:

MENSTRUAL HISTORY:

At what age did you begin to menstruate?: _____

What were the date your last two menstrual periods? _____

Have you ever gone more than 2 months without having a period? _____ Yes _____ No

If so, how long? (mos./yrs.) _____ Approximate date(s) when this occurred:

Are you normally regular or irregular? (Circle) If irregular, please describe:

What is the average length of your menstrual cycle? (Interval from 1st day of bleeding until day before bleeding of next cycle): _____

Has this changed since puberty? _____ Explain: _____

How many days does your period last? _____

Is your flow light, medium, or heavy? (Circle one) Does this vary? _____

Do you have pain during periods? _____ Yes _____ No (Describe) _____

Any pain between periods? _____ Yes _____ No (Describe) _____

Do you bleed between periods? _____ Yes _____ No Describe frequency and amount of blood loss:

Frequency of intercourse: _____ times per week or _____ times per month _____ N/A

Do you have any problems with intercourse? _____ Yes _____ No _____ N/A

Any changes in libido? _____ Yes _____ No _____ N/A

Any pain during or after intercourse? _____ Yes _____ No _____ N/A

Do you have any noticeable discharge? _____ Yes _____ No

If yes, describe your discharge: _____
(color, consistency, presence of odor, itching, etc.)

CONTRACEPTION: _____ Not Applicable (continue on to next section)

Please check (✓) any of the following methods of contraception you are currently using and/or have used in the past. Fill in the dates of usage.

<u>Method</u>	<u>Dates of Usage</u>
Birth Control Pills _____ Type: _____	_____
IUD _____ TYPE: _____	_____
Diaphragm _____	_____
Condom _____	_____
Jellies/Foam _____	_____
Withdrawal _____	_____
Sterilization _____ Male _____ Female	_____
Other: _____	_____

OBSTETRICAL HISTORY: _____ **Not Applicable(continue on to next section)**

	Number	Date(s)	Sex/Wt.	Vag./c-Sect.
Full Term Delivers (>5 lbs. 9 oz.)	_____	_____	_____	_____
Premature Deliveries	_____	_____	_____	_____
	Number	Dates(s)	Estimated Weeks of Term	
Miscarriages	_____	_____	_____	
Induced Abortions	_____	_____	_____	
Premature Deliveries	_____	_____	_____	
Ectopic Pregnancies	_____	_____	_____	
Stillbirths	_____	_____	_____	
Newborn deaths	_____	_____	_____	

Were there any complications during your deliveries? Yes No (Circle)

If yes, state which delivery and describe the complication(s).

Number of pregnancies with your present husband/partner: _____

Number of living children from this marriage/relationship: _____

Did you have any pregnancies/children born from a previous spouse/partner? _____

If yes, list the number of pregnancies: _____ And living children: _____

If applicable, number of pregnancies through artificial insemination

(Donor sperm only): _____ And living children: _____

PAST HISTORY:

Your general health: _____ Excellent _____ Good _____ Fair _____ Poor

Childhood illnesses: _____ Routine (chicken pox, measles, mumps, etc.)
_____ Unusual (Describe): _____

Do you have any allergies? (Specify) _____

List all **serious medical illnesses** requiring hospitalization, the date (s), duration of your hospitalization (s) and name of hospital (s): _____

List all **surgical procedures** you have had, the approximate date (s), duration of your hospitalization (s) and name hospital (s): _____

List current medications: State the name of medication and how long you've taken it.

Medications	Date (s) / Duration	Medication	Date (s)/Duration
1.	_____	4.	_____
2.	_____	5.	_____
3.	_____	6.	_____

Have you ever been in a serious accident and suffered a head injury? (describe) _____

Have you ever had a blood transfusion? Yes No (circle) Approximate date; _____

Do you drink alcohol? Frequently Occasionally Seldom Never (circle)

Do you smoke cigarettes? Yes No (circle) Number of packs per day: _____
If you smoked in the past and have quit, give the approximate dates of smoking: _____

FAMILY HISTORY:

Check (√) all of the following disorders you have a family history of. Next to each item, state which **blood relative** (mother/father/sister(s)/brother(s), maternal/paternal grandmother or grandfather, maternal/paternal aunt(s) or uncles(s), cousins) had the disorder. (**Do not** include yourself or your husband's relatives.)

- () Cancer (specify) _____ () Seizures
- () Tuberculosis () Obesity
- () Blood clotting disorders () Psychiatric disorders
- () Diabetes () Other: (specify) _____
- () Thyroid disorders _____
- () Heart disease _____
- () Hypertension

REVIEW OF SYSTEMS:

Check (√) any of the following disorders **you** currently have or have a history of.

Central Nervous System _____ Physician Notes
() Seizures

- Migraine headaches
- Other:

EENT

- Wear contact lenses
- Eye disorders
- Problems with sense of smell
- Other:

Cardiovascular

- Chest pain
- Palpitations
- Diagnosed with Rheumatic fever
- Heart valve disease
- High blood pressure
- Mitral valve prolapse
- Given prophylactic antibiotics
- Other:

Respiratory

- Shortness of breath
- Asthma (Date of Last Attack)
- Bronchitis
- Pneumonia
- Blood in sputum
- Other:

Gastrointestinal

- Nausea/vomiting
- Blood in stool
- Ulcers
- Hepatitis
- Constipation
- Spastic colon
- Other:

Genito-urinary

- Bladder infections (cystitis)
- Kidney infection
- Gonorrhea
- Syphilis
- Herpes
- Vaginal infections
- Pelvic inflammatory disease
- Pelvic pain
- Other:

Hematologic

- Blood clotting disorder
- Sickle cell anemia or trait
- Other:

Endocrine

- Diabetes
- Thyroid disease
- Excessive growth of hair on various parts of the body
- Unexplained excretion of milk from breasts
- Rapid weight gain

