USC Fertility
Alternatives for Today & Tomorrow

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FEMALE PATIENT HISTORY

I. IDENTIFYING INFORMATION

Date _____

Name _____ Partner's Name _____

Date of Birth _____ Partner's Date of Birth _____ Duration of Relationship _____ Duration of Infertility _____

Nature of present employment (title, brief description) _____

_____

II. MEDICAL HISTORY

	YES	NO
Weight _____ Height _____ Blood Type (if known) _____		
Have you lost greater than 20 pounds of weight in the last year?	☐	☐
Do you follow a particular food diet or have any special dietary habits?	☐	☐
If yes, please specify: _____		
List the forms and frequency of regular vigorous exercise (swimming, cycling, running) and age you began:		
Exercise: _____ Hrs/Wk: _____ Age: _____ Exercise: _____ Hrs/Wk: _____ Age: _____		
Have you ever had pelvic surgery?	☐	☐
If yes, please specify date and type: _____		

Do you have or have you ever had (check all that apply):

- ☐ Anemia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Blood Transfusions
- ☐ Breast Milky Discharge
- ☐ Breast Soreness
- ☐ Breast Tenderness
- ☐ Cancer / Specify _____ _____
- ☐ Chlamydia
- ☐ Chronic Bronchitis
- ☐ Chronic Headaches
- ☐ Colitis
- ☐ Color Blind
- ☐ Diabetes
- ☐ Dizziness
- ☐ Endometriosis
- ☐ Epilepsy
- ☐ Gallbladder Problems
- ☐ Gonorrhea
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ Hirsutism (Excess hair growth)
- ☐ High Blood Pressure
- ☐ Immunization: German Measles
- ☐ Kidney Infection
- ☐ Liver Problems
- ☐ Loss of Balance
- ☐ Measles: German
- ☐ Measles: Regular
- ☐ Neurological Problems
- ☐ Nongonococcal Urethritis
- ☐ Ovarian Cysts
- ☐ Parasitic Infection
- ☐ Pelvic Infection
- ☐ Pneumonia
- ☐ Poor Sense of Smell
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Syphilis
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Vaginitis (Trichomoniasis, yeast) # of episodes _____
- ☐ Visual Disturbances
- ☐ Any Allergies: List _____ _____ _____

Have you ever been treated for cancer?	☐	☐
If yes, explain therapy: _____		
Have you every received X-rays to the pelvic area for therapy or diagnosis?	☐	☐
If yes, please specify: _____		
Within the last year, have you taken any prescription medications?	☐	☐
If yes, please list all prescriptions and problems for which you were taking them: _____		

_____

YES NO

Are you taking any over-the-counter medications on a regular basis? ☐ ☐

If yes, please list all medications and diagnoses: _____

_____

Do you use or have you ever used (check all that apply):

☐ Alcohol – How many glasses per week do you usually drink? Wine _____ Beer _____ Cocktails _____

☐ Cigarettes – Number of packs per day _____

☐ Illicit or Recreational Drugs (Marijuana, Cocaine, etc.) If you would feel more comfortable not writing anything down, please discuss directly with your physician. _____

III. MENSTRUAL AND PREGNANCY HISTORY

Age at first menstrual cycle _____ Date of last menstrual cycle _____

Are your menstrual cycles regular? ☐ ☐

If yes, what is the number of days between menstrual cycles? _____
If no, how many times per year do you menstruate? _____

What is the usual duration of your period (how many days)? _____ Use: ☐ Tampons? ☐ Pads?

Are cramps present before, during, or after your period? _____
Are cramps: ☐ Mild ☐ Moderate ☐ Severe

Do you have to take pain medication for cramps? ☐ ☐
If yes, please specify medication: _____

Do you bleed or spot between periods? ☐ ☐

How many pregnancies (including abortions) have you had? _____

	When? (Year)	End in abortion?	End in miscarriage	Ectopic pregnancy?	Infertility therapy required to conceive?	How long to conceive?	Baby born alive?	Is current partner the father?
1st Pregnancy								
2nd Pregnancy								
3rd Pregnancy								
4th Pregnancy								
5th Pregnancy								

Were there any complications during or after your pregnancies? ☐ ☐
If yes, please explain: _____

Did your mother have any difficulty with conception or pregnancy? ☐ ☐
If yes, explain: _____

How long have you been trying to get pregnant? _____

Did your mother take diethylstilbestrol (DES) when she was pregnant with you? ☐ ☐

IV. CONTRACEPTIVE / SEXUAL HISTORY

What form of contraception do you use now or have you used in the past? Check all that apply:

☐ Pills / Name: _____ ☐ IUD / Name: _____ ☐ Diaphragm ☐ Withdrawal ☐ Foams/Jellies
☐ Condom ☐ Rhythm ☐ None ☐ Other: _____

For each contraception method used, specify length of use and reason for discontinuation:

Method	Length of Use	Reason for Discontinuation
_____	_____	_____
_____	_____	_____
_____	_____	_____

	YES	NO
If you've ever been on oral contraceptives (pills), were your periods regular after stopping the pills?	☐	☐
How many times per week do you and your partner have sexual intercourse? _____		
How many times do you have intercourse around ovulation? _____		
Is intercourse painful or difficult for you?	☐	☐
Do you use lubricants for intercourse?	☐	☐
If yes, which one(s)? _____		
Do you douche before or after intercourse?	☐	☐

V. FAMILY HISTORY

Is there a family history of infertility?	☐	☐
If yes, who (list all members and relationship to you): _____		
_____		
Is there a history of hormonal disorders in your family?	☐	☐
If yes, who and type: _____		
_____		

VI. HISTORY OF FERTILITY THERAPY

Have you been treated for infertility before?	☐	☐
If yes, who was your physician? _____		
What cause of infertility was diagnosed? _____		

What drugs have you taken for infertility? Check all that apply:

- ☐ clomiphene citrate (Clomid®)
- ☐ hMG (Repronex®, Pergonal®)
- ☐ Estrogens
- ☐ Progesterone
- ☐ Prednisone (or cortisone-like drugs)
- ☐ Antibiotics
- ☐ GnRH or LHRH (Factrel®)
- ☐ hCG (Profasi®)
- ☐ bromocriptine (Parlodel®)
- ☐ danazol (Danocrine®)
- ☐ urofollitropin or FSH (Follistim®)
- ☐ Other – specify _____
- ☐ None

Which of the following tests have you had performed? Heck all that apply and the results if known:

☐ BBT	When? _____	Results: _____
☐ Post coital Test	When? _____	Results: _____
☐ Hormonal Assays (FSH, LH, prolactin DHEA-S, testosterone, progesterone)	When? _____	Results: _____
☐ Endometrial Biopsy	When? _____	Results: _____
☐ Hysterosalpingogram	When? _____	Results: _____
☐ Ultrasound	When? _____	Results: _____
☐ Antibodies	When? _____	Results: _____
☐ Laparoscopy, Hysteroscopy	When? _____	Results: _____
☐ Mycoplasma/Chlamydia Cultures	When? _____	Results: _____
☐ Thyroid Tests	When? _____	Results: _____
☐ Other – Specify _____	When? _____	Results: _____

	YES	NO
Have you ever had a tubal reversal?	☐	☐
If yes, please specify dates: _____		
Have you every had surgery for lysis of adhesions?	☐	☐
Have you ever had cervical conization or cautery?	☐	☐
Have you ever had any other surgery (D&C, ovarian, appendectomy, thyroid)?	☐	☐
If yes, please specify: _____		
Have you ever undergone artificial insemination or in vitro fertilization?	☐	☐
If yes, using partner or donor sperm? _____		
Is your partner seeing a doctor for evaluation of infertility?	☐	☐
If yes, specify physician name and location: _____		
Does the doctor feel that your partner has an infertility problem?	☐	☐
If yes, what is the diagnosis and how is he being treated? _____		
Has he ever fathered a child with another woman?	☐	☐
If yes, when? _____		

ADDITIONAL COMMENTS: _____

_____

_____

_____