USC Fertility
Alternatives for Today & Tomorrow

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FEMALE PATIENT HISTORY

DATE: _____

I. IDENTIFYING INFORMATION

Name: _____ Partner's Name: _____

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

II. MEDICAL HISTORY

Weight: _____ Height: _____ Blood Type (if known): _____

	YES	NO
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 surgeries? If yes, please specify: _____	☐	☐
Do you have any medical issues? If yes, please specify: _____	☐	☐
Do you have any allergies? If yes, please specify: _____	☐	☐

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

☐ Anemia	☐ Dizziness	☐ Neurological Problems
☐ Appendicitis	☐ Endometriosis	☐ Ovarian Cysts
☐ Arthritis	☐ Epilepsy	☐ Parasitic Infection
☐ Blood Transfusions	☐ Gallbladder Problems	☐ Pelvic Infection
☐ Breast Milky Discharge	☐ Gonorrhea	☐ Pneumonia
☐ Breast Soreness	☐ Heart Disease	☐ Poor Sense of Smell
☐ Breast Tenderness	☐ Hepatitis	☐ Seizures
☐ Cancer/ Specify: _____	☐ Herpes	☐ Syphilis
☐ Chlamydia	☐ Hirsutism (excessive hair growth)	☐ Thyroid Problems
☐ Chronic Headaches	☐ High Blood Pressure	☐ Tuberculosis
☐ Colitis	☐ Kidney Infection	☐ Ulcers
☐ Color Blind	☐ Liver Problems	☐ Visual Disturbances
☐ Diabetes	☐ Loss of Balance	☐ Vaginitis (Trichomoniasis, yeast)

	YES	NO
Have you ever been treated for cancer? If yes, please explain treatment: _____	☐	☐
Within the last year, have you taken any prescription medications? If yes, please specify: _____	☐	☐
Any over-the-counter medications: _____		
Have you had a high fever (over 102°F) during the past 3-4 months?	☐	☐

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 & PREGNANCY HISTORY

YES NO

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 you period (how many days)? _____Use: Tampons ☐ Pads ☐

Describe any cramping during your period: Mild ☐ Moderate ☐ Severe ☐

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

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, explain: _____ ☐ ☐

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

IV. CONTRACEPTIVE / SEXUAL HISTORY

Have you used contraception in the past? If yes, for each contraception method used, specify length of use and reason for discontinuation:

Method Length of Use Reason for Discontinuation

_____ _____ _____

_____ _____ _____

_____ _____ _____

How many times per week do you and your partner have sexual intercourse? _____

How many times per week do you have intercourse around ovulation? _____

Is intercourse painful or difficult for you? If yes, please explain: _____ ☐ ☐

Do you use lubricants for intercourse? If yes, what? _____ ☐ ☐

Do you douche before or after intercourse? ☐ ☐

How long have you been trying to get pregnant? _____

How do you track ovulation?

☐ Ovulation Predictor Kits ☐ Basal Body Temperature ☐ Mobile App ☐ Calendar

V. FAMILY HISTORY

Is there a family history of infertility or early menopause? If yes, please specify: _____ ☐ ☐

Is there a history of hormonal disorders in your family? If yes, please specify: _____ ☐ ☐

VI. HISTORY OF FERTILITY THERAPY

	YES	NO
Have you been treated for infertility before? If yes, who was your physician? _____	☐	☐
What cause of infertility was diagnosed? _____	☐	☐
Is your partner seeing a doctor for evaluation of infertility? If yes, what physician? _____	☐	☐
Does the doctor feel that your partner has an infertility problem? If yes, what issue? _____	☐	☐
Has he ever fathered a child with another woman? If yes, when? _____	☐	☐

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

- ☐ Clomiphene citrate (Clomid®)
- ☐ Menopur®
- ☐ FSH (Follistim® or Gonal-f®)
- ☐ Growth hormone
- ☐ hCG (Pregnyl®)
- ☐ Estrogens
- ☐ Progesterone
- ☐ Other: _____

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

- ☐ Hormonal Assays (FSH, LH, DHEA-S, prolactin, testosterone, progesterone) When? _____ Results: _____
- ☐ Endometrial Biopsy When? _____ Results: _____
- ☐ Hysterosalpingogram (HSG) When? _____ Results: _____
- ☐ Ultrasound (regular or saline) When? _____ Results: _____
- ☐ Laparoscopy, Hysteroscopy When? _____ Results: _____
- ☐ Other – Specify: _____ When? _____ Results: _____

What fertility treatment(s) have you undergone?

Type: _____ When? _____ Outcome: _____
Type: _____ When? _____ Outcome: _____
Type: _____ When? _____ Outcome: _____
Type: _____ When? _____ Outcome: _____

ADDITIONAL COMMENTS:

_____
_____
_____
_____
_____
_____
_____

Ethnicity Questionnaire for Genetic Screening

At USC Fertility we recommend preconception genetic screening for all of our patients, regardless of ethnicity. However, your ethnic background will determine what type of testing we do.

Patients Name: _____

Please check which ethnic background(s) applies to **you:**

	Caucasian- Southern European (Italian, Greek)
	Caucasian- Northern European (British, German, Irish)
	Asian- East (Chinese, Korean, Japanese)
	Asian- South Asian (Indian, Pakistani)
	Asian- South East Asian (Filipino, Vietnamese)
	Hispanic/Latino
	Indian
	African American
	Ashkenazi Jewish
	Middle Eastern
	Native American
	French Canadian/Cajun
	Pacific Islander
	Unknown
	Other (please specify)
	Decline to state

Partners Name: _____

Please check which ethnic background(s) applies to **your partner:**

	Caucasian- Southern European (Italian, Greek)
	Caucasian- Northern European (British, German, Irish)
	Asian- East (Chinese, Korean, Japanese)
	Asian- South Asian (Indian, Pakistani)
	Asian- South East Asian (Filipino, Vietnamese)
	Hispanic/Latino
	Indian
	African American
	Ashkenazi Jewish
	Middle Eastern
	Native American
	French Canadian/Cajun
	Pacific Islander
	Unknown
	Other (please specify)
	Decline to state

Please see back side

Genetic Screening at USC Fertility

Of the hundreds of diseases that we may acquire in our lifetime, many of them are related to defective changes in our genetic code (DNA). Mutations in specific genes within our DNA can cause alterations in our body functions resulting in specific diseases, which can have limited or severely life altering affects.

We have two copies of every gene, one from each parent. A person is considered a "carrier" when they carry the genetic mutation but do not have any medical symptoms of the disease (typically that person has one defective copy and one normal copy). A carrier can pass down the defective gene to their child. Carriers are often identified only by a specific genetic test. Many genetic disorders are double-recessive, which means both you and your partner would have to be carriers for your baby to possibly have the disease.

Carrier status for a recessive disease is commonly passed silently from generation to generation, and depending on the disease is more prevalent in families of a certain ethnicity. Therefore, you may be at an increased risk of getting or passing on a genetic disorder because of your ethnic background.

We are currently recommending ethnic based genetic screening for all of our patients. Genetic screening and counseling before pregnancy may reassure a couple that their children are not at increased risk for a specific inherited disease.

There is no single test that will detect the risk of any genetic disease in a couple's offspring. No medical test is 100% accurate, and many diseases may have causes (genetic or otherwise) that are currently unknown, and therefore can not be tested for currently. Therefore, all genetic testing should be considered risk reducing and not risk eliminating. In addition, birth defects may occur that are not genetically based (e.g., environmental and toxic exposure, or random and unexplained) and may not be detected with genetic screening.

If you are concerned about your genetic family history, a genetic counselor may be helpful to identify what your specific risks may be and to determine which tests are the most appropriate. Therefore, we recommend not only speaking with your physician, but a genetic counselor as well if you know or suspect that you may be a carrier of a genetic disorder.

☐ I agree to undergo genetic testing according to the recommendations of my physician

☐ I do not wish to undergo genetic testing or wish to only undergo partial genetic testing recommended by my physician and I understand the consequences of this decision.

PATIENT NAME (Print) **PATIENT SIGNATURE** **DATE**

Your signature above indicates that you have read the entire preceding document and that you have had an opportunity to ask questions, and that your questions have been answered to your satisfaction.