Female Patient's History Form

North Shore LIJ The Center for Human Reproduction

PATIENT'S NAME: _____ **FEMALE PATIENT'S HISTORY FORM**

TODAY'S DATE: _____

DIVISION OF HUMAN REPRODUCTION

TODAY'S DATE:

NAME: AGE: BIRTH DATE:

(Formerly) BIRTH PLACE:

CELL PHONE:

ADDRESS: HOME PHONE:

YOUR OCCUPATION: BUS. TEL:

EMAIL:

YOUR EMPLOYER: MARITAL STATUS

[ ] SINGLE [ ] DIVORCED

[ ] MARRIED [ ] WIDOWED

RELIGION: [ ] SAME SEX COUPLE

REFERRED BY
MD: RELATIVE/FRIEND:

ADDRESS: ADDRESS:

OBSTETRICS & GYNECOLOGY- MEDICAL HISTORY

PARTNER: AGE:

PARTNER'S OCCUPATION:

PARTNER'S EMPLOYER:

BUS.ADDRESS:

BUS.TEL: CELL:

RELIGION:

YOUR PRIMARY INSURANCE:

CARD.NO. GROUP NO.:

ALL PREVIOUS OCCUPATIONS:

LIST ALL STATES OR COUNTRIES IN WHICH YOU HAVE LIVED:

EDUCATION: PLEASE CIRCLE THE LAST GRADE YOU COMPLETED HIGH SCHOOL 1 2 3 4 COLLEGE 1 2 3 4 DEGREES POST GRAD._____YRS

DATE OF LAST PHYSICAL EXAM AND PAP SMEAR: _____

CHIEF COMPLAINTS: (PLEASE LIST REASON FOR VISIT)

1._____
2._____
3._____
4._____

REASON FOR VISIT: [ ] INFERTILITY EVALUATION [ ] HORMONAL PROBLEM

[ ] OTHER_____

Do you have any personal, ethical, or religious objections to any of our tests or treatments such as insemination, in vitro fertilization, egg donation, sperm donation, masturbation to collect a semen sample, etc.? [ ]NO [ ]YES_____

How long have you been having intercourse without using any form of birth control?_____

FAMILY HISTORY	AGE	IF LIVING, What is their health?	AGE AT DEATH	IF DECEASED, CAUSE
FATHER				
MOTHER				
BROTHER OR SISTER 1				
2				
3				
4				
5				
HUSBAND OR WIFE				
SON OR DAUGHTER 1				
2				
3				
4				
5				
6				

HAS ANY BLOOD RELATIVES HAD:	PLEASE CIRCLE	WHO.
CANCER	NO	YES
TUBERCULOSIS	NO	YES
DIABETES	NO	YES
HEART TROUBLE	NO	YES
HIGH BLOOD PRESSURE	NO	YES
STROKE	NO	YES
EPILEPSY	NO	YES
MENTAL ILLNESS	NO	YES
MISCARRIAGE	NO	YES
INFERTILITY	NO	YES
MENSTRUAL PROBLEMS	NO	YES
CONGENITAL DEFORMITIES	NO	YES
EARLY MENOPAUSE	NO	YES
FIBROIDS	NO	YES
ENDOMETRIOSIS	NO	YES
GENETIC DISEASES	NO	YES

PERSONAL HISTORY

ILLNESS: HAVE YOU HAD (PLEASE CIRCLE ALL ANSWERS NO OR YES)

MEASLES OR GERMAN MEASLES	NO	YES
CHICKEN POX OR MUMPS	NO	YES
PNEUMONIA OR PLEURISY	NO	YES
RHEUMATIC FEVER OR HEART DISEASE	NO	YES
ARTHRITIS, LUPUS	NO	YES
ANY BONE OR JOINT DISEASE	NO	YES
NEUROLOGICAL DISEASE	NO	YES
SCIATICA	NO	YES
FIBROIDS	NO	YES
KIDNEY DISEASE	NO	YES
ENDOMETRIOSIS	NO	YES
CANCER	NO	YES
HIV or AIDS	NO	YES
HEPATITUS B or C	NO	YES
GONORRHEA,SYPHILIS,HERPES, CHLAMYDIA, or HPV	NO	YES
PELVIC INFECTION	NO	YES
ANEMIA OR JAUNDICE	NO	YES
EPILEPSY	NO	YES
MIGRAINE HEADACHES	NO	YES
TUBERCULOSIS	NO	YES
DIABETES	NO	YES
HIGH BLOOD PRESURE	NO	YES
PSYCHIATRIC ILLNESS	NO	YES
ASTHMA	NO	YES
HIVES, ECZEMA, PSORIASIS	NO	YES
FREQUENT INFECTIONS	NO	YES
ANY OTHER DISEASE (Please indicate what type of disease)	NO	YES

ALLERGIES: ARE YOU ALLERGIC TO:

PENICILLIN OR SULFA	NO	YES
ASPIRIN,CODEINE OR MORPHINE	NO	YES
MYCINS OR OTHER ANTIBIOTICS	NO	YES
IODINES	NO	YES
ANY OTHER DRUG	NO	YES
ANY FOOD	NO	YES
ADHESIVE TAPE	NO	YES
LATEX	NO	YES

TRANSFUSIONS: HAVE YOU EVER HAD
BLOOD OR PLASMA TRANSFUSION... NO YES

WEIGHT: NOW_____ONE YEAR AGO_____

MAX._____ WHEN_____

HEIGHT_____

Please review the section you have just completed and wherever you answered "YES", fill in the year (guess if necessary), where there is more than one illness listed on the line, circle the ones you had. For example: CHICKEN POX or MUMPS:.....NO YES

DO YOU WISH INFORMATION ON ADVANCED DIRECTIVES? NO YES GIVEN _____

HAVE YOU EVER BEEN ADVISED TO HAVE ANY SURGICAL OPERATION WHICH HAS NOT BEEN DONE? NO YES WHAT: _____

NOTE: **THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY AND WILL BE KEPT IN THIS OFFICE. INFORMATION CONTAINED HERE WILL NOT BE RELEASED TO ANY PERSON EXCEPT WHEN YOU HAVE AUTHORIZED US TO DO SO.**

North Shore LIJ The Center for Human Reproduction

PATIENT'S NAME: _____

TODAY'S DATE: _____

FEMALE PATIENT'S HISTORY FORM

SURGERY: HAVE YOU HAD:

TONSILLECTOMY..... [ ]NO [ ]YES
APPENDECTOMY..... [ ]NO [ ]YES
ANY OTHER OPERATION..... [ ]NO [ ]YES (GIVE DETAILS)

Give DETAILS below of all hospitalizations for surgery or illness including date of surgery/illness, name and address of Doctor and Hospital.

SYMPTOMS Please check those you have had.

Trouble with: [ ]NOSE [ ]SINUSES [ ]MOUTH [ ]THROAT

EYE DISEASE [ ]	FAINTING SPELLS [ ]	DIZZINESS [ ]	**HABITS: ..... Do You:**
EYE INJURY [ ]	LOSS OF CONSCIOUSNESS [ ]	DEPRESSION OR	SLEEP WELL? NO YES
IMPAIRED	CONVULSIONS [ ]	ANXIETY [ ]	Alcoholic beverages? NO YES
SIGHT [ ]	PARALYSIS [ ]	HALLUCINATIONS [ ]	(everyday?) NO YES
EAR	FREQUENT OR SEVERE	ENLARGED GLANDS [ ]	SMOKE? NO YES
DISEASE [ ]	HEADACHES [ ]	GOITER OR ENLARGED	DRUG USE? NO YES
EAR INJURY OR	SKIN DISEASE [ ]	THYROID [ ]	(if so, which drugs):
IMPAIRED	SHORTNESS OF BREATH [ ]	SWELLING OF HANDS,	
HEARING [ ]	NIGHT SWEATS [ ]	FEET, OR ANKLES [ ]	IS YOUR DIET
CHRONIC OR	PALPITATION OR FLUTTERING	VARICOSE VEINS [ ]	WELL BALANCED? NO YES
FREQUENT	HEART [ ]	EXTREME TIREDNESS	
COUGH [ ]	KIDNEY DISEASE OR STONES [ ]	OR WEAKNESS [ ]	
CHEST PAIN OR	BLADDER DISEASE [ ]	DIFFICULTY IN	
ANGINA	ALBUMIN, SUGAR, PUS, etc.,	URINATING [ ]	
PECTORIS [ ]	IN URINE [ ]	AWAKE TO URINATE	
SPITTING UP	STOMACH TROUBLE OR ULCERS [ ]	NIGHTLY [ ]	
OF BLOOD [ ]	LIVER OR GALL	CONSTIPATION OR	
INDIGESTION [ ]	BLADDER DISEASE [ ]	DIARRHEA [ ]	
BLEEDING	HEMORRHOIDS OR RECTAL	COLITIS OR OTHER	
DISORDERS [ ]	BLEEDING [ ]	BOWEL DISEASE [ ]	
RECENT CHANGE IN	RECENT CHANGE		
APPETITE OR	IN BOWEL ACTION		
EATING HABITS [ ]	OR STOOLS [ ]		

LIST ANY DRUGS OR MEDICATIONS YOU TAKE REGULARLY OR FREQUENTLY

Total number of ALL pregnancies:_____ Number of miscarriages (less than 20 weeks):_____

Number of Ectopic/Tubal Pregnancies:_____ Number of Elective Terminations (Abortions):_____

Number of Full Term Deliveries: _____ Of these, how many were live births?_____ Stillbirths?_____

Number of Premature (less than 37 weeks) Deliveries:_____ Of these, how many were live births?_____ How many were stillborn?_____

Any Pregnancies with Birth Defects? ( )No ( )Yes- explain_____

Date Pregnancy Ended Or Delivered	Months to Conception	Treatments to Conceive	Delivery Type D&C/Complications	Current Partner
				[ ]Y [ ]N
				[ ]Y [ ]N
				[ ]Y [ ]N
				[ ]Y [ ]N
				[ ]Y [ ]N

GYNECOLOGICAL HISTORY

Age of first menstration_____

Are menstrual cycles regular? NO YES

Are your periods similar? NO YES

Interval between periods: _____

Length of flow: _____ Date of last menstrual cycle: _____

Amount of flow: Light [ ] Moderate [ ] Heavy [ ]

Has there been bleeding in between periods? [ ]NO [ ]YES, specify:

DYSMENORRHEA (MENSTRUAL DISCOMFORT) [ ]NO [ ]YES, specify: mild/ moderate/ severe

Type of menstrual discomfort:

[ ]None [ ]Dull [ ]Cramp
[ ]Sharp [ ]Ache [ ]Backache

PREMENSTRUAL SYMPTOMS

BLOATING	[ ]NO [ ]YES	HEADACHE	[ ]NO [ ]YES
BREAST TENDERNESS	[ ]NO [ ]YES	IRRITABILITY	[ ]NO [ ]YES
PELVIC PAIN	[ ]NO [ ]YES	EDERNS	[ ]NO [ ]YES
BACKACHE	[ ]NO [ ]YES	ACNE	[ ]NO [ ]YES

INTERMENSTRUAL DISCHARGE

Type: ..... [ ]None [ ]Yellow [ ]White
[ ]Tan [ ]Bloody [ ]Other (specify)

Amount of discharge [ ]Scant [ ]Moderate [ ]Heavy

ITCHING [ ]NO [ ]YES

ODORLESS [ ]NO [ ]YES

FREQUENT [ ]NO [ ]YES

MARITAL DATES _____

Prior marriage? [ ]NO [ ]YES, (Dates):

Is sex entirely satisfactory ? [ ]NO [ ]YES

Is there discomfort during sex? [ ]NO [ ]YES

Orgasm? [ ]NO [ ]YES

Estimated frequency of sexual intercourse per month? _____

Sexual problems? [ ]YES

Prior contraception methods? _____

Use of lubricants? [ ]NO [ ]YES

Age of first coital experience _____

Was pregnancy achieved? [ ]NO [ ]YES

REMARKS: _____

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PATIENT'S NAME: _____ **FEMALE PATIENT'S HISTORY FORM**

TODAY'S DATE: _____

PRIOR INFERTILITY TESTING AND TREATMENT (check all that apply):

Have you had prior infertility testing or treatment elsewhere? [ ]Yes [ ]No

Prior tests (check all that apply):

[ ] Basal body temperature chart (date_____/results_____)
[ ] Thyroid test (date_____/results_____)
[ ] Day 3 blood test for FSH level (date_____/results_____)
[ ] Prolactin blood test (date_____/results_____)
[ ] Progesterone blood test (date_____/results_____)
[ ] Ovulation test kit (date_____/results_____)
[ ] Hysterosalpingogram (HSG) (date_____/results_____)
[ ] Hysteroscopy surgery (date_____/results_____)
[ ] Laparoscopy surgery (date_____/results_____)

TREATMENT

	Number of cycles	Dates (mo/yr) to (mo/yr)	Outcome
[ ] Intrauterine inseminations	_____	___/___to___/___	___ Pregnant: ___Delivered ___Ectopic ___Miscarriage___Not Pregnant
[ ] Clomiphene citrate with timed intercourse: maximum # of tablets per day?_____	_____	___/___to___/___	___ Pregnant ___Delivered ___Ectopic ___Miscarriage___Not Pregnant
[ ] Clomiphene citrate with insemination: maximum # of tablets per day?_____	_____	___/___to___/___	___ Pregnant: ___Delivered ___Ectopic ___Miscarriage___Not Pregnant
[ ] Daily fertility drug injections with insemination: maximum # of vials per day?_____	_____	___/___to___/___	___ Pregnant: ___Delivered ___Ectopic ___Miscarriage___Not Pregnant
[ ] Completed in vitro fertilization cycle(s):		Dates (mo/yr)	
1.# eggs____ # embryos transferred____ # frozen____	_____	_____/_____	___ Pregnant: ___Delivered ___Ectopic ___Miscarriage___Not Pregnant
2.# eggs____ # embryos transferred____ # frozen____		_____/_____	___ Pregnant: ___Delivered ___Ectopic ___Miscarriage___Not Pregnant
3.# eggs____ # embryos transferred____ # frozen____		_____/_____	___ Pregnant: ___Delivered ___Ectopic ___Miscarriage___Not Pregnant
4.# eggs____ # embryos transferred____ # frozen____		_____/_____	___ Pregnant: ___Delivered ___Ectopic ___Miscarriage___Not Pregnant
5.# eggs____ # embryos transferred____ # frozen____		_____/_____	___ Pregnant: ___Delivered ___Ectopic ___Miscarriage___Not Pregnant
[ ] Frozen embryo transfers:			
1. # embryos tranferred_____	_____	_____/_____	___ Pregnant: ___Delivered ___Ectopic ___Miscarriage___Not Pregnant
2. # embryos tranferred_____.		_____/_____	___ Pregnant: ___Delivered ___Ectopic ___Miscarriage___Not Pregnant
3. # embryos tranferred_____		_____/_____	___ Pregnant: ___Delivered ___Ectopic ___Miscarriage___Not Pregnant
4. # embryos tranferred_____		_____/_____	___ Pregnant: ___Delivered ___Ectopic ___Miscarriage___Not Pregnant
5. # embryos tranferred_____		_____/_____	___ Pregnant: ___Delivered ___Ectopic ___Miscarriage___Not Pregnant

Cancelled IVF (In-Vitro Fertilization) attempts: _____

Any other prior treatment (describe):_____

- Additional Information/Complications:_____

_____

_____

EMOTIONAL STATUS

- On a scale of 1-10 (10 being the worst), estimate the level of stress you feel due to infertility and other pressures._____
- Do you see a counselor? [ ] No [ ] Yes- For how long?_____ How often?_____
- List any antidepressant/antianxiety medications you are currently taking._____
- Describe any emotional, martial, or sexual problems caused by your infertility._____

_____

_____