FEMALE PATIENT HISTORY

I. IDENTIFYING INFORMATION

Date _____

Name _____ Partner's Name _____

Address _____

Telephone Number - Day: ( ) _____ Evening: ( ) _____

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

Insurance Company _____ Insurance I.D. # _____

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, specify: _____		
List the forms and frequency of regular vigorous exercise (swimming, cycling, running) and age you began:		
Exercise: _____ Hrs/Week _____ Age _____ Exercise: _____ Hrs/Week _____ Age _____		
Have you ever had pelvic surgery?	☐	☐
If yes, 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
- ☐ Ulcers
- ☐ Vaginitis (Trichomoniasis, yeast)
  # of episodes _____
- ☐ Visual Disturbances
- ☐ Any Allergies: List _____

	YES	NO
Have you ever been treated for cancer?	☐	☐
If yes, explain therapy: _____		
Have you ever received X-rays to the pelvic area for therapy or diagnosis?	☐	☐
If yes, specify: _____		
Within the last year, have you taken any prescription medications?	☐	☐
If yes, list all prescriptions and problems for which you were taking them: _____		
Are you taking any over-the-counter medications on a regular basis?	☐	☐
If yes, 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 this directly with your physician. Specify: _____

_____

III. MENSTRUAL AND PREGNANCY HISTORY

	YES	NO
Age at first period?_____When was your last period? _____		
Are your periods regular?	☐	☐
If yes, what is the usual number of days between periods? _____		
If no, how many times per year do you menstruate? _____		
What is the usual duration of your period? _____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, 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, explain:_____		
Did your mother have any difficulty with conception or pregnancy?	☐	☐
If yes, explain:_____		
How long have you now been trying to get pregnant? _____		
Did your mother take diethylstilbestrol (DES) when she was pregnant with you?	☐	☐

IV. CONTRACEPTIVE/SEXUAL HISTORY

YES NO

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 contraceptive method used, specify length of use and reason for discontinuation:

Method	Length of Use	Reason for Discontinuation

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?	☐	☐

	YES	NO
Do you use lubricants for intercourse?	☐	☐
If yes, which one? _____		
Do you douche before or after intercourse?	☐	☐

V. FAMILY HISTORY

	YES	NO
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 what type: _____		
_____		

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? _____		

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

- ☐ clomiphene citrate (Serophene®, Clomid®)
- ☐ hMG (Pergonal®)
- ☐ estrogens
- ☐ progesterone
- ☐ prednisone (or cortisone-like drugs)
- ☐ antibiotics
- ☐ GnRH or LHRH (Factrel®)
- ☐ hCG (Profasi®, A.P.L.®)
- ☐ bromocriptine (Parlodel®)
- ☐ danazol (Danocrine®)
- ☐ urofollitropin or FSH (Metrodin®)
- ☐ Other - Specify _____
- ☐ None

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

☐ BBT	When?_____ Results:_____
☐ Postcoital Test	When?_____ Results:_____
☐ Hormonal Assays (FSH, LH, prolactin, estrogen 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:_____

Have you ever had surgery for tubal reversal?	☐	☐
If yes, specify dates: _____		
Have you ever 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?_____		

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VII. PHYSICAL FINDINGS

VIII. SURGERY

IX. OTHER COMMENTS

X. COURSE OF ACTION

Serono The world leader in infertility therapy
Serono Laboratories, Inc., 100 Longwater Circle, Norwell, MA 02061 (800) 283-8088 (617) 982-9000

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