California Center for REPRODUCTIVE MEDICINE

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# Reproductive Endocrinology and Fertility

## NEW PATIENT HISTORY

### A. FEMALE IDENTIFYING DATA

Date this form completed _____

Your name: _____ Partner's Name: _____

Age_____ Birth date_____ Height_____ Weight _____

How long have you been trying to get pregnant? _____

Have you previously been pregnant? _____

Have you previously tried to get pregnant? _____

Reason for your visit today? _____

_____

### B. PREGNANCY HISTORY

Times pregnant_____ Term births_____ Premature births _____

Miscarriages_____ Elective abortion_____ Adopted children _____

**Pregnancies:**

| Pregnancy (include all pregnancies | When ? (Year) | How long to conceive | Sex and weight | Is current partner the father (Y/N) | Outcome (miscarriage, abortion, ectopic, vaginal delivery, cesarean section, stillbirth, complications if any. |
|---|---|---|---|---|---|
| First | | | | | |
| Second | | | | | |
| Third | | | | | |
| Fourth | | | | | |
| Fifth | | | | | |

Comments: _____

**Contraceptive Use**

| | From when to when | Reason discontinued | Complications |
|---|---|---|---|
| Intrauterine device (IUD) | | | |
| Oral contraceptives Type: | | | |
| Other | | | |

## C. MENSTRUAL HISTORY

**Menstrual (hormonal) history**

Date your last menstrual period began _____
Your age at your first period _____
Are your periods regular? _____
How many days from onset to onset? _____
How many days does your period last? _____
Do you bleed between periods? _____
Do you have premenstrual symptoms ☐ almost always ☐ rarely ☐ never
Have you ever needed medication to bring on your period? Yes ☐ No ☐
If yes, what medication: _____ When? _____
If you have a hormonal disorder, please specify and treatment _____

**Pelvic pain/cramps:** ☐ none ☐ during your period ☐ before your period ☐ after your period
☐ at mid-cycle ☐ during intercourse ☐ with urination ☐ with bowel movements
☐ cause you to miss usual activities ☐ cause you to miss work
**Pelvic cramps/pain are:** ☐ mild ☐ moderate ☐ severe ☐ getting worse ☐ improving
☐ not changing ☐ on the right side ☐ on the left side ☐ in the middle
What medications do you take for pain/cramps? _____
Do you have painful intercourse: ☐ Yes ☐ No

Do you have or have you had:

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Pelvic inflammatory disease (PID) | ☐ | ☐ | Vision problems | ☐ | ☐ |
| Intrauterine device (IUD) | ☐ | ☐ | Chronic headaches | ☐ | ☐ |
| DES exposure | ☐ | ☐ | Head injury | ☐ | ☐ |
| Breast discharge (galactorrhea) | ☐ | ☐ | Seizure disorder | ☐ | ☐ |
| Breast biopsy | ☐ | ☐ | Weight gain (> 10 pounds) | ☐ | ☐ |
| Thyroid disease. | ☐ | ☐ | Weight loss (> 10 pounds) | ☐ | ☐ |
| Increased facial or body hair | ☐ | ☐ | Special dietary habits | ☐ | ☐ |
| Loss of hair | ☐ | ☐ | Vomiting | ☐ | ☐ |
| Increased acne | ☐ | ☐ | Excessive stress | ☐ | ☐ |
| Decreased breast size | ☐ | ☐ | Autoimmune disease | ☐ | ☐ |
| Deepening of voice | ☐ | ☐ | Psychiatric treatment | ☐ | ☐ |
| Hot flashes or night sweats | ☐ | ☐ | Rh sensitized | ☐ | ☐ |
| Poor sense of smell | ☐ | ☐ | | | |

If you answered yes to any questions, please explain _____

## D. GYNECOLOGICAL HISTORY

Do you have or have you had:

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Abnormal uterus (shape, etc) | ☐ | ☐ | Ovarian cysts | ☐ | ☐ |
| Colitis or enteritis | ☐ | ☐ | Pelvic adhesions | ☐ | ☐ |
| Endometriosis | ☐ | ☐ | Uterine fibroids or myomas | ☐ | ☐ |

Gynecologist: _____

Primary Care Physician: _____

Last Pap smear _____ Last mammogram _____

Any abnormal Pap smears?_____, dates _____ Any abnormal mammograms? _____

Do you have or have you had:

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Cryo (freezing) or surgery of the cervix | ☐ | ☐ | Chlamydia | ☐ | ☐ |
| Genital warts/condyloma | ☐ | ☐ | Gonorrhea | ☐ | ☐ |
| Vaginal discharge | ☐ | ☐ | Herpes: Genital | ☐ | ☐ |
| Recurring vaginitis | ☐ | ☐ | Mycoplasma/Ureaplasma | ☐ | ☐ |
| Trichomonas | ☐ | ☐ | Syphilis | ☐ | ☐ |
| Cervical stenosis | ☐ | ☐ | Cytomegalovirus (CMV) | ☐ | ☐ |
| Cervicitis | ☐ | ☐ | Recurrent urinary infections | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| Use of lubricants | ☐ | ☐ |
| Douche before/after intercourse | ☐ | ☐ |
| Bleeding/spotting after intercourse | ☐ | ☐ |
| Sexual problems at this time | ☐ | ☐ |

If yes, explain: _____

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

How many times do you have intercourse around ovulation? _____

## F. MEDICAL HISTORY

**Past Medical History**

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Anemia | ☐ | ☐ | Liver problems | ☐ | ☐ |
| Appendicitis | ☐ | ☐ | Lung disease | ☐ | ☐ |
| Arthritis | ☐ | ☐ | Lupus | ☐ | ☐ |
| Asthma | ☐ | ☐ | Migraine headaches | ☐ | ☐ |
| Bleeding disorders | ☐ | ☐ | Radiation exposure | ☐ | ☐ |
| Blood clots | ☐ | ☐ | Rheumatic fever | ☐ | ☐ |
| Blood transfusion | ☐ | ☐ | Toxic exposure | ☐ | ☐ |
| Cancer | ☐ | ☐ | Tuberculosis | ☐ | ☐ |
| Chronic bronchitis | ☐ | ☐ | Ulcers | | |
| Diabetes | ☐ | ☐ | | | |
| Eating disorder | ☐ | ☐ | Chickenpox (varicella) | ☐ | ☐ |
| Gallbladder problems | ☐ | ☐ | Chickenpox vaccine | ☐ | ☐ |
| Heart disease | ☐ | ☐ | German measles (rubella) | ☐ | ☐ |
| Hepatitis A, B or C | ☐ | ☐ | Rubella immunization | ☐ | ☐ |
| High blood pressure | ☐ | ☐ | | | |
| Kidney disease | ☐ | ☐ | | | |
| Kidney infection | ☐ | ☐ | | | |

If yes, explain _____

List all serious or chronic illnesses or injuries not already described _____

**Medications: Please list all prescriptions and over-the-counter drugs used during the past year.**

| Medication | Dosage and frequency | From when to when | Reason for taking |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Allergies**

| To what (drug or substance)? | When | What type of reaction? |
|---|---|---|
| | | |
| | | |

## G. PAST SURGICAL HISTORY

**Operations and Hospitalizations**

| Date | Diagnosis | Operation | Where performed | Physician | Complications of anesthesia |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## H. FEMALE FAMILY HISTORY

Ethnic background (circle): African/American Asian Asian-Indian Caucasian Hispanic

Jewish Indian Mediterranean Middle Eastern Other _____

| Ethnic group (Circle all that apply) | Have you been tested for: | Yes | No | Date | Result |
|---|---|---|---|---|---|
| African, African/American | Sickle cell trait | | | | |
| Asian, Mediterranean or Hispanic | Thalassemia | | | | |
| Caucasian, Jewish | Cystic fibrosis | | | | |
| Jewish, Cajun, French Canadian | Tay Sachs | | | | |
| Ashkenazi Jew | Ashkenazi Jewish Panel (11) | | | | |
| | | | | | |

Do any family members have:

| | Yes | Who | | Yes | Who |
|---|---|---|---|---|---|
| Cancer of the uterus /breast/ovaries | | | Hemophilia | | |
| Birth defects, genetic (inherited) | | | Infertility | | |
| Bleeding disorders | | | Irregular menstrual cycles | | |
| Chromosomal disorders | | | Lack of sense of smell | | |
| Connective tissue disease | | | Learning problems | | |
| Cystic fibrosis | | | Mental retardation / Autism / Fragile X | | |
| Delayed development | | | Metabolic disorders | | |
| Down's syndrome | | | Miscarriages (2 or more) | | |
| Early menopause < 40 yrs old | | | Muscular dystrophy | | |
| Early puberty | | | Short stature | | |
| Endometriosis | | | Spina bifida | | |
| Excess body hair | | | Stillborn child | | |
| Genital abnormalities | | | Spinal Muscular Atrophy | | |
| Other | | | | | |

Comments: _____

## H. SOCIAL HISTORY

Cigarettes – packs smoked/day _____

Alcohol – type and number of drinks/week _____

Marijuana – amount _____

Other drugs – type and amount _____

Ever used intravenous drugs? _____

How much do you exercise? _____

Do you have a dog or cat? _____

Comments: _____

## I. PREVIOUS EVALUATION

Have you had:

| | Not Done | Result: Normal | Result: Abnormal | Approx date | Values (if known) |
|---|---|---|---|---|---|
| Basal body temperature (BBT) | ☐ | ☐ | ☐ | _____ | _____ |
| Urine LH surge | ☐ | ☐ | ☐ | _____ | _____ |
| Endometrial biopsy | ☐ | ☐ | ☐ | _____ | _____ |
| Blood tests: | | | | | |
| FSH | ☐ | ☐ | ☐ | _____ | _____ |
| LH | ☐ | ☐ | ☐ | _____ | _____ |
| Prolactin | ☐ | ☐ | ☐ | _____ | _____ |
| Thyroid tests (TSH, T4) | ☐ | ☐ | ☐ | _____ | _____ |
| DHEAS | ☐ | ☐ | ☐ | _____ | _____ |

| | Not Done | Result: Normal | Result: Abnormal | Approx date | Values (if known) |
|---|---|---|---|---|---|
| Testosterone | ☐ | ☐ | ☐ | _____ | _____ |
| Estradiol | ☐ | ☐ | ☐ | _____ | _____ |
| Progesterone | ☐ | ☐ | ☐ | _____ | _____ |
| Postcoital test | ☐ | ☐ | ☐ | _____ | _____ |
| Mycoplasma culture | ☐ | ☐ | ☐ | _____ | _____ |
| Chlamydia culture | ☐ | ☐ | ☐ | _____ | _____ |
| Antichlamydial antibodies | ☐ | ☐ | ☐ | _____ | _____ |
| Hysterosalpingogram (HSG) | ☐ | ☐ | ☐ | _____ | _____ |
| Ultrasound | ☐ | ☐ | ☐ | _____ | _____ |
| Kidney x-ray (IVP) | ☐ | ☐ | ☐ | _____ | _____ |
| Laparoscopy | ☐ | ☐ | ☐ | _____ | _____ |
| Hysteroscopy | ☐ | ☐ | ☐ | _____ | _____ |
| Karyotype | ☐ | ☐ | ☐ | _____ | _____ |
| Anticardiolipin antibodies | ☐ | ☐ | ☐ | _____ | _____ |
| Lupus anticoagulant | ☐ | ☐ | ☐ | _____ | _____ |
| Antinuclear antibodies (ANA) | ☐ | ☐ | ☐ | _____ | _____ |
| Coagulation screen | ☐ | ☐ | ☐ | _____ | _____ |
| Biochemistry/hematology panel | ☐ | ☐ | ☐ | _____ | _____ |
| Blood type | ☐ | | | | |
| Other_____ | ☐ | ☐ | ☐ | _____ | _____ |

Comments: _____

K: PREVIOUS TREATMENT

| | Approx dates taken | Outcome |
|---|---|---|
| Clomiphene (Clomid, Serophene) | _____ | _____ |
| HMG (Profasi) | _____ | _____ |
| Injectable gonadotropins | _____ | _____ |

Progesterone _____ _____

K: PREVIOUS TREATMENT (continued)

| | **Approx dates taken** | **Outcome** |
|---|---|---|
| Lupron | _____ | _____ |
| GnRH agonist (Synarel, Lupron) | _____ | _____ |
| Intrauterine insemination (IUI) | _____ | _____ |
| Insemination with donor sperm | _____ | _____ |
| In vitro fertilization (IVF) | _____ | _____ |
| ICSI | _____ | _____ |
| GIFT | _____ | _____ |
| Other _____ | _____ | _____ |

Please use the remainder of this page to explain any additional information you think the doctor may need.