FEMALE PATIENT HISTORY

Date _____ Name_____
Weight_____ Height _____ Blood Type (if known) _____
How long have you been trying to get pregnant? _____

Past history: (if applicable):

	Year Born alive?	Miscarriage?	Abortion?	Ectopic?	Fert drugs required?	Current partner?	Preterm labor?	Preterm delivery?	How many weeks?	Pregnancy-induced hypertension?
1st pregnancy	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
2nd pregnancy	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
3rd pregnancy	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
4th pregnancy	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
5th pregnancy	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____

Has your partner ever fathered a child? (circle) **YES** **NO**
If yes, how many children/pregnancies?_____

Infertility History:
Have you ever been treated for infertility?_____
If yes, have you used infertility medications (ie: follicle stimulation hormone-FSH or Clomid)? _____
How many cycles of medications? _____
Have you ever undergone an IVF cycle? (circle) **YES** **NO**
If yes, when and what were the results? _____

Menses:
When was the first day of your last period? _____ Are your periods regular? _____
If yes, how many days between periods? _____ Usual duration of menses? _____
If no, how many times per year do you menstruate? _____
Are your periods *mild*, *moderate, severe*, or *none* in terms of pain? _____
Is intercourse painful for you? _____
Do you have any issues with bowels during menses? (diarrhea, constipation, dumping syndrome)?
_____
Have you ever used an ovulation predictor kit? (circle) **YES** **NO**
If yes, when in your cycle do you have a positive surge? _____

Procedure History:
Have you had any pelvic surgery(ies) performed? (circle) **YES** **NO**
If yes, please explain: _____
D & C procedure(s)? **YES** **NO** If yes, how many and when? _____
Have you ever had a hysterosalpingogram (HSG) performed? (circle) **YES** **NO**
If yes, who performed the HSG and what were the results? _____
Have you had a tubal ligation? **YES** **NO** Have you been diagnosed with endometriosis? **YES** **NO**
Please list all types and dates of surgeries you have undergone:_____
_____

Pap History:
When was your last pap smear done? _____Where? _____
Was it normal or abnormal? _____ (office and physician name)
Have all of your paps been normal? (circle) **YES** **NO**
Have you had any lab work done? (If yes, please describe tests, results, and where performed):_____
_____

Medical History:
Are you currently experiencing any medical problems? (If yes, please describe):_____
_____
Family history of blood clotting disorders? **YES** **NO**
Anyone with cystic fibrosis in your family? (circle) **YES** **NO**
Have you ever been treated for cancer? (circle) **YES** **NO**
If yes, please explain: _____

Do you currently have, or have you ever had (circle all that apply):

Anemia	Diabetes	Liver problems	Rheumatic fever
Appendicitis	Dizziness	Loss of balance	Scarlet fever
Arthritis	Epilepsy	Measles: German	Seizures
Bleeding disorder	Gall bladder problems	Measles: Regular	Syphilis
Blood transfusion	Gonorrhea	Mumps	Testes infection
Chlamydia	Heart disease	Mumps w/testes involved	Testes injury
Chronic bronchitis	Hepatitis	Neurological problems	Testes tumor
Chronic headaches	Herpes	Nongonococcal urethritis	Thyroid problems
Colitis	High blood pressure	Parasitic infection	Tuberculosis
Cystic Fibrosis	Kidney infection	Pneumonia	Visual disturbances

What medications do you regularly take? (Prescription and/or over the counter drugs; include dosage):_____

_____

What local pharmacy do you prefer?_____

Do you currently or have you ever, used:

Alcohol? How many drinks per week?_____

Cigarettes? How many packs per day?_____

Illicit or recreational drugs?_____

Allergies? (circle) **YES** **NO** If yes, please list:_____

Countries of origin:

Mother's family:_____ Father's family:_____

Ethnic background (circle):

African American Asian Asian-Indian Caucasian Hispanic

Jewish American Indian Mediterranean Middle Eastern Other:_____

Ethnic Group: (check all that apply)	**Have you ever been tested for:**	**Yes**	**No**	**Date**	**Result**
African, African/American	Sickle cell trait				
Chinese, Southeast Asian, Mediterranean (Greek or Italian) or Hispanic	Thalassemia				
Caucasian, Jewish	Cystic Fibrosis				
Jewish	Bloom Syndrome				
	Canavan Familial Dysautonomia (FD)				
	Fanconi Anemia (type C)				
	Gaucher Disease (Type I)				
	Glycogen Disease (Type 1a)				
	Maple Syrup Urine Disease				
	Mucolipidosis (Type IV ML IV)				
	Niemann – Pick Type A				
	Spinal Muscular Atrophy (SMA)				
	Tay Sachs				

Other inherited disorders?:_____

Would you like to take the test(s) recommended for your specific ethnic group? (Circle) **YES** **NO**

Are you related to your spouse (consanguinity)? (Circle) **YES** **NO**

Fragile X testing is recommended if the exact etiology of the mental retardation is unknown. Would you like this testing performed? (Circle) **YES** **NO**