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**