



Female History Questionnaire

Reason for Visit: Infertility Evaluation Recurrent Miscarriage Other _____

What are your expectations for this visit? _____

What questions do you want answered at this visit? _____

How many months have you and your partner been having intercourse without using any form of birth control? _____

Pregnancy Summary:

Number of pregnancies with current partner _____ With past partner(s) _____ Total _____

Number of Therapeutic Abortions _____

Number of Ectopic/Tubal Pregnancies _____ Number of Miscarriages (<20weeks) _____

Number of Full Term Deliveries _____ Live Births _____ Stillborn _____

Number of Premature (<37 weeks) _____ Live Births _____ Stillborn _____

Any Pregnancies with Birth Defects No Yes- Explain _____

Please Record all Pregnancies:

	Delivery/End Date of Pregnancy	Months to Conception	Treatments to Conceive	Delivery Type/ D&C/Complications	Current Partner	Previous Partner
1						
2						
3						
4						
5						
6						

Menstrual History:

Menstrual Cycle Pattern (check all that apply):

Regular Periods Irregular Periods Spotting Before Periods No Periods

Heavy Periods Light Periods Bleeding Between Periods

Number of days between the start of one period to the start of the next period _____

How many days of bleeding do you have? _____

Dates of the first day of your last 2 menstrual periods (dd/mm/yy) ____/____/____; ____/____/____

Age when you had your first period: _____

Age when you first noticed: Breast Development _____; Pubic Hair _____; Underarm Hair _____

How many periods do you have per year? _____

Do you need medication to bring on a period? No Yes- what type? _____

If you do not have periods, at what age did you stop having them? _____

Do you have severe cramping or pelvic pain with your periods?

No Yes; Always__ Sometimes__ Recently__ In the Past__

Contraceptive History

None

Condoms-dates of use _____ to _____

Diaphragm-dates of use _____ to _____

IUD-dates of use _____ to _____

Birth Control Pills _____ to _____

Injectable Contraception (Depo-Provera, Lunelle, etc) dates of use _____ to _____

Tubal Sterilization procedure (tubes tied) - date (month/year) _____

Performed by? (Include address) _____

Complications? _____

Other _____

Sexual History

How many times a week do have intercourse? _____ None Not applicable

Have you used over the counter ovulation kits to time intercourse? No Yes

Do you have pain with intercourse? No Yes

Do you use lubricants during intercourse? No Yes-what types? _____

Have you had any of the following Sexually Transmitted diseases or pelvic infections?

Chlamydia-date _____

Gonorrhea-date _____

Herpes-date _____

HIV/AIDS-date _____

Syphilis- date _____

Genital Warts(HPV) _____

Hepatitis-date _____

Other- date _____

Pap Smear History

When was your last pap smear? (mm/yy) - ____ / ____ Normal Abnormal

When was your last abnormal pap smear? (mm/yy) - ____ / ____

Have you undergone any procedures as a result of an abnormal pap smear?

No

Yes (check all that apply)

- Colposcopy Cryosurgery (freezing) Laser Treatment
- Conization LEEP procedure

Breast Screening History

Have you ever had a mammogram? No

Yes- date _____

Normal

Abnormal- explain _____

Do you perform Breast Self Examinations? No Yes

Medical History

What is your: Height _____ (cm) Weight _____ (kg)

or _____ (in) _____ (lb)

Are you allergic to any medications? No Yes (please list and describe reactions)

Are you allergic to any foods? (peanuts, eggs, seafood etc) No Yes (please list and describe)

List any medications you are currently taking, including over the counter medications.

Do you take any herbal medicines/vitamins or health food store supplements? No Yes

If Yes, please list _____

Do you have any medical problems? No Yes (Please list type, dates and treatment)

1. _____
2. _____
3. _____

Did you have any of these childhood illnesses? (check all that apply)

Chickenpox (Varicella) German Measles Don't know Other _____

Did your mother take DES during pregnancy to prevent miscarriage? No Yes Don't Know

Social History

How many caffeinated beverages (coffee, tea, soda) do you drink per day? _____

Do you smoke cigarettes? No Yes-how many/day? _____

how many years? _____ quit?-when _____

Do you drink alcohol? No Yes

Beer-#/week _____ Wine-#/week _____ Liquor-#/week _____

Do you use marijuana, cocaine, or any other similar drug? No Yes

Describe: _____

Do you exercise? No Yes,

Describe _____

Are you aware of any radiation exposures other than X-rays? No Yes

Describe: _____

Surgical History

Have you had any surgeries? No Yes (List all surgeries in chronological order)

Year	Reason and Type of Surgery
_____	_____
_____	_____
_____	_____

Did you have any anesthesia problems? No Yes (describe) _____

Physical Symptoms

General:

- Recent Weight gain or loss
- Anorexia/Bulimia
- Lack of Energy
- Fever/Chills
- Other _____
- None

Endocrine/Hormonal

- Diabetes
- Thyroid gland problems
- Rapid weight gain or loss
- Excessive hunger/thirst
- Temperature intolerance- hot flashes or feeling cold
- Hair loss
- Other _____
- None

Gastrointestinal:

- Nausea/Vomiting
- Hepatitis
- Blood in stool
- Irritable bowel syndrome
- Change in bowel habits
- Ulcers
- Colitis (ulcerative or Crohn's)
- Diarrhea
- Constipation
- Other _____
- None

Musculoskeletal

- Unusual muscle weakness
- Decreased energy/stamina
- Rheumatoid arthritis
- Lupus Erythematosis
- Myasthenia gravis
- Other _____
- None

Mental Health Problems:

- Depression
- Other _____

Head, Eyes, Ears, Nose, and Throat

- Dizziness
- Headaches
- Loss of sense of smell
- Blurred Vision
- Chronic nasal congestion
- Hearing loss/deafness
- Ringing ears
- Other _____
- None

Breasts:

- Discharge (clear __bloody__milky__)
- Lumps
- Pain
- Cancer
- Abnormal Mammogram
- Reduction
- Augmentation/Breast implants (saline? __silicone? __)
- Other _____
- None

Genito-Uriary

- Bladder Infections
- Kidney Infections
- Vaginal Infections
- Frequent urination
- Leaking Urine
- Blood in Urine
- Herpes
- Other _____
- None

Haematologic:

- Blood clotting disorder/blood clot
- Sickle Cell Anemia
- Easy Bruising
- Swollen glands/lymph nodes
- Blood transfusions _____
- Thrombophlebitis
- Other _____
- None

Respiratory:

- Shortness of breath
- Asthma
- Bronchitis
- Pneumonia
- Tuberculosis
- Bloody Cough
- Other _____
- None

Neurological Problems:

- Weakness/Loss of Balance
- Seizures/Epilepsy
- Headaches
- Migraine headaches
- numbness
- Memory Loss
- Other _____
- None

Skin/Extremities

- Unexplained rash/ inflammation
- Acne
- Skin Cancer
- Burn injury
- Moles changing in appearance
- Excess hair growth/facial hair
- Other _____
- None

Cardiovascular:

- Palpitations/Skipped beats
- Chest pain
- Stroke
- High blood pressure
- Rheumatic Fever
- Heart attack
- Mitral Valve Prolapse
- Murmurs
- Other _____
- None

- Schizophrenia
- None

Family History:

	Living		Cause of Death/Age at Death
Mother	<input type="checkbox"/> Yes - age _____	<input type="checkbox"/> No	_____
Father	<input type="checkbox"/> Yes - age _____	<input type="checkbox"/> No	_____
Brother(s)	<input type="checkbox"/> Yes - age _____	<input type="checkbox"/> No	_____
	<input type="checkbox"/> Yes - age _____	<input type="checkbox"/> No	_____
Sister(s)	<input type="checkbox"/> Yes - age _____	<input type="checkbox"/> No	_____
	<input type="checkbox"/> Yes - age _____	<input type="checkbox"/> No	_____
Maternal Grandmother	<input type="checkbox"/> Yes - age _____	<input type="checkbox"/> No	_____
Maternal Grandfather	<input type="checkbox"/> Yes - age _____	<input type="checkbox"/> No	_____
Paternal Grandmother	<input type="checkbox"/> Yes - age _____	<input type="checkbox"/> No	_____
Paternal Grandfather	<input type="checkbox"/> Yes - age _____	<input type="checkbox"/> No	_____

Disorders in Your Family:

	Relationship to you		
Breast Cancer	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
Ovarian Cancer	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
Colon Cancer	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
Other Cancer _____	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
Diabetes	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
Thyroid problems	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
Heart Disease	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
Blood Clots	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
Obesity	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
Psychiatric problems	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
Tuberculosis	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
Endometriosis	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
Infertility	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
Menopause before 40 years	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
Birth Defects	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
Cystic Fibrosis	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
Irregular Menses	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
Painful Menses	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
Recurrent Miscarriage	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
Polycystic Ovarian Syndrome	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
Neurologic (brain/spine)	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
Neural Tube Defects	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
Spina Bifida	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
Bone/Skeletal Defects	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
Developmental Delay	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
Down Syndrome	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
Other Chromosomal Defects	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
Hemophilia	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
Sickle Cell Anemia	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
Thalassemia	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
<input type="checkbox"/> None of the above			
<input type="checkbox"/> Other (please specify) _____			

Prior Infertility Testing and Treatment:

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 _____
- Ovulation Kit date _____/results _____
- Day 3 blood test for FSH level date _____/results _____
- Hysterosalpingogram (HSG x-ray) date _____/results _____
- Laparoscopy surgery date _____/results _____
- Hysteroscopy surgery date _____/results _____
- Progesterone blood test date _____/results _____
- Prolactin blood test date _____/results _____

Prior Treatment (check all that apply):

Treatment	# of Cycles	Date (mm/yy)	Outcome
<input type="checkbox"/> Intrauterine Insemination			<input type="checkbox"/> Pregnant: <input type="checkbox"/> delivered <input type="checkbox"/> Non Pregnant
<input type="checkbox"/> Daily Fertility Drug Injections with/without insemination:			<input type="checkbox"/> Pregnant: <input type="checkbox"/> delivered <input type="checkbox"/> Non Pregnant
<input type="checkbox"/> Clomiphene citrate with timed intercourse- maximum # tabs/day _____			<input type="checkbox"/> Pregnant: <input type="checkbox"/> delivered <input type="checkbox"/> Non Pregnant
<input type="checkbox"/> Clomiphene citrate with insemination maximum # tabs/day _____			<input type="checkbox"/> Pregnant: <input type="checkbox"/> delivered <input type="checkbox"/> Non Pregnant
<input type="checkbox"/> Completed IVF Cycles:			
1. #eggs _____ #embryos transferred _____ # frozen _____			<input type="checkbox"/> Pregnant: <input type="checkbox"/> delivered <input type="checkbox"/> Non Pregnant
2. #eggs _____ #embryos transferred _____ # frozen _____			<input type="checkbox"/> Pregnant: <input type="checkbox"/> delivered <input type="checkbox"/> Non Pregnant
3. #eggs _____ #embryos transferred _____ # frozen _____			<input type="checkbox"/> Pregnant: <input type="checkbox"/> delivered <input type="checkbox"/> Non Pregnant
4. #eggs _____ #embryos transferred _____ # frozen _____			<input type="checkbox"/> Pregnant: <input type="checkbox"/> delivered <input type="checkbox"/> Non Pregnant
<input type="checkbox"/> Frozen Embryo Transfers:			
1. # embryos transferred _____			<input type="checkbox"/> Pregnant: <input type="checkbox"/> delivered <input type="checkbox"/> Non Pregnant
2. # embryos transferred _____			<input type="checkbox"/> Pregnant: <input type="checkbox"/> delivered <input type="checkbox"/> Non Pregnant
3. # embryos transferred _____			<input type="checkbox"/> Pregnant: <input type="checkbox"/> delivered <input type="checkbox"/> Non Pregnant
4. # embryos transferred _____			<input type="checkbox"/> Pregnant: <input type="checkbox"/> delivered <input type="checkbox"/> Non Pregnant
<input type="checkbox"/> Cancelled IVF attempt(s):			
<input type="checkbox"/> Any other prior treatment (describe):			

Additional Comments/Complications:
