

**PIEDMONT REPRODUCTIVE ENDOCRINOLOGY GROUP (PREG)
FEMALE PATIENT HISTORY: INFERTILITY**

1. Identifying Information

Date: _____

Name: _____ Partner's Name _____

Address _____ City _____ State _____ Zip _____

Telephone No: Day () _____ Evening () _____

Cell Phone # _____ Referring Physician: Name _____

Practice Name _____ Address _____ Phone # _____

Age: _____ Date of Birth: _____ Partner's Age _____ Date of Birth _____

Race (check one) Caucasian African/American Asian Hispanic Jewish Mediterranean
 Other

II. Pregnancy History

How many pregnancies (including abortions) have you had? _____

*	When (year)	How long to conceive (months)	Fertility Therapy Used (Y/N)	Is Current Partner the Father (Y/N)	Duration of Pregnancy (months)	Outcome*	Complications
1st pregnancy							
2 nd pregnancy							
3 rd pregnancy							
4 th pregnancy							
5 th pregnancy							

*Outcomes: Vaginal delivery=VD; Cesarean Section=CS; Abortion=AB; Miscarriage=MS; Ectopic (tubal)= EP

III. Fertility History

How long have you and your present partner been trying to conceive: _____

How often do you have vaginal intercourse (sex) each week? _____

Have you ever been infertile with a past partner: yes no If so, how long: _____

Have you had any of the following tests performed: (Check all that apply and results)

	Date	Results
* Basal Body Temperature	_____	_____
* Urinary LH (Ovulation) Predictor Kits	_____	_____
* Post-coital Test	_____	_____
* Hormone Tests	_____	_____
* Endometrial Biopsy	_____	_____
* Hysterosalpingogram (HSG)	_____	_____
* Sonohysterogram	_____	_____
* Ultrasound	_____	_____
* Anti-sperm Antibodies	_____	_____
* Laparoscopy	_____	_____
* Hysteroscopy	_____	_____
*Gonorrhea/Chlamydia Cultures	_____	_____

- * Rubella (German measles) _____
- * Hepatitis B or C _____
- * HIV _____
- * RPR (Syphilis) _____
- * Blood type and Rh _____
- * Antibody Screen _____

What types of fertility therapy have you received in the past?

Drug / Treatment	Dosage	How Long or How Many Cycles	When
Clomiphene Citrate (Clomid Serophene)			
Gonadotropins (Pergonal, Repronex, Humegon, Metrodin, Fertinex, Gonal-F Follistim, Bravelle)			
HCG (Profasi, Pregnyl)			
Lupron, Zoladex, Synarel			
Progesterone			
Prednisone or Dexamethasone			
Bromocriptine (Parlodel) Dostinex			
Artificial Insemination			
Donor Insemination			
In Vitro Fertilization / ICSI			

IV. Gynecological History

How old were you when you started having periods: _____ Date your last period started: _____

Are your periods regular without medicines? ___ Yes ___ No

If yes, how many days between periods (start until start) _____

If no, how many periods per year do you have: _____

Do you require medicine (birth control pills or progesterone) to regulate your period? ___ Yes ___ No

How many days do your periods last: _____ Do you have cramps with your periods ___ Yes ___ No

If yes, are they ___ Mild ___ Moderate ___ Severe

Have you ever missed work of school due to menstrual pain: ___ Yes ___ No

Do you have pain with intercourse: ___ Yes ___ No

Were you ever diagnosed with endometriosis: ___ Yes ___ No

What type of contraceptive have you used in the past: (Check all that apply)

___ Birth Control ___ IUD ___ Depo Provera (birth control shots)

___ Condoms ___ Diaphragm ___ Foams/Jellies

___ Withdrawal ___ Rhythm ___ Tubal Ligation

Contraceptive Complications: _____

When did you last use contraception: _____

Have you ever had an abnormal Pap smear: ___ Yes ___ No If so, when: _____

What was done about it: _____

When was your last Pap smear: _____ Doctor/Practice: _____

Have you ever had any of the following: (Check all that apply)

___ Gonorrhea	___ Venereal Warts	___ Syphilis
___ Chlamydia	___ Genital Herpes	___ Pelvic Inflammatory Disease PID

How many sexual partners have you had in the past? _____

V. Medical History

Do you or have you ever had: (Check all that apply)

<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression / Anxiety	<input type="checkbox"/> Polycystic Ovarian Syndrome
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Ovarian Cysts
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Gallbladder Problems	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Blood Transfusions	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Rubella (German Measles)
<input type="checkbox"/> Breast Discharge	<input type="checkbox"/> Hirsutism (excess facial hair)	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Breast Pain	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Seizures
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Kidney Infections	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Chronic Bronchitis	<input type="checkbox"/> Liver Problems	<input type="checkbox"/> Tuberculosis (TB)
<input type="checkbox"/> Chronic Headaches	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Colitis	<input type="checkbox"/> Neurological Problems	<input type="checkbox"/> Vision Problems

List any other medical conditions or problems (current or past): _____

Current Medications: (prescribed or over the counter) _____

Natural, herbal or alternative medicines _____

Are you allergic to any medications: Yes No What: _____

Are you allergic to latex Yes No; Iodine/Shrimp/Shellfish Yes No; Peanuts Yes No

Have you ever had surgery before: Yes No Date and type _____

VI. Social History

Current or Recent Employer/Position _____

Do you drink alcohol: Yes No Number of drinks per week: _____

Do you smoke: Yes No Number of cigarettes per day: _____ Number of years smoking: _____

Do you now, or have you ever, used illicit drugs (marijuana, cocaine, etc): Yes No
If yes, please specify: _____

Do you have a special exercise program: Yes No
If yes, type: _____ Number of hours per week: _____

Are you on a special diet: Yes No

VII. Review of Systems:

What is your height: _____ Current weight: _____ Ideal Weight: _____

Have you had more than a 10 pound weight gain/loss this past year: Yes No
If so how much: _____ Was this intentional: Yes No

What is your blood type: (if known) A B AB O Rh (Positive, Negative) _____
Do you have problems with your eyes, ears, nose or throat: Yes No

If yes, please specify: _____
Do you have heart problems, chest pain or irregular heart beat: Yes No

If yes, please specify: _____
Do you have asthma, wheezing, shortness of breath or trouble breathing: Yes No

If yes, please specify: _____

Do you have breast pain, breast discharge or a lump in your breast: Yes No
 If yes, please specify: _____

Do you have chronic nauseas, twitching, stomach pain, blood in your stool or a history of ulcers: Yes No
 If yes, please specify: _____

Do you have urinary burning, incontinence or blood in your urine: Yes No
 If yes, please specify: _____

Do you have chronic joint or muscle pain or swelling? Yes No
 If yes, please specify: _____

Do you have any chronic skin rashes or moles: Yes No
 If yes, please specify: _____

Do you have changes in cold or hot tolerance, changes in skin tone or body hair growth: Yes No
 If yes, please specify: _____

Any history of (or family members with) blood clot problems or bleeding disorder: _____

VIII. Family History

Any history of breast cancer, ovarian or colon cancer: Yes No

Did your mother take diethylstilbestrol (DES; a tablet given to women with a history of miscarriage or bleeding during pregnancy) when she was pregnant with you: Yes No

Do any family members have significant health problems or inherited diseases: Yes No

Check all that apply:

<input type="checkbox"/> Birth Defects	<input type="checkbox"/> Down Syndrome	<input type="checkbox"/> Muscular Dystrophy
<input type="checkbox"/> Brain/Spinal Defects	<input type="checkbox"/> Fragile X Syndrome	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Tay-Sachs Disease
<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Thalassemia
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Thyroid Disease

Who: _____

I confirm that all the above information is true and valid to the best of my knowledge. I also agree that this information or my medical records from this office may be subject to peer review by an outside agency if needed for any credentialing organization.

Signed: _____ Date: _____