New England Fertility Institute

1275 Summer Street • Suite 201 • Stamford, CT 06905 • Tel: (203) 325-3200 • Fax: (203) 323-3130
9 Washington Avenue • Hamden, CT 06518 • Tel: (203) 248-2353 • Fax: (203) 248-2074
4 Corporate Drive • Suite 286 • Shelton, CT 06484 • Tel: (203) 929-6412 • Fax: (203) 929-6428

FEMALE PATIENT HISTORY

I. IDENTIFYING INFORMATION

Date ______________________

Name ______________________ Partner's Name ______________________

Address ______________________

City ______________________ State ______________________ Zip ______________________

Telephone Number: Day: ( ) ______________________ Evening: ( ) ______________________

Date of Birth ______________________ Partner's Date of Birth ______________________

Duration of Relationship ______________________ Duration of Infertility ______________________

II. TRAVEL/WORK AND GENERAL BACKGROUND

Present Employment		
Title	*Brief Description*	*# of Years Employed*
Past Employment		
Title	*Brief Description*	*# of Years Employed*

III. MEDICAL HISTORY

YES **NO**

Weight: ____________ Height ____________ Blood Type (if known) ____________

Have you lost/gained greater than 20 pounds of weight in the last year?.. ☐ ☐

Do you follow a particular food diet or have any special dietary habits?.. ☐ ☐

If yes, specify: ______________________

List the forms and frequency of regular vigorous exercise (swimming, cycling, running) and the age you began:

Exercise	Hrs/Week	Age	Exercise	Hrs/Week	Age

Do you frequently take saunas or steam baths? .... ☐ ☐

Have you ever had pelvic surgery? .... ☐ ☐

If yes, specify date and type: ______________________

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

- ☐ Anemia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Blood transfusions
- ☐ Breast Milky Discharge
- ☐ Breast Soreness
- ☐ Cancer: Specify ______________________
- ☐ Chlamydia
- ☐ Chronic Bronchitis
- ☐ Chronic Headaches
- ☐ Colitis
- ☐ Color Blind
- ☐ Diabetes
- ☐ Dizziness
- ☐ Endometriosis
- ☐ Epilepsy
- ☐ Gallbladder Problems
- ☐ Gonorrhea
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ Hirsutism *(Excess Hair Growth)*
- ☐ High Blood Pressure
- ☐ Immunization: *German Measles*
- ☐ Kidney Infection
- ☐ Liver Problems
- ☐ Loss of Balance
- ☐ Measles: German
- ☐ Measles: Regular
- ☐ Neurological Problems
- ☐ Non-gonococcal Urethritis
- ☐ Ovarian Cysts
- ☐ Parasitic Infection
- ☐ Pelvic Infection
- ☐ Pneumonia
- ☐ Poor Sense of Smell
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Syphilis
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Vaginitis -*Trichomoniasis,yeast* # of episodes ____________
- ☐ Visual Disturbances
- ☐ Any Allergies: List ______________________ ______________________ ______________________ ______________________

	YES	NO
Have you ever been treated for cancer?........................	☐	☐
If yes, explain therapy: ____________		
Have you ever received x-rays to the pelvic area for therapy or diagnosis?........................	☐	☐
If yes, specify: ____________		
Within the last year, have you taken prescription medications?	☐	☐
If yes, please list all prescription and problems for which you are taking them: ____________		
Are you taking over-the-counter medications on a regular basis?	☐	☐
If yes, list all medications and diagnoses: ____________		

Do you use or have you ever used (check all that apply):

☐ Alcohol – How many glasses per week do you usually drink?

Wine ____________ Beer ____________ Cocktails ____________

☐ Cigarettes – Number of packs per day ____________

☐ Illicit or Recreational Drugs (Marijuana, cocaine, etc.) If you would feel more comfortable not writing anything down, please discuss this directly with your Physician. Specify: ____________

IV. MENSTRUAL AND PREGNANCY HISTORY

	YES	NO
Age at first period: ____________ When was your last period? ____________		
Are your periods regular?	☐	☐
If yes, what is the usual number of days between periods? ____________		
If no, how many times per year do you menstruate? ____________		
What is the usual duration of your period? ____________		
Use: ☐ Tampons ☐ Pads		
Are cramps present before, during, or after your period?........................	☐	☐
Are cramps: ☐ Mild ☐ Moderate ☐ Severe		
Do you have to take pain medication for cramps?........................	☐	☐
If yes, specify medication: ____________		
Do you bleed or spot between periods?	☐	☐
How many pregnancies (including abortions) have you had? ____________		

	When? (Year)	End in Abortion?	End in Miscarriage?	Ectopic Pregrancy	Infertility therapy required to conceive?	How long to conceive?	Baby born alive?	Is current partner the father?
1st Pregnancy								
2nd Pregnancy								
3rd Pregnancy								
4th Pregnancy								
5th Pregnancy								

	YES	NO
Were there any complications during or after your pregnancies?..	☐	☐
If yes, explain: ________________		
Did your mother have any difficulty with conception or pregnancy?	☐	☐
If yes, explain: ________________		
How long have you been trying to get pregnant? ________________		
Did your mother take diethylstilbestrol (DES) when she was pregnant with you?	☐	☐

V. CONTRACEPTIVE/SEXUAL HISTORY

What form of contraception do you use now or have used in the past? Check all that apply:

☐ Pills: Name ________ ☐ IUD: Name ________ ☐ Diaphragm

☐ Withdrawal ☐ Foams/Jellies ☐ Condom

☐ Rhythm ☐ None ☐ Other ________

For each contraceptive method used, specify length of use and reason for discontinuation:

Method	Length of Use	Reason for Discontinuation

If you've ever been on oral contraceptives (pills), were your periods regular after stopping the pills?	☐	☐
How many times per week do you and your partner have sexual intercourse? ________________		
How many times do you have intercourse around ovulation? ________________		
Is intercourse painful or difficult for you?	☐	☐
Do you use lubricants for intercourse?...	☐	☐
If yes, which one? ________________		
Do you douche after intercourse?..	☐	☐

V. FAMILY HISTORY

	YES	NO
Is there a family history of infertility?	☐	☐
If yes, who (list all members and relationship to you): ________________		
Is there a history of hormonal disorders in your family?..	☐	☐
If yes, list who (relationship to you) and what type: ________________		

VI. HISTORY OF FERTILITY THERAPY:

	YES	NO
Have you ever been treated for infertility before?	☐	☐
If yes, who was your Physician? ________________		
What cause of infertility was diagnosed? ________________		

What drugs have you taken for infertility? Check all that apply:

- ☐ Clomiphene Citrate (Serophene, Clomid)
- ☐ hMG (Pergonal, Follistim)
- ☐ Estrogens
- ☐ Progesterone
- ☐ Prednisone (or cortisone-like drugs)
- ☐ Antibiotics
- ☐ Danazol (Danocrine)
- ☐ hCG (Profasi, A.P.L)
- ☐ Bromocriptine (Parlodel)
- ☐ GnRH or LHRH (Factrel)
- ☐ Urofollitropin or FSH (Bravelle, Gonal-F)
- ☐ Other: Specify________________
- ☐ None

Which of the following tests have you had performed? Check all that apply and the results if known:

Test	When	Results
☐ BBT	When ____________	Results ____________
☐ Postcoital Test	When ____________	Results ____________
☐ Hormonal Assays (FSH, LH, Prolactin, Estrogen, DHEA-S, Testosterone, Progesterone)	When ____________	Results ____________
☐ Endometrial Biopsy	When ____________	Results ____________
☐ Hysterosalpingogram	When ____________	Results ____________
☐ Ultrasound	When ____________	Results ____________
☐ Antibodies	When ____________	Results ____________
☐ Laparoscopy, Hysteroscopy	When ____________	Results ____________
☐ Mycoplasma/Chlamydia Cultures	When ____________	Results ____________
☐ Thyroid Test	When ____________	Results ____________
☐ Other: Specify	When ____________	Results ____________

	YES	**NO**
Have you ever had surgery for tubal reversal?.	☐	☐
If yes, specify dates: ____________________		
Have you ever had surgery for lysis of adhesions?..	☐	☐
Have you ever had cervical conization or cautery?..	☐	☐
Have you had any other surgery (D&C, ovarian, appendectomy, thyroid)?..................	☐	☐
If yes, please specify: ____________________		
Have you ever undergone artificial insemination or in vitro fertilization?..................	☐	☐
If yes, using partner or donor sperm? ____________________		
Is your partner seeing a doctor for evaluation of infertility?..................................	☐	☐
If yes, specify Physician name and location: ____________________		
Does the doctor feel that your partner has an infertility problem?	☐	☐
If yes, what is the diagnosis and how is it being treated? ____________________		
Has he ever fathered a child with another woman?..	☐	☐
If yes, when? ____________________		