



LOS OLIVOS
WOMEN'S MEDICAL GROUP
Infertility History Form

Date form completed: _____

Patient's name: _____ Partner's name: _____

Age: _____ Date of Birth: _____ Age: _____ Date of Birth: _____

Occupation: _____ Occupation: _____

Prior marriage: Yes ___ No ___ # _____ Prior marriage: Yes ___ No ___ # _____

Attempted pregnancy prior marriage? Yes ___ No ___ Attempted pregnancy prior marriage? Yes ___ No ___

Ethnic origin _____ Ethnic Origin: _____

Woman's Medical History

1. Reason for visit: ___ Infertility ___ Donor Insemination ___ Recurrent pregnancy Loss
___ Other: _____

2. Duration of infertility: _____ months.

Pregnancy History

1. Number of pregnancies: _____
2. Number of pregnancies greater than 20 weeks: _____
3. Number of pregnancies less than 20 weeks: _____
4. Number of tubal pregnancies (ectopic): _____
5. Number of elective termination of pregnancies: _____
6. Number of living children: _____

| Date of delivery | Months to conceive | Vaginal or C-Section | Fathered by Current Partner? |
|------------------|--------------------|----------------------|------------------------------|
| _____ | _____ | _____ | Y ___ N ___ |
| _____ | _____ | _____ | Y ___ N ___ |
| _____ | _____ | _____ | Y ___ N ___ |

| Date of Miscarriage or termination | Months to conceive | Weeks of Pregnancy | D&C | Fathered by Current Partner? |
|------------------------------------|--------------------|--------------------|-------------|------------------------------|
| _____ | _____ | _____ | Y ___ N ___ | Y ___ N ___ |
| _____ | _____ | _____ | Y ___ N ___ | Y ___ N ___ |
| _____ | _____ | _____ | Y ___ N ___ | Y ___ N ___ |
| _____ | _____ | _____ | Y ___ N ___ | Y ___ N ___ |

Menstrual History

For Doctor's Use Only

Date of last period ___/___/___

1. Are your periods:
 heavy normal light
 regular irregular Days from start to start _____
2. Do you have spotting between periods? Yes No
 after period before period mid cycle
3. Do you have severe pain with periods?
 Yes No Sometimes Always

Sexual History

1. How often do you have intercourse during your fertile period?
 _____ # times per week.
2. Do you have pain with intercourse?
 Yes No Sometimes Always
3. Do you use lubrication during intercourse?
 No Yes Name _____
4. Do you use an ovulation kit to time intercourse?
 Yes No

Medical History

1. Do you have any medical illnesses?
 Yes No
 Please list: _____

2. Do you take any routine medications, including herbal preparations? Yes No
 Please list: _____

3. Are you allergic to any medications?
 Yes No
 Please list: _____

4. Do you have any marital, sexual or emotional problems related to infertility?
 Yes No
5. Do you have any of the following medical conditions:
 Check all that apply
 Bleeding disorders
 Thrombophlebitis
 Pulmonary embolism (blood clot in lung)
 Antiphospholid syndrome
 Lupus
 Other collagen disease
 Diabetes
 High Blood Pressure
 Heart Disease

- Celiac Disease (gluten intolerance)
- Chronic Anemia
- Chronic Fatigue
- Osteoporosis
- Frequent Abdominal pain
- Frequent Diarrhea
- Eating Disorder
- Depression

Surgical History

List all of your pelvic surgeries

| Date | Type | Diagnosis |
|-------|-------|-----------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Endocrine History

Do you have or have you had any of the following:

- Thyroid disease
- Hashimoto's disease
- Polycystic ovary disease
- Acne
- Increased facial or body hair
- Insulin resistance
- Gestational diabetes
- Hair loss
- Increased prolactin
- Inappropriate breast milk production

Social History

1. Do you smoke? No Yes: Amount? _____
2. Do you drink alcohol? No Yes: Amount? _____
3. Do you use recreational drugs? No Yes: Amount _____
Type _____
4. Are you on a special diet? No Yes: Type? _____
Do you exercise? No Yes:
Type and amount:

5. Have you had any of the following sexually transmitted infections?
 None
Check all that apply
 Gonorrhea
 Chlamydia
 HPV (human papilloma virus)

- Herpes
- Tubal infection (PID)
- HIV (AIDS)
- Hepatitis B
- Hepatitis C
- Mycoplasma or ureoplasma

Prior Infertility Testing

1. Blood hormone testing? Yes No unknown
Results:

- FSH _____
- Estradiol _____
- TSH _____
- Prolactin _____
- LH _____
- Inhibin B _____
- Anti Mullerian Hormone _____
- Fasting Glucose _____
- Fasting Insulin _____

2. Have you had any immunology or thrombophilia testing?
 Yes No unknown

3. Have you had any of the following tests?
Check all that apply:
 X-ray of tubes (HSG)
 Antral follicle count
 Sonohysterogram (saline ultrasound)
 Hysteroscopy
 Laparoscopy

Prior Infertility Treatment

1. Have you had any of the following treatments?

- Clomiphene citrate: No Yes
#of cycles _____
Outcome: not pregnant pregnant miscarriage
- Intrauterine inseminations: No Yes # of cycles _____
Outcome: not pregnant pregnant miscarriage
- Clomiphene and insemination: No Yes
of cycles _____
Outcome: not pregnant pregnant miscarriage
- Gonadotropin and insemination: No Yes
of cycles _____
Outcome: not pregnant pregnant miscarriage

IVF (inVtro Fertilization) ___No ___Yes

of cycles _____

Outcome: ___not pregnant ___pregnant ___miscarriage

Frozen Embryo Transfer: ___No ___Yes

#of cycles _____

Outcome: _____not pregnant ___pregnant ___miscarriage

Have you used donor eggs or donor sperm as part of your treatment?

___No ___Yes

Please list the names and approximate date of physicians you have seen for infertility:

Genetic History

1. Have you, your spouse or your families had a history of any of the following disorders? (check all that apply)

- ___Mental retardation
- ___Learning Problems
- ___Fragile X Syndrome
- ___Cystic Fibrosis
- ___Muscular dystrophy
- ___Thalassemia A or B
- ___Down's Syndrome
- ___Tay Sach's Disease
- ___Hemophilia
- ___Von Willebrand's disease
- ___Bleeding disorders
- ___Thrombophilia
- ___Blood clots in veins
- ___Celiac Disease
- ___Polycystic kidneys
- ___Hypospadias
- ___Other birth defects
- ___Cancer of breast, ovary or colon
- ___Menopause before age 40
- ___Bone defects
- ___Neural tube defects
- ___Sickle cell anemia
- ___None of the above