

Houston Fertility Center

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Infertility History Form

Patient Name: _____ **Date:** _____

Date of Birth: _____

How long have you been attempting pregnancy? _____

As you understand it, what is preventing you from getting pregnant? (Circle all that apply: Unexplained, Endometriosis, Tubal Causes, Uterine Causes, Ovulatory Dysfunction, Diminished Ovarian Reserve, Male Causes, Immunologic Causes, Cervical Causes, Recurrent Pregnancy Losses, Other)

Notes:

Pregnancy Summary:

~ Total Number of ALL pregnancies: _____ ~ Number of Miscarriages: _____
~ Number of Ectopic/Tubal pregnancies: _____ ~ Number of Elective Terminations: _____
~ Number of Full Term Deliveries: _____ ~ Number of Preterm deliveries: _____
~ Any pregnancies with birth defects? () No () Yes Please explain: _____

Date Pregnancy Ended or Delivered	Pregnancy Length	Outcome (Delivery Type/ D&C/Complications)	Father (Current or Previous Partner)
1.			
2.			
3.			
4.			
5.			

Menstrual Summary:

~ How many periods do you have per year? _____
~ When was your last period? _____ ~ Can you tell when you ovulate? () No () Yes
~ What type of contraception have you used? _____

Sexual History:

~ How many times per month do you have intercourse? _____ () None () Not applicable
~ Do you have pain with intercourse? () No () Yes If yes, describe the pain _____

Have you had any of the following sexually transmitted or pelvic infection? (Check all that apply)

() Chlamydia () Gonorrhea () Genital Warts () Syphilis () HIV/AIDS () Hepatitis
() Other _____

Name: _____

Pap Smear History:

~ When was your last PAP Smear? (month and year) _____ () Normal () Abnormal

~ When was your last abnormal PAP Smear? (month and year) _____ () Not applicable

Breast Screening History:

Have you ever had a mammogram? () No () Yes Date: _____ Result: () Normal () Abnormal

Medical History:

~ Are you allergic to any foods or medications? () No () Yes (Please list and describe reaction)

~ Please list all medications you are taking, including over the counter medications and herbal medicines/vitamins:

Surgical History:

~ Have you had any surgeries? () No () Yes (Please list in chronological order):

<u>Year</u>	<u>Reason and type of Surgery</u>
_____	_____
_____	_____
_____	_____
_____	_____

~ Did you have any anesthesia problems? () No () Yes (Describe): _____

Occupation/Leisure History:

	Yes	No	Dates/Comments
Exposed to chemical or x-rays in work or hobby Please list amount per day	_____	_____	_____
Caffeine	_____	_____	_____
Smoking	_____	_____	_____
Alcohol	_____	_____	_____
Marijuana	_____	_____	_____
Nutritional supplements, herbs, etc.	_____	_____	_____
Drugs	_____	_____	_____

Name: _____

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

- Weight loss or gain Shortness of breath Headaches Asthma Diabetes
 Thyroid problems Seizures Abnormal mammogram Stroke
 Blood clotting disorder Rheumatoid arthritis
 Lupus erythematosus High blood pressure
 Mitral valve prolapse

Disorders in family: Relationship to You Disorders in family: Relationship to You

- | | | | |
|--|-------|--|-------|
| <input type="checkbox"/> Breast cancer | _____ | <input type="checkbox"/> Gaucher disease | _____ |
| <input type="checkbox"/> Ovarian cancer | _____ | <input type="checkbox"/> Hemochromotosis | _____ |
| <input type="checkbox"/> Other cancer | _____ | <input type="checkbox"/> Neimann | _____ |
| <input type="checkbox"/> Infertility | _____ | <input type="checkbox"/> Fanconi Anemia | _____ |
| <input type="checkbox"/> Menopause before 40 | _____ | <input type="checkbox"/> Familial Dysautonomia | _____ |
| <input type="checkbox"/> Birth Defects | _____ | <input type="checkbox"/> Chromosomal prob. | _____ |
| <input type="checkbox"/> Cystic Fibrosis | _____ | <input type="checkbox"/> Marfan syndrome | _____ |
| <input type="checkbox"/> Tay-Sachs disease | _____ | <input type="checkbox"/> Hemophilia | _____ |
| <input type="checkbox"/> Canavan disease | _____ | <input type="checkbox"/> Sickle Cell Anemia | _____ |
| <input type="checkbox"/> Bloom syndrome | _____ | <input type="checkbox"/> Thalassemia | _____ |

What is your ancestry?

- African American American Indian Ashkenazi
 Asian-American Cajun/French Caucasian
 Eastern European Hispanic/Caribbean Northern European
 Southern European Other Specify _____

Name: _____

Previous Infertility Testing:

Length of time currently attempting pregnancy _____ Years _____ Months

Length of time not using contraceptives _____

	Yes	No	Year	Normal	Abnormal	If yes, give dates/results
Temperature charts	()	()	___	()	()	_____
Hysterosalpingogram	()	()	___	()	()	_____
Hysteroscopy	()	()	___	()	()	_____
Endometrial Biopsy	()	()	___	()	()	_____
Post Coital Test	()	()	___	()	()	_____
Semen Analysis	()	()	___	()	()	_____
Laparoscopy	()	()	___	()	()	_____
Hormone Test	()	()	___	()	()	_____
Day 3 FSH	()	()	___	()	()	_____
Day 3 Estradiol	()	()	___	()	()	_____
Clomid Challenge	()	()	___	()	()	_____
Thyroid Tests	()	()	___	()	()	_____
Chromosome Test	()	()	___	()	()	_____

List all fertility treatments:

Preferred pharmacy: _____ phone# _____

For Office Use Only!

LMP: _____ Referred by: _____

Notes:

