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 ( ) Syphillis ( ) 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):

Year	**Reason and type of Surgery**
_____	_____
_____	_____
_____	_____
_____	_____

~ 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**
( ) Breast cancer	_____	( ) Gaucher disease	_____
( ) Ovarian cancer	_____	( ) Hemochromotosis	_____
( ) Other cancer	_____	( ) Neimann	_____
( ) Infertility	_____	( ) Fanconi Anemia	_____
( ) Menopause before 40	_____	( ) Familial Dysautonomia	_____
( ) Birth Defects	_____	( ) Chromosomal prob.	_____
( ) Cystic Fibrosis	_____	( ) Marfan syndrome	_____
( ) Tay-Sachs disease	_____	( ) Hemophilia	_____
( ) Canavan disease	_____	( ) Sickle Cell Anemia	_____
( ) Bloom syndrome	_____	( ) 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 treatment: _____

_____

For Office Use Only!

LMP: _____ Referred by: _____

Notes: