The Women's Medical Clinic

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New Patient Gynecologic History for Infertility

A. Identifying Data

Date this form completed ______________

Your name________________________ Partner's name_________________________
Age _______ Birth date _______________ Height ________ Weight ______________
Length of marriage (or relationship) ______________________________________
How long have you been trying unsuccessfully to get pregnant? ___________
Have you previously been pregnant? _______________________________________
Have you previously tried to get pregnant? ________________________________
Reason for your visit today ____
____

B. Pregnancy History

Times pregnant________ Term births________ Premature births ________
Miscarriages________ Elective abortion________ Adopted children________

	Date	Mis-carriage?	Elective abortion?	Ectopic?	Months to Conceive?	Infertility treatment?	Weight & sex?	C-section?	Compli-cations?	Is current partner the father?
1.										
2.										
3.										
4.										
5.										
6.										

C. Contraceptive Use

	Type	From when to when	Reason discontinued
1.			
2.			
3.			

D. Operations and Hospitalizations

	Date	Diagnosis	Operation	Where performed	Physician
1.					
2.					
3.					
4.					
5.					
6.					

E. Medications: *Please list all prescriptions and over-the-counter drugs used during the past year.*

	Date	Dosage and frequency	From when to when	Reason for taking
1.				
2.				
3.				
4.				
5.				
6.				

F. Allergies

To what (drug or substance)	When	What type of reaction?

G. Menstrual (hormonal) history

Date your last menstrual period began ___________________________

Your age at your first period ___________________________

Are your periods regular? ___________________________

How many days from onset to onset? ___________________________

How many days does your period last? ___________________________

Do you bleed between periods? ___________________________

Do you have premenstrual symptoms? (circle) almost always – rarely - never
Vigorous exercise: Type ________________________ hours/week ___________
Type ________________________ hours/week ___________
If you have a hormonal disorder, please specify type and treatment
____

Pelvic pain/cramps (circle): none - during your period - before your period - after your period at mid-cycle - during intercourse - with urination - with bowel movements - cause you to miss usual activities - cause you to miss work

Pelvic pain/cramps are (circle) - mild – moderate – severe - getting worse – improving - not changing - on the right side - on the left side - in the middle

What medications do you take for pain/cramps? ____________________________

Do you have or have you had (circle):

Hot flashes	Increased facial or body hair
Breast discharge	Increased acne
Vision problems	Weight gain (>10 pounds)
Poor sense of smell	Weight loss (<10 pounds)
Chronic headache	Special dietary habits
Head injury	Vomiting
Seizures	Diabetes
Thyroid disorder	Autoimmune disease
Excessive stress	Psychiatric treatment

If you circled any of the above, please explain:
____
____
____
____

H. Physical Conditions/infections

Do you have or have you had (circle):

Pelvic infection	Appendicitis
Chlamydia	Colitis or enteritis
Antichlamydial antibodies	Endometriosis
Gonorrhea	Pelvic adhesions
Syphilis	Uterine fibroids or myomas
Mycoplasma	Abnormal uterus (shape, etc.)
Ureaplasma	Ovarian cysts
Tuberculosis	Toxoplasmosis
	Cytomegalovirus (CMV)

I. Combined

Do you have or have you had (circle):

Cervicitis
Genital herpes
Genital warts/condyloma
Trichomonas
Recurring vaginitis
Abnormal pap smears
Cryo (freezing) or surgery of the cervix

How many times per week do you have sexual intercourse? ________________________
How many times do you have intercourse around ovulation? _______________________
Do you use lubricants for intercourse? ____
Do you douche before or after intercourse? ____
Have you ever had unwanted sexual experiences? ______________________________________
Do you have any sexual problems at this time? _______________________________________

J. Other Medical History

Your occupation____
Years of formal education____
Cigarettes-packs smoked/day____
Alcohol-type and number of drinks/week_______________________________________
Marijuana-amount____
Other drugs-type and amount____
Ever used intravenous drugs? ____
Caffeine drinks per day____
Radiation exposure____
Toxic exposure____
Video display terminal-hours/day ____
Electric blanket use ____
Hot tub or sauna use____
List all serious or chronic illnesses or injuries not already described _________
____
____

K. Partner's Medical History

Your partner's age _________ Occupation______________________________________
List all serious or chronic illnesses or injuries ________________________________
Medications ____
____
Cigarettes-packs smoked/day____
Alcohol-type and number of drinks/week_______________________________________
Marijuana-amount____
Other drugs-type and amount____
Ever used intravenous drugs? ____
Caffeine drinks per day____
Radiation exposure____
Toxic exposure____

Video display terminal-hours/day ________________________________

Electric blanket use ____

Hot tub or sauna use____

Any problems with erection or ejaculation? ____________________

Has semen analysis ever been abnormal? ______________________

Has your partner seen a doctor for infertility evaluation? ___________

Doctor ____

Diagnosis ____

Treatment ____

Has your partner ever fathered a pregnancy with another woman? ______

Any inherited diseases in your partner's family? _________________

Does you partner have or has he had (circle):

Chlamydia
Antichlamydial antibodies
Gonorrhea
Syphilis
Genital herpes
Genital warts/condyloma
Mycoplasm
Ureaplasma
Urethritis/epididymitis
Prostatitis
Penile discharge or pain
Undescended testicle
Injury to the testicle(s)
Mumps with injury to testicles
Physical abnormality
DES exposure in womb

Vasectomy
Vasectomy reversal
Varicocele
Varicocele surgery
Biopsy of testicles
Hernia surgery
Abdominal surgery
Cancer
High blood pressure
Diabetes
Colitis
Seizures
Psychiatric treatment
Excessive stress
Strenuous exercise
Tight underwear

I . Previous Evaluation

Have you had:

	Not Done	Result		Approx. date	Values (if known)
		Normal	Abnormal		
Basal body Temperature (BBT)	☐	☐	☐	________	________
Urine LH surge	☐	☐	☐	________	________
Endometrial biopsy	☐	☐	☐	________	________
Blood tests:					
FSH	☐	☐	☐	________	________
LH	☐	☐	☐	________	________
Prolactin	☐	☐	☐	________	________
Thyroid tests (TSH, T_4)	☐	☐	☐	________	________
DHEAS	☐	☐	☐	________	________
Testosterone	☐	☐	☐	________	________
Estradiol	☐	☐	☐	________	________
Progesterone	☐	☐	☐	________	________
Postcoital test	☐	☐	☐	________	________
Cervical mucus Penetration test	☐	☐	☐	________	________
Mycoplasma culture	☐	☐	☐	________	________
Chlamydia culture	☐	☐	☐	________	________
Antichlamydial antibodies	☐	☐	☐	________	________
Female antisperm antibodies	☐	☐	☐	________	________
Hysterosalpingogram (HSG)	☐	☐	☐	________	________
Ultrasound	☐	☐	☐	________	________
IVP (kidney –ray)	☐	☐	☐	________	________
Laparoscopy	☐	☐	☐	________	________
Hysteroscopy	☐	☐	☐	________	________
Karyotype	☐	☐	☐	________	________
Anticardiolpin antibodies	☐	☐	☐	________	________
Lupus anticoagulant	☐	☐	☐	________	________
Antinuclear anitbodies (ANA)	☐	☐	☐	________	________
Coagulation screen	☐	☐	☐	________	________
Biochemistry/ hematology panel	☐	☐	☐	________	________

	Not Done	Result: Normal	Result: Abnormal	Approx. date	Values (if known)
Blood type	☐	☐	☐	______	______
Other	☐	☐	☐	______	______
Has your partner had:					
Semen analysis	☐	☐	☐	______	______
Hamster egg penetration essay	☐	☐	☐	______	______
Semen antisperm antibodies	☐	☐	☐	______	______

List causes of infertility previously diagnosed ______________________________

____

____

M. Previous Treatment

	How many months?	Dose (if known)	Approx. dates taken
Antibodies	______	______	______
Clomiphene (Clomid, Serophene)	______	______	______
hMG (Pergonal)	______	______	______
hCG (Profasil)	______	______	______
Progesterone	______	______	______
Dexamethasone	______	______	______
GnRH agonist (Synarel, Lupron)	______	______	______
Danazol	______	______	______
Intrauterine insemination	______	______	______
Insemination with donor sperm	______	______	______
IVF (in vitro fertilization)	______	______	______
GIFT	______	______	______
Other:			

Please use the remainder of this page to explain any additional information you feel your doctor may need.

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