



**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 \_\_\_\_\_

**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  
Have you undergone any of the following procedures as a result of an abnormal PAP Smear?  
( ) Colposcopy ( ) Cryosurgery (freezing) ( ) Conization ( ) Laser ( ) LEEP

**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): \_\_\_\_\_

**Vaccinations:** (check all that apply)

- ( ) Chickenpox (varicella) ( ) Hepatitis A ( ) Tetanus ( ) Influenza ( ) MMR
- ( ) BCG (tuberculosis) ( ) Hepatitis B ( ) Polio

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

**Physical Symptoms:**

**General:**

- Weight loss or gain
- Anorexia/Bulimia
- Lack of energy
- Fever/Chills
- Other \_\_\_\_\_

**Head/Eye/Ears/Nose/Throat:**

- Dizziness     Loss of sense of smell
- Headaches     Chronic nasal congestion
- Blurred vision     Ringing ears
- Hearing Loss
- Other \_\_\_\_\_

**Respiratory:**

- Shortness of breath
- Asthma
- Pneumonia
- Bloody cough
- Other \_\_\_\_\_

**Endocrine/Hormonal:**

- Diabetes
- Thyroid problems
- Rapid weight gain
- Excessive hunger/thirst
- Temperature
- Other \_\_\_\_\_

**Breasts:**

- Discharge (clear, bloody or milky?)
- Lumps     Pain     Cancer
- Abnormal mammogram
- Reduction
- Augmentation (saline or silicone)
- Other \_\_\_\_\_

**Neurological:**

- Weakness
- Seizures
- Headaches
- Numbness
- Memory loss
- Other \_\_\_\_\_

**Gastrointestinal:**

- Nausea/vomiting
- Hepatitis
- Blood in stool
- Diarrhea/constipation
- IBS
- Other \_\_\_\_\_

**Genito/Urinary:**

- Bladder infections
- Kidney infections
- Vaginal infections
- Frequent urination
- Blood in urine
- Other \_\_\_\_\_

**Skin/Extremities**

- Acne
- Skin cancer
- Burn injuries
- Excess hair growth
- Other \_\_\_\_\_

**Musculoskeletal:**

- Muscle weakness
- Rheumatoid arthritis
- Lupus erythematosus
- Myasthenia gravis
- Other \_\_\_\_\_

**Hematologic:**

- Blood clotting disorder
- Sickle cell anemia
- Easy bruising
- Swollen glands/lymph nodes
- Other \_\_\_\_\_

**Cardiovascular:**

- Palpitations
- Stroke
- High blood pressure
- Mitral valve prolapse
- Other \_\_\_\_\_

**Disorders in family:**

- Breast cancer \_\_\_\_\_
- Ovarian cancer \_\_\_\_\_
- Other cancer \_\_\_\_\_
- Infertility \_\_\_\_\_
- Menopause before 40 \_\_\_\_\_
- Birth Defects \_\_\_\_\_
- Cystic Fibrosis \_\_\_\_\_
- Tay-Sachs disease \_\_\_\_\_
- Canavan disease \_\_\_\_\_
- Bloom syndrome \_\_\_\_\_

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

- Gaucher disease \_\_\_\_\_
- Hemochromatosis \_\_\_\_\_
- Neimann \_\_\_\_\_
- Fanconi Anemia \_\_\_\_\_
- Familial Dysautonomia \_\_\_\_\_
- Chromosomal prob. \_\_\_\_\_
- Marfan syndrome \_\_\_\_\_
- Hemophilia \_\_\_\_\_
- Sickle Cell Anemia \_\_\_\_\_
- Thalassemia \_\_\_\_\_

**Relationship to You**

**What is your ancestry?**

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

**Prior Infertility Testing and Treatment:**

Have you had prior infertility or treatment elsewhere?  Yes  No

**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	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hysterosalpingogram	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hysteroscopy	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endometrial Biopsy	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Post Coital Test	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Semen Analysis	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Laparoscopy	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hormone Test	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Day 3 FSH	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Day 3 Estradiol	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Clomid Challenge	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Tests	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chromosome Test	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Prior Treatment:**

Ovulation Induction	With Intrauterine Inseminations?	# of cycles	Month/Year	Outcome
Clomiphene citrate (Clomid) Maximum number of tablets per day				
Daily fertility Injections Maximum # of vials per day ____ Name of drug used				
Other:				

LMP: \_\_\_\_\_

Notes:

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