GENETICS & IVF Institute

# Patient History Form

**Today's Date**: _____

Please complete all applicable sections of this questionnaire to the best of your ability.
Your confidential answers will be reviewed by a physician and will help to give you the best possible care.

## PATIENT INFORMATION

**Patient Legal Name:** _____ Preferred Name: _____

Sex assigned at birth: ☐ Male ☐ Female Personal Pronoun (she/he/they): _____

Date of Birth: _____/_____/_____ Age: _____ Last menstrual period (if applicable): _____/_____/_____

Allergies: _____

**Partner/Spouse Legal Name** *(if applicable)*: _____ Preferred Name: _____

Sex assigned at birth: ☐ Male ☐ Female Personal Pronoun (she/he/they): _____

Date of Birth: ____/_____/_____ Age: _____

**Who is your Primary Care Physician, OB/GYN, and/or other important providers?**

| | | |
|---|---|---|
| Name: _____ | Name: _____ | Name: _____ |
| Address: _____ | Address: _____ | Address: _____ |
| _____ | _____ | _____ |
| Phone: _____ | Phone: _____ | Phone: _____ |
| Specialty: ☐ Primary Care ☐ OB/Gyn ☐ Other: _____ | Specialty: ☐ Primary Care ☐ OB/Gyn ☐ Other: _____ | Specialty: ☐ Primary Care ☐ OB/Gyn ☐ Other: _____ |

Would you like a summary letter sent? ☐ Yes ☐ No Notes: _____

**How long have you been actively trying to conceive, if applicable? _____**

How long have you been having unprotected vaginal intercourse? _____

Frequency of unprotected intercourse: _____

Have you used ovulation predictor kits and if so, note results: _____

**What is the primary reason for your consultation?** (use the back of the page if needed)

## REPRODUCTIVE & GYN HEALTH HISTORY

**CONTRACEPTION HISTORY:** *Have you ever used the following contraception methods?*

| METHOD | YES | NO | TIME PERIOD/DATES OF USE |
|---|---|---|---|
| Condoms | ☐ | ☐ | |
| Diaphragm | ☐ | ☐ | |
| Depo-Provera | ☐ | ☐ | |
| Implant | ☐ | ☐ | |
| Intrauterine Device (IUD) hormonal | ☐ | ☐ | |
| Intrauterine Device (IUD) copper | ☐ | ☐ | |
| Patch | ☐ | ☐ | |
| Oral contraceptives pills | ☐ | ☐ | |
| Sterilization | ☐ | ☐ | |
| Other methods: _____ _____ | ☐ | ☐ | |

**PREGNANCY HISTORY** *(please include all):*

| **Pregnancy** | **Year of Conception or Delivery** | **Conceived with current partner?** | **Time to Conceive** (weeks/ months if known) | **Weeks at Delivery** | **Delivery Method** (Vaginal or C-Section) | **Baby's Sex & Weight at Birth** | **Outcomes/Complications** (miscarriage, termination, ectopic, preterm delivery, etc.) |
|---|---|---|---|---|---|---|---|
| First | | Yes No | | | Select One | Choose On | |
| Second | | Yes No | | | Select One | Choose On | |
| Third | | Yes No | | | Select One | Choose On | |
| Fourth | | Yes No | | | Select One | Choose On | |
| Fifth | | Yes No | | | Select One | Choose On | |

Page Comments: _____

_____

_____

## MENSTRUAL & GYN HISTORY:

Age at first menstrual period: _____ Menstrual pattern (regular/irregular): _____

# of days from the start of a menstrual cycle to the beginning of the next, new menstrual cycle:

average: _____ shortest: _____ longest: _____

Have you ever gone longer than 3 months without a menstrual period? ☐ YES ☐ NO

Average duration of your menstrual flow (days): _____ My typical menstrual flow is: ☐ Light ☐ Moderate ☐ Heavy

Severity of menstrual cramping: ☐ Mild ☐ Moderate ☐ Severe

Do you experience pain with vaginal intercourse? ☐ YES ☐ NO

Do you have midcycle: Spotting? ☐ YES ☐ NO
Pain? ☐ YES ☐ NO

**When was your last Pap smear?** _____ Result: _____

Any prior abnormal Paps and treatment (colposcopy/LEEP/cone/cryo etc.): _____

**When was your last Mammogram?** _____ Result: _____

Any prior history of abnormal mammograms? _____

## PRIOR FERTILITY TESTS & TREATMENTS:

*Please complete this section to the best of your ability and provide medical records if possible.*

| **Prior Fertility Tests** | **Result** | **Date of Test** |
|---|---|---|
| Hormones (FSH, AMH, TSH) | | |
| Pelvic ultrasound | | |
| Hysterosalpingogram (HSG) | | |
| Hysterosonogram | | |
| Endometrial Biopsy | | |
| Infectious disease screening (HIV/Hepatitis B/Hepatitis C/Syphilis) | | |
| **Prior Fertility Treatments** | **Outcome** | **Date of Treatment** |
| Intrauterine insemination (IUI) – specify if medicated | | |
| In Vitro Fertilization (IVF) | | |
| Frozen Embryo Transfer (FET) | | |
| Donor Egg | | |
| Other (please specify) | | |

Comments: _____

_____

## MEDICAL & HEALTH HISTORY

**Do you have or have you ever had (check all that apply)**:

| Infectious Problems | ✓ | Gynecologic Problems | ✓ | Medical Problems | ✓ | Medical Problems | ✓ |
|---|---|---|---|---|---|---|---|
| positive HIV test | ☐ | blocked fallopian tubes | ☐ | anemia | ☐ | liver disease | ☐ |
| chicken pox (varicella) | ☐ | pelvic adhesions | ☐ | bleeding disorders | ☐ | nausea/vomiting | ☐ |
| chicken pox vaccination | ☐ | endometriosis | ☐ | blood clots | ☐ | irritable bowel | ☐ |
| hepatitis A, B or C | ☐ | uterine anomalies | ☐ | blood transfusion | ☐ | inflammatory bowel disease | ☐ |
| hepatitis A vaccination | ☐ | uterine fibroids | ☐ | diabetes | ☐ | change in bowel habits | ☐ |
| hepatitis B vaccination | ☐ | cervical stenosis | ☐ | cancer | ☐ | blood in stool or urine | ☐ |
| German measles (rubella) | ☐ | DES exposure | ☐ | sickle cell disease or trait | ☐ | ulcers | ☐ |
| rubella vaccination (MMR) | ☐ | breast discharge | ☐ | heart disease | ☐ | appendicitis | ☐ |
| rheumatic fever | ☐ | hot flashes or night sweats | ☐ | high blood pressure | ☐ | elevated prolactin | ☐ |
| chronic bronchitis/cough | ☐ | chronic/recurrent pelvic pain | ☐ | mitral valve prolapse | ☐ | thyroid problems | ☐ |
| pneumonia | ☐ | | | chest pain or palpitations | ☐ | temperature intolerance | ☐ |
| chlamydia | ☐ | **Neurological Problems** | ✓ | shortness of breath | ☐ | rapid weight gain/loss | ☐ |
| gonorrhea | ☐ | weakness/numbness | ☐ | asthma | ☐ | anorexia/bulimia | ☐ |
| syphilis | ☐ | severe headaches/migraines | ☐ | lung disease | ☐ | hair loss | ☐ |
| herpes | ☐ | seizures/epilepsy | ☐ | lupus | ☐ | excess facial hair | ☐ |
| genital warts | ☐ | loss of smell | ☐ | arthritis | ☐ | blurry vision/visual changes | ☐ |
| trichomonas | ☐ | memory loss | ☐ | autoimmune problems | ☐ | psychiatric problems | ☐ |
| recurrent urinary infections | ☐ | pituitary tumor | ☐ | urinary frequency/burning | ☐ | depression | ☐ |
| pelvic inflammatory dz (PID) | ☐ | | | kidney disease | ☐ | anxiety | ☐ |
| kidney infection | ☐ | | | kidney stones | ☐ | sleep apnea | ☐ |

Comments: _____

_____

## MEDICAL HISTORY:

Height _____ Weight _____

| Do you follow a particular food diet or have any special dietary habits? | How much do you exercise? |
|---|---|
| | |

| Toxicant Exposure | Yes | No | Date Last Exposed | Notes |
|---|---|---|---|---|
| Alcohol | _____ drinks/week | ☐ | | |
| Recreational Drugs | ☐ | ☐ | | |
| Smoking | _____ packs/day | ☐ | | |
| Pesticides | ☐ | ☐ | | |
| Other Chemicals | ☐ | ☐ | | |
| Radiation | ☐ | ☐ | | |

**List all medications:** (prescriptions, vitamins, and over the counter preparations)

| Drug | Dose | Dates |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Are you taking prenatal vitamins?

YES NO

_____
_____
_____
_____

**List all allergic reactions you have had:**

| Drug or Allergen | Type of Reaction | Date |
|---|---|---|
| | | |
| | | |
| | | |

**List all prior surgeries** (including on cervix, uterus, ovarian cysts, tubes, endometriosis, appendix, etc.):

| Type of Surgery | Date |
|---|---|
| | |
| | |
| | |

**List any chronic conditions/serious illnesses:**

_____

_____

## PATIENT FAMILY HISTORY:

**Ethnic Background/Ancestry**: ☐ African/American ☐ Asian ☐ Southeast Asian ☐ Caucasian ☐ Hispanic ☐ Jewish ☐ Native American ☐ Mediterranean ☐ Middle Eastern ☐ Other:_____

Have you had any genetic carrier screening (e.g. cystic fibrosis, spinal muscular atrophy, fragile X, Tay-Sachs, etc.):

_____

Are you related to your current partner (consanguinity)? _____

**Is there anyone in the family who has had any of the following illnesses?**

| Condition | Yes | Relationship | Condition | Yes | Relationship |
|---|---|---|---|---|---|
| abnormal genitals | ☐ | | colon cancer | ☐ | |
| birth defects | ☐ | | breast cancer | ☐ | |
| chromosomal disorders | ☐ | | ovarian cancer | ☐ | |
| learning problems | ☐ | | pituitary tumor | ☐ | |
| mental retardation | ☐ | | other cancer | ☐ | |
| delayed development | ☐ | | metabolic disorder | ☐ | |
| early puberty | ☐ | | hormone disorders | ☐ | |
| endometriosis | ☐ | | bleeding/clotting disorders | ☐ | |
| excess body hair | ☐ | | congenital deafness/blindness | ☐ | |
| infertility | ☐ | | heart disease | ☐ | |
| early menopause < age 40 | ☐ | | thyroid disease | ☐ | |
| Two (2) or more miscarriages | ☐ | | genetic disease/mutation | ☐ | |
| diabetes | ☐ | | hypertension | ☐ | |
| polycystic ovary syndrome | ☐ | | irregular periods | ☐ | |

Comments/Other Family History: _____

## MALE PARTNER HISTORY *(if applicable)*

Height _____ Weight _____

**Ethnic Background/Ancestry**: ☐ African/American ☐ Asian ☐ Southeast Asian ☐ Caucasian ☐ Hispanic ☐ Jewish ☐ Native American ☐ Mediterranean ☐ Middle Eastern ☐ Other:_____

Have you had any genetic carrier screening (e.g. cystic fibrosis, spinal muscular atrophy, fragile X, Tay-Sachs, etc.):

_____

| Toxicant Exposure | Yes | No | Date Last Exposed | Notes |
|---|---|---|---|---|
| Alcohol | _____ drinks/week | ☐ | | |
| Recreational Drugs | ☐ | ☐ | | |
| Smoking | _____ packs/day | ☐ | | |
| Pesticides | ☐ | ☐ | | |
| Other Chemicals | ☐ | ☐ | | |
| Radiation | ☐ | ☐ | | |

**List all medications:** (prescriptions, vitamins, and over the counter preparations)

| Drug | Dose | Dates |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## MALE PARTNER HISTORY *(continued)*:

**List all allergic reactions you have had:**

| Drug or Allergen | Type of Reaction | Date |
|---|---|---|
| | | |
| | | |
| | | |

**List all prior surgeries and any Chronic/Serious Illness:**

| Type of Surgery/Illness | Date |
|---|---|
| | |
| | |
| | |
| | |

**Have you had any pregnancies with any other partner(s)? If yes, please list dates and outcomes:**

| Pregnancy Date | Outcomes |
|---|---|
| | |
| | |
| | |

**Have you had any prior semen analysis? If yes, please list dates and results:**

| Date | Results |
|---|---|
| | |
| | |

**Have you had any of the following? If yes, please write more details (dates, treatments, etc.):**

| Condition | Yes | Details |
|---|---|---|
| erectile dysfunction | ☐ | |
| undescended testes | ☐ | |
| delayed puberty | ☐ | |
| breast enlargement | ☐ | |
| varicocele | ☐ | |
| testicular torsion, swelling, or trauma | ☐ | |
| sexually transmitted diseases (gonorrhea, chlamydia, herpes, syphilis, HIV) | ☐ | |
| prostatitis | ☐ | |
| recent high fever | ☐ | |
| hot tub use | ☐ | |

**List any family history of infertility, cancer, or serious illness:**

_____

_____