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 Legal Name: _____ Preferred Name: _____

Date of Birth: ____/___/_____ Age: _____ Start Date of last menstrual period: _____

Sex assigned at birth: ☐ Male ☐ Female Pronouns: _____ Height: _____ Weight: _____

Ethnic Background/Ancestry (check all that apply):

☐ African American ☐ East Asian ☐ Southeast Asian ☐ Caucasian

☐ Hispanic ☐ Jewish ☐ Native American ☐ Mediterranean ☐ Middle Eastern ☐ Other: _____

- Related to partner? ☐ Yes – describe: _____ ☐ No
- Did your mother take DES during pregnancy? ☐ Yes ☐ No ☐ Don't know

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

Partner Date of Birth: ____/___/_____ Partner Age: _____ Height: _____ Weight: _____

Sex assigned at birth: ☐ Male ☐ Female Pronouns: _____

Ethnic Background/Ancestry (check all that apply):

☐ African American ☐ East Asian ☐ Southeast Asian ☐ Caucasian

☐ Hispanic ☐ Jewish ☐ Native American ☐ Mediterranean ☐ Middle Eastern ☐ Other: _____

- Related to partner? ☐ Yes – describe: _____ ☐ No
- Did your mother take DES during pregnancy? ☐ Yes ☐ No ☐ Don't know

Who is your OB/GYN? Name/Practice: _____ Phone/Fax: _____

Address: _____

☐ Check here if you would like a summary of your consult sent to your Ob/Gyn and/or your referring clinician

Any other clinician you regularly see to manage your health? (cardiologist, hematologist, urologist, endocrinologist, PCP, etc.) Name/Practice: _____ Phone/Fax: _____

Address: _____

Goals/expectations for consultation:

Select the option that applies:

☐ **Infertility Evaluation** ☐ **Recurrent Pregnancy Loss**

☐ **Donor Sperm** ☐ **Donor Egg** ☐ **Fertility Preservation -** ☐ **Egg or** ☐ **Embryo**

☑ **IVF** ☐ **IVF for Gender Selection** ☐ **IVF with Gestational Carrier/ Surrogacy**

☐ **Reciprocal IVF** (***a process where one partner's eggs are used, and the other partner carries the pregnancy***)

☐ **Second Opinion** ☐ **Other:** _____

Explain in your own words, what brings you to our facility:

_____

_____

_____

_____

_____

How many months have you been actively trying to conceive? _____ ☑ N/A

How many months have you been having vaginal intercourse without using any form of birth control? _____ ☐ N/A

How many times do you have vaginal intercourse per **week**? _____times per week ☐ None/Not Applicable

Have you used over-the-counter ovulation predictor kits to time intercourse? ☐ Yes ☑ No

SEXUAL & CONTRACEPTION HISTORY:

Do you use lubricants (K-Y Jelly®, etc.) during intercourse? ☐ No ☐ Yes, types: _____

History of STDs or Pelvic Infections – Do you currently or have you had any of the following?

(Please list condition(s) and dates, or write "None." (Ex: Chlamydia - 03/2000)*)*

Patient Responses	Spouse /Partner Responses

(List all form(s) of current contraception used, list approximate dates & complications, and indicate who used it)

Contraception Method	Patient – Dates of Use / Complications	Spouse/Partner – Dates of Use / Complications
☐ Tubal Sterilization (tubes tied)	Procedure date:	Procedure date:
☐ Vasectomy	Procedure date:	Procedure date:

PATIENT PREGNANCY HISTORY*:*

Total Number of ALL Pregnancies: _____ Total Number of Pregnancy loss under 20 weeks: _____

Number of Ectopic/Tubal Pregnancies: _____ Number of Elective Termination (Abortions): _____

Number of Full-Term Deliveries: _____ Of theses, how many live births: _____ Stillbirth:_____

Number of Premature Deliveries (less than 37 weeks): ____ Of these, how many were live births: ____ Stillbirth: ____

PATIENT PREGNANCY HISTORY CONT'D:

Month and Year (MM/ YYYY) Pregnancy Ended or Delivered	**Months to Conception** (how long did it take to get pregnant)	**Treatments to Conceive** *if any*	**Delivery Type** *if applicable* Vaginal or C-Section	**Baby Sex & Weight** at birth	**Outcomes/Complications** (full-term, miscarriage, termination, ectopic, preterm delivery, etc.)	**Conceived with Current Partner?**
1.			☐vaginal ☐c-section			☐ Yes ☐ No
2.			☐vaginal ☐c-section			☐ Yes ☐ No
3.			☐vaginal ☐c-section			☐ Yes ☐ No
4.			☐vaginal ☐c-section			☐ Yes ☐ No
5.			☐vaginal ☐c-section			☐ Yes ☐ No

PARTNER/ SPOUSE – list any pregnancies not conceived with current partner:

_____

MENSTRUAL & GYN HISTORY:

Question	Patient	Spouse/Partner
Age at first menstrual period		
How many days of bleeding do you usually have?		
Menstrual cycle pattern (check all that apply)	☐ Regular ☐ Irregular ☐ No Periods ☐ Midcycle spotting ☐ Light ☐ Moderate ☐ Heavy	☐ Regular ☐ Irregular ☐ No Periods ☐ Midcycle spotting ☐ Light ☐ Moderate ☐ Heavy
Number of days between the start of one period to the start of the next period		
If irregular: shortest and longest number of days	_____ - _____ days	_____ - _____ days
Have you ever gone longer than 3 months without a menstrual period?		
Severity of cramping or pelvic pain with your periods	☐ Mild ☐ Moderate ☐ Severe	☐ Mild ☐ Moderate ☐ Severe
Do you experience midcycle cramping?		
Do you experience pain with vaginal intercourse?		
Month/Year of your last Pap smear	Result: ☐ Normal ☐ Abnormal	Result: ☐ Normal ☐ Abnormal
Have you had an abnormal Pap smear in the past?	☐ No ☐ Yes: date	☐ No ☐ Yes: date
Procedures as a result of abnormal Pap smear	☐ Colposcopy ☐ Cryosurgery ☐ Laser ☐ Conization ☐ LEEP ☐ No	☐ Colposcopy ☐ Cryosurgery ☐ Laser ☐ Conization ☐ LEEP ☐ No
Month/Year of your most recent Mammogram		
Result of most recent Mammogram	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal

Any prior history of abnormal mammograms?		

PRIOR FERTILITY TESTS & TREATMENTS *(Please provide medical records if possible):*

Tests	Patient – Dates & Results	Spouse/Partner - Dates & Results
Hormonal blood test (FSH/AMH/TSH)		
Pelvic Ultrasound		
Hysterosonogram/Saline Sonogram		
Hysterosalpingogram (HSG)		
Endometrial Biopsy		
Infectious disease screening (HIV/Hep B, C/Syphilis)		
Have you had any genetic testing done? (e.g. carrier screening, chromosome analysis)		
Have you been evaluated by a urologist?	☐ No ☐ Yes – MD name & date:	☐ No ☐ Yes – MD name & date:
Have you had a semen analysis?	☐ No ☐ Yes – results:	☐ No ☐ Yes – results:
Treatment	**Patient – Dates & Results**	**Spouse/Partner - Dates & Results**
Intrauterine insemination – ☐ medicated ☐ un-medicated/natural		
In-Vitro Fertilization		
Frozen Embryo Transfer (FET)		
Donor Egg		

ALLERGIES: List all allergies to medications, food, other allergens; include reactions

Patient Responses	Spouse /Partner Responses
☐ No ☐ Yes – explain	☐ No ☐ Yes - explain

List any medications you are taking, including over-the counter medicines, vitamins, & supplements:

Patient Responses	Spouse /Partner Responses

List any chronic conditions / serious illnesses:

Patient Responses	Spouse /Partner Responses

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

Patient Responses (Year & Reason/ Type)	Spouse /Partner Responses (Year & Reason/ Type)

General Medical History - Are you experiencing, or have you previously been diagnosed with any of the following?

General:	Patient	Partner
Recent unintentional weight gain or loss of greater than 15 pounds	☐ Y ☐ N	☐ Y ☐ N
Anorexia/Bulimia	☐ Y ☐ N	☐ Y ☐ N
Lack of energy	☐ Y ☐ N	☐ Y ☐ N
Fever/Chills	☐ Y ☐ N	☐ Y ☐ N
Chronic Pain	☐ Y ☐ N	☐ Y ☐ N

Cardiovascular:	Patient	Partner
Palpitations/Skipped beats	☐ Y ☐ N	☐ Y ☐ N
Chest pain	☐ Y ☐ N	☐ Y ☐ N
Heart attack	☐ Y ☐ N	☐ Y ☐ N
Stroke	☐ Y ☐ N	☐ Y ☐ N
Murmurs	☐ Y ☐ N	☐ Y ☐ N
High blood pressure	☐ Y ☐ N	☐ Y ☐ N
Rheumatic fever	☐ Y ☐ N	☐ Y ☐ N
Mitral Valve prolapse	☐ Y ☐ N	☐ Y ☐ N

Genito-Urinary:	Patient	Partner
Bladder infections/recurrent UTIs	☐ Y ☐ N	☐ Y ☐ N
Kidney infections	☐ Y ☐ N	☐ Y ☐ N
Vaginal infections	☐ Y ☐ N	☐ Y ☐ N
Frequent urination	☐ Y ☐ N	☐ Y ☐ N
Leaking urine	☐ Y ☐ N	☐ Y ☐ N
Blood in the urine	☐ Y ☐ N	☐ Y ☐ N
Endometriosis	☐ Y ☐ N	☐ Y ☐ N
Fibroids	☐ Y ☐ N	☐ Y ☐ N
Polycystic Ovarian Syndrome (PCOS)	☐ Y ☐ N	☐ Y ☐ N
Undescended testicles	☐ Y ☐ N	☐ Y ☐ N
Testicular trauma	☐ Y ☐ N	☐ Y ☐ N
Testicular pain	☐ Y ☐ N	☐ Y ☐ N
Retrograde Ejaculation	☐ Y ☐ N	☐ Y ☐ N
Erectile Dysfunction	☐ Y ☐ N	☐ Y ☐ N
Varicocele	☐ Y ☐ N	☐ Y ☐ N

Hematologic:	Patient	Partner
Blood clotting disorder/Blood clots	☐ Y ☐ N	☐ Y ☐ N
Sickle cell Anemia	☐ Y ☐ N	☐ Y ☐ N
Easy bruising	☐ Y ☐ N	☐ Y ☐ N
Swollen glands/lymph nodes	☐ Y ☐ N	☐ Y ☐ N
Blood transfusions (list dates/reasons)	☐ Y ☐ N	☐ Y ☐ N

Mental Health Conditions:	Patient	Partner
Depression	☐ Y ☐ N	☐ Y ☐ N
Anxiety disorder	☐ Y ☐ N	☐ Y ☐ N
Schizophrenia	☐ Y ☐ N	☐ Y ☐ N

Head, Eyes, Ears, Nose, and Throat:

	Patient	Partner
Dizziness	☐ Y ☐ N	☐ Y ☐ N
Loss/poor sense of smell	☐ Y ☐ N	☐ Y ☐ N
Blurred vision	☐ Y ☐ N	☐ Y ☐ N
Ringing ears	☐ Y ☐ N	☐ Y ☐ N
Hearing loss/deafness	☐ Y ☐ N	☐ Y ☐ N
Sinus problems/hay fever/allergic rhinitis	☐ Y ☐ N	☐ Y ☐ N

Breasts:	Patient	Partner
Discharge: ☐ clear ☐ bloody ☐ milky ☐ Lumpy	☐ Y ☐ N	☐ Y ☐ N
Significant or Regular Pain	☐ Y ☐ N	☐ Y ☐ N
Cancer	☐ Y ☐ N	☐ Y ☐ N

Skin:	Patient	Partner
Unexplained rash/inflammation	✔ Y ☐ N	☐ Y ☐ N
Acne	☐ Y ☐ N	☐ Y ☐ N
Skin cancer	☐ Y ☐ N	☐ Y ☐ N
Moles changing in appearance	☐ Y ☐ N	☐ Y ☐ N
Excess hair growth	☐ Y ☐ N	☐ Y ☐ N

Neurological Problems:	Patient	Partner
Weakness/Loss of balance	☐ Y ☐ N	☐ Y ☐ N
Seizures/Epilepsy	☐ Y ☐ N	☐ Y ☐ N
Severe Headaches or Migraines	☐ Y ☐ N	☐ Y ☐ N
Numbness	☐ Y ☐ N	☐ Y ☐ N
Memory loss	☐ Y ☐ N	☐ Y ☐ N

Respiratory:	Patient	Partner
Shortness of breath	☐ Y ☐ N	☐ Y ☐ N
Asthma	☐ Y ☐ N	☐ Y ☐ N
Bronchitis	☐ Y ☐ N	☐ Y ☐ N
Pneumonia	☐ Y ☐ N	☐ Y ☐ N
Tuberculosis	☐ Y ☐ N	☐ Y ☐ N
Bloody cough	☐ Y ☐ N	☐ Y ☐ N

Gastrointestinal:	Patient	Partner
Nausea/Vomiting	☐ Y ☐ N	☐ Y ☐ N
Ulcers	☐ Y ☐ N	☐ Y ☐ N
Hepatitis	☐ Y ☐ N	☐ Y ☐ N
Diarrhea	☐ Y ☐ N	☐ Y ☐ N
Blood in your stools	☐ Y ☐ N	☐ Y ☐ N
Constipation	☐ Y ☐ N	☐ Y ☐ N
Irritable Bowel Syndrome	☐ Y ☐ N	☐ Y ☐ N
Change in bowel habits	☐ Y ☐ N	☐ Y ☐ N
Colitis (ulcerative or Crohn's)	☐ Y ☐ N	☐ Y ☐ N
GERD/heartburn	☐ Y ☐ N	☐ Y ☐ N

Endocrine/Hormonal:	Patient	Partner
Diabetes	☐ Y ☐ N	☐ Y ☐ N
Hair loss	☐ Y ☐ N	☐ Y ☐ N
Thyroid gland problems	☐ Y ☐ N	☐ Y ☐ N
Excessive hunger/thirst	☐ Y ☐ N	☐ Y ☐ N
Temperature intolerance (hot flashes or feeling cold)	☐ Y ☐ N	☐ Y ☐ N

Musculoskeletal:	Patient	Partner
Unusual muscle weakness	☐ Y ☐ N	☐ Y ☐ N
Rheumatoid arthritis	☐ Y ☐ N	☐ Y ☐ N
Lupus Erythematosus	☐ Y ☐ N	☐ Y ☐ N
Myasthenia gravis	☐ Y ☐ N	☐ Y ☐ N

Vaccination History

Vaccine	Patient Outcome	Partner/Spouse Outcome
Chickenpox (Varicella)	☐ No ☐ Yes - date:	☐ No ☐ Yes - date:
MMR (Measles, Mumps & Rubella	☐ No ☐ Yes - date:	☐ No ☐ Yes - date:
BCG (Tuberculosis)	☐ No ☐ Yes - date:	☐ No ☐ Yes - date:
Polio	☐ No ☐ Yes - date:	☐ No ☐ Yes - date:
Hepatitis A	☐ No ☐ Yes - date:	☐ No ☐ Yes - date:
Hepatitis B	☐ No ☐ Yes - date:	☐ No ☐ Yes - date:
Tetanus	☐ No ☐ Yes - date:	☐ No ☐ Yes - date:
Influenza (Flu)	☐ No ☐ Yes - date:	☐ No ☐ Yes - date:
Covid-19	☐ No ☐ Yes - date:	☐ No ☐ Yes - date:

Social History

Question	Patient	Partner/Spouse
Do you follow a particular food diet or have any special dietary habits?	☐ No ☐ Yes – describe:	☐ No ☐ Yes – describe:
How many caffeinated beverages (coffee, tea, energy drinks, soda) do you drink per day?		
Do you smoke cigarettes?	☐ No ☐ Yes – how many/day? How many years? ☐ Quit – when?	☐ No ☐ Yes – how many/day? How many years? ☐ Quit – when?
Do you drink alcohol?	☐ No ☐ Yes: # per week	☐ No ☐ Yes: # per week
Do you use marijuana, cocaine, or any other recreational drug?	☐ No ☐ Yes – frequency:	☐ No ☐ Yes – frequency:

Do you exercise?	☐ No ☐ Yes – describe:	☐ No ☐ Yes – describe:
Are you aware of any exposure to radiation, chemotherapy, or harmful chemicals?	☐ No ☐ Yes – describe:	☐ No ☐ Yes – describe:
Do you have any concerns with abuse, past or present?		

Family History – Is there anyone in the family who has had any of the following disorders?

Condition	Who (Patient/Partner= PR or /Both)	Relationship to you
Breast Cancer	☐ Pt ☐ PR ☐ Both	
Ovarian Cancer	☐ Pt ☐ PR ☐ Both	
Colon Cancer	☐ Pt ☐ PR ☐ Both	
Other cancer or tumor	☐ Pt ☐ PR ☐ Both	
Diabetes	☐ Pt ☐ PR ☐ Both	
Thyroid problems	☐ Pt ☐ PR ☐ Both	
Heart disease	☐ Pt ☐ PR ☐ Both	
Hypertension/ Stroke	☐ Pt ☐ PR ☐ Both	
Blood clots/ blood disorder	☐ Pt ☐ PR ☐ Both	
Congenital deafness/ blindness	☐ Pt ☐ PR ☐ Both	
Developmental delay	☐ Pt ☐ PR ☐ Both	
Learning delay or disorder	☐ Pt ☐ PR ☐ Both	
Tuberculosis	☐ Pt ☐ PR ☐ Both	
Endometriosis	☐ Pt ☐ PR ☐ Both	
Infertility	☐ Pt ☐ PR ☐ Both	
Menopause before age 40	☐ Pt ☐ PR ☐ Both	
Two (2) or more miscarriages	☐ Pt ☐ PR ☐ Both	
Polycystic Ovarian Syndrome (PCOS)	☐ Pt ☐ PR ☐ Both	
Birth defects	☐ Pt ☐ PR ☐ Both	
Malignant Hyperthermia	☐ Pt ☐ PR ☐ Both	
Inherited diseases	☐ Pt ☐ PR ☐ Both	

Other relevant Family History/ Comments: _____

_____