Sincera
REPRODUCTIVE MEDICINE

Patient Health History Form

Female History

Name _____ Date _____

Date of Birth_____ Age_____

Reason for your visit_____

How did you hear about our practice?

| Doctor: If so, which Doctor: _____

| Nurse | Internet/Website

| Friend/Family | Insurance Co. | Social Media

| Other _____

Fertility History

How long have you been actively trying to get pregnant? _____

How long have you been having unprotected sex? _____

How many total pregnancies have you had? _____

How many live births have you had? _____

Pregnancy History						
Pregnancy #	Year	Was this pregnancy a live birth?	How long did it take you to conceive?	Was any infertility treatment required to conceive?	Was this pregnancy with your current partner?	Were there any complications?
1						
2						
3						
4						
5						

Gynecological History

What age were you when you got your first menstrual cycle?

What is the date of the first day of your last menstrual cycle?

Usual number of days from the start of one period to the start of the next period?

Usual number of days of bleeding _____ Usual # periods in one year _____

Do you have pain with your periods? _____

If Yes, when did the pain with your periods begin? _____

Do you have pain with intercourse? _____

If Yes, when did pain with intercourse begin? _____

Have you ever been diagnosed with any of the following conditions?

Ovarian cysts: Y N Date _____ Resolved _____

Endometriosis: Y N Date _____ Stage _____

Polycystic Ovarian Syndrome: Y N Date_____

How old was your mother when she entered menopause? _____

Previous method of birth control (including an IUD) _____

Age(s) when you used birth control? _____

Have you ever had a sexually transmitted disease? Y N

(Chlamydia, gonorrhea, HPV or genital warts, trichomonas, herpes, syphilis)

Start Date_____ End Date_____ Condition_____

Infertility Testing

Have you and your partner had any of the following tests performed?

HSG (Hysterosalpingogram): Y N Date _____ Result _____

Hysteroscopy: Y N Date _____ Result _____

Day 3 FSH labs: Y N Date _____ Result _____

Laparoscopy: Y N Date _____ Result _____

Recurrent miscarriage tests: Y N Date _____ Result _____

Infertility Treatment

Have you had any of the following treatments?

Clomid: Y N Dose _____ With or without IUI _____ Number of cycles _____

Results _____

Injectable gonadotropins: Y N Dose_____ Number of cycles _____

Number of follicles produced _____ Results _____

IVF (In Vitro Fertilization): Y N Number of cycles _____

IVF Cycle 1: Medication protocol _____

Number of eggs _____ Number of fertilized _____ Number of embryos transferred _____

Number of embryos frozen _____ ICSI: Y N Did the cycle result in pregnancy? Y N

IVF Cycle 2: Medication protocol _____

Number of eggs _____ Number of fertilized _____ Number of embryos transferred _____

Number of embryos frozen _____ ICSI: Y N Did the cycle result in pregnancy? Y N

Personal Health History		
List any medical problems that you have ever been diagnosed with: (diabetes, high blood pressure, thyroid disorders, psychological/psychiatric disorders, etc.)		
Start Date	End Date	Condition

Surgical History		
List all surgeries such as tonsillectomy, gallbladder, wisdom teeth, colposcopy, laparoscopy, etc.		
Date	Surgery	Hospital

Medications		
List all current prescribed medications and over-the-counter drugs including vitamins, herbal supplements and inhalers.		
Date Started	Name of Medication	Dose/Frequency

Allergies		
List all allergies to medications, environment or food.		
Date Occured	Allergy	Reaction

Have you had any recent weight loss/gain? Change in diet/exercise habits? Please specify:

_____

What is your current height? _____ What is your current weight? _____

Have you ever smoked cigarettes? _____ Number of packs/day _____

Age started _____ Stop date (if applicable) _____

Do you drink alcohol? _____ Number of drinks/day _____

Do you use recreational drugs (marijuana, cocaine, etc)?

Last used _____

What is your occupation? _____

Do you have any exposures to toxins, radiation, or other harmful substances? Y N

Genetics and Family History:
(If you are unsure about your family history please speak with family members)

Have you or anyone in your family ever had the following conditions:

Down syndrome: Y N Cystic fibrosis: Y N Other chromosome abnormality: Y N

Huntington disease: Y N Mental retardation or learning difficulty: Y N

Muscular dystrophy: Y N Autism: Y N Short stature/dwarfisma: Y N

Spina bifida (opening in the spine): Y N Marfan syndrome: Y N
Anencephaly (opening in head/brain): Y N Sickle cell disease: Y N
Heart defect at birth: Y N Thalassemia: Y N Cleft lip and/or cleft palate: Y N
Hemophilia: Y N Stillbirth: Y N Cancer before age 50: Y N
2 or more pregnancy losses: Y N Seizure disorder: Y N Blindness: Y N
Kidney problems: Y N Excessive bleeding/clotting: Y N Deafness/hearing loss: Y N
Any birth defect not listed above?_____
Any other inherited (genetic) condition?_____
Any other serious medical condition or surgery?_____
Any other family history that is of concern to you? _____
Are you adopted? Y N Are you and your partner related to each other? Y N
Please tell us anything else you feel it is important for us to know in order to better understand your care:

_____
_____
_____
_____
_____