FERTILITY CENTER OF THE CAROLINAS

PATIENT HISTORY: GYNECOLOGY

I. Identifying Information

Date: ______________________________

Name: ______________________________ Partner's Name: ______________________________

Age: ________ Date of Birth: ________________ Partner's Age: ________ Date of Birth: ________________

Address: ____

City: ______________________________ State: __________ Zip Code: ________________

Telephone Number: Day (_____) ____________________ Evening (_____) ____________________

Referring Physician: Name ____

Address ____

II. Pregnancy History

How many pregnancies (including abortions) have you had: ______________________________

	When (Year)	How Long to Conceive (Months)	Fertility Therapy Used (Yes / No)	Is Current Partner the Father (Yes / No)	Duration of Pregnancy (Months)	Outcome*	Complications
1st Pregnancy							
2nd Pregnancy							
3rd Pregnancy							
4th Pregnancy							
5th Pregnancy							

*Outcomes: Vaginal Deliver = VD; Cesarean Section = CS; Abortion = AB; Miscarriage = MS; Ectopic = EP

III. Fertility History

How long have you and your present partner been trying to conceive: ______________________________

Have you ever been infertile with a past partner: ☐ YES ☐ NO If so, how long: ____________________

Have you had any of the following tests performed: (Check all that apply and the results)

	Date	Results
☐ Anti-Sperm Antibodies	____________	____________________
☐ Antibody Screen	____________	____________________
☐ Basal Body Temperature	____________	____________________
☐ Blood type and Rh	____________	____________________
☐ Endometrial Biopsy	____________	____________________
☐ Gonorrhea/Chlamydia Cultures	____________	____________________
☐ Hepatitis B or C	____________	____________________
☐ HIV	____________	____________________
☐ Hormone Tests	____________	____________________

Fertility History CONTINUED | **Date** | **Results**

	Fertility History CONTINUED	Date	Results
☐	Hysterosalpingogram (HSG)	________	________
☐	Hysteroscopy	________	________
☐	Laparoscopy	________	________
☐	Post-coital Test	________	________
☐	RPR (Syphilis)	________	________
☐	Rubella (German Measles)	________	________
☐	Sonohysterogram	________	________
☐	Ultrasound	________	________
☐	Urinary LH (Ovulation) Predictor Kits	________	________

What types of fertility therapy have you previously received:

Drug / Treatment	Dosage	How Long or How Many Cycles	When
Clomiphene Citrate (Clomid, Seraphene) Letrozole (Femara)			
Gonadotropins (Pergonal, Repronex, Gonal-F, Follistim, Menopur)			
HCG (Profasi, Pregnyl, Ovidrel)			
Progesterone			
Prednisone or Dexamethasone			
Bromocriptine (Parlodel, Dostinex)			
Artificial Insemination			
Donor Insemination			
In Vitro Fertilization = ICSI			

IV. Gynecological History

How old were you when you started having periods: __________ Date your last period started: ______________________

Are your periods regular: ☐ YES ☐ NO

If yes, how many days between periods (start until start): ______________________

If no, how many periods per year do you have: ______________________

How many days do your periods last: __________ Do you have cramps with your periods: ☐ YES ☐ NO

If yes, are they: ☐ Mild ☐ Moderate ☐ Severe

Have you ever missed work or school due to menstrual pain: ☐ YES ☐ NO

Do you have pain with intercourse: ☐ YES ☐ NO

Were you ever diagnosed with endometriosis: ☐ YES ☐ NO

Have you ever been told you have/had fibroid tumors in your uterus: ☐ YES ☐ NO

How often do you and your partner have intercourse: ______________________

What type of contraception have you used in the past or are using now: (Check all that apply)

☐ Birth Control ☐ IUD ☐ Depo Provera (birth control shots)

☐ Condoms ☐ Diaphragm ☐ Foams/Jellies

☐ Withdrawal ☐ Rhythm ☐ Tubal Ligation

History of contraceptive complications: ______________________

____

When did you last use contraception: ______________________

Have you ever had an abnormal Pap smear: ☐ YES ☐ NO If so, when: ____________________

What was done about it: ____________________

When was your last Pap smear: ____________________

Have you ever had any of the following: (Check all that apply)

☐ Conorrhea ☐ Venereal Warts ☐ Syphilis
☐ Ghlamydia ☐ Genital Herpes ☐ Pelvic Inflammatory Disease (PID)

V. Medical History

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

☐ Anemia
☐ Appendicitis
☐ Arthritis
☐ Blood Transfusions
☐ Breast Discharge
☐ Breast Pain
☐ Chicken Pox
☐ Chronic Bronchitis
☐ Chronic Headaches
☐ Colitis
☐ Diabetes
☐ Gallbladder Problems
☐ Heart Disease
☐ Hepatitis
☐ Hirsutism (excess facial hair)
☐ High Blood Pressure
☐ Kidney Infections
☐ Liver Problems
☐ Migraine Headaches
☐ Neurological Problems
☐ Ovarian Cysts
☐ Pneumonia
☐ Rheumatic Fever
☐ Rubella (German Measles)
☐ Scarlet Fever
☐ Seizures
☐ Thyroid Problems
☐ Tuberculosis (TB)
☐ Ulcers
☐ Vision Problems

Current Medications: ____________________

____

Are you allergic to any medications: ☐ YES ☐ NO What: ____________________

Have you ever had surgery before: ` ☐ YES ☐ NO

Date and type: ____________________

VI. Social History

Current or Recent Employer/Position: ____________________

Do you drink alcohol: ☐ YES ☐ NO Number of drinks per week: ________

Do you smoke: ☐ YES ☐ NO

Number of cigarettes per day: ____________ Number of years smoking: ________

Do you now, or have you ever, used illicit drugs (marijuana, cocaine, etc.): ☐ YES ☐ NO

If yes, please specify: ____________________

Do you have a special exercise program: ☐ YES ☐ NO

If yes, type: ____________________ Number of hours per week: ________

Are you on a special diet: ☐ YES ☐ NO If yes, type: ____________

VII. Family History

Do any family members have significant health problems or inherited diseases: (Check all that apply)

☐ Birth Defects
☐ Brain/Spinal Defects
☐ Cancer
☐ Cystic Fibrosis
☐ Diabetes
☐ Down Syndrome
☐ Fragile X Syndrome
☐ Heart Disease
☐ Hemophilia
☐ High Blood Pressure
☐ Muscular Dystrophy
☐ Sickle Cell Disease
☐ Tay-Sachs Disease
☐ Thalassemia
☐ Thyroid Disease

Who: ____________________

VIII. Review of Systems

What is your usual height: ____________ Current weight: _____________ Ideal weight: ______________

Have you had more than a 10-pound weight gain or loss in the past 12 months: ☐ YES ☐ NO
If yes, how much: ____________ Was this intentional: ☐ YES ☐ NO

Please check the following that apply to you:

Breast	☐ Discharge ☐ Masses ☐ Pain ☐ Other
Cardiovascular	☐ Chest pain ☐ Difficulty breathing on exertion ☐ Palpitations ☐ Swelling ☐ Other
Constitutional	☐ Fatigue ☐ Fever ☐ Sleep problems ☐ Other
Ear, Nose, Throat	☐ Headache ☐ Hearing loss ☐ Sinusitis ☐ Ulcers
Endocrine	☐ Abnormal hair growth ☐ Diabetes ☐ Hair loss ☐ Heat/cold intolerance ☐ Other
Eyes	☐ Glasses/contacts ☐ Vision changes ☐ Other
Gastrointestinal	☐ Bloody stool ☐ Constipation ☐ Diarrhea ☐ Nausea/vomiting ☐ Pain ☐ Other
Genitourinary	☐ Blood in urine ☐ Incontinence ☐ Urinary frequency/burning ☐ Other
Hematologic/Lymph	☐ Bleeding ☐ Blood clots ☐ Bruising ☐ Swollen lymph nodes ☐ Other
Musculoskeletal	☐ Muscle or joint pain ☐ Muscle swelling ☐ Muscle weakness ☐ Other
Neurologic	☐ Fainting spells ☐ Memory loss ☐ Numbness ☐ Seizures ☐ Other
Psychiatric	☐ Anxiety ☐ Crying spells ☐ Depression Other
Respiratory	☐ Asthma ☐ Cough ☐ Shortness of breath ☐ Wheezing ☐ Other
Skin	☐ Dry skin ☐ Moles ☐ Rash ☐ Ulcers ☐ Other

Please bring this form with you to your first appointment. Ensure that records from your current or previous physician have been sent or faxed to the address below at least one week in advance of your visit. We look forward to meeting you.

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