



Female History

Patient: _____ Age: _____ Today's Date: _____

If married, which marriage for you? _____ Marriage date? _____

How long have you been sexually active with your current partner? _____

How long have you not prevented pregnancy? _____ Intercourse frequency? _____

All previous contraception used? _____

Please review the following questions. Give details for all positive responses.

Questions			Details of positive responses
Ever pregnant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
How many times	_____		_____
Pregnancies with current partner	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Difficulty conceiving	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Infertility treatment success	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Deliveries	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Miscarriages	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Tubal / ectopic pregnancy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Children adopted out	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Infertility in a previous relationship	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Any adopted children	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Change in menstrual periods	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Spotting before &/or after periods	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Worsening menstrual cramps	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Cramps several days before period	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Pain with intercourse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Bleeding after intercourse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Lubrication used with intercourse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Douche after intercourse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Sexual problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Acne problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Excessive hair growth anywhere	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Significant weight gain or loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
More than occasional alcohol intake	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Past / present recreational drug use	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Previous partner who used drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Sexually Transmitted Diseases	<input type="checkbox"/> Yes	<input type="checkbox"/> No	{Gonorrhea, Chlamydia, Warts, Herpes, etc.} _____
Hepatitis or HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Exposure to STD / Hepatitis / HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Age at first intercourse	_____		
Number of sexual partners	_____		

Female History (continued)

Have you had any of these fertility studies?

Details of positive responses

Basal body temperature charts (BBT)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<hr/>
Hysterosalpingogram (HSG)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<hr/>
Post-Coital test (PK)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<hr/>
Endometrial biopsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<hr/>
Hormonal blood tests	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<hr/>
Ultrasound	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<hr/>
Laparoscopy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<hr/>
Hysteroscopy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<hr/>
Semen Analysis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<hr/>
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<hr/>

What infertility problems have been diagnosed already?

Details of positive responses

Endometriosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<hr/>
Pelvic adhesions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<hr/>
Blocked or damaged tubes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<hr/>
Irregular or absent ovulation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<hr/>
Corpus luteal defect	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<hr/>
Uterine fibroids	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<hr/>
Hostile cervical mucus	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<hr/>
Male infertility	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<hr/>
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<hr/>

What infertility treatments have you and / or your partner been through?

Treatment:	Doctor:	When:	# of cycles:
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Notes: