Comprehensive History Form

Duration of relationship _____

Duration of unprotected intercourse _____

How long have you been actively attempting pregnancy? _____

Contraceptive practices

	(yes)	(no)	(dates)
Intrauterine device (IUD)	_____	_____	_____
Oral contraceptives	_____	_____	_____
Other	_____	_____	_____

	(yes)	(no)
Use of lubricants	_____	_____
Douche after intercourse	_____	_____
Painful intercourse	_____	_____
Bleeding/spotting after intercourse	_____	_____

Pregnancies (female):

Pregnancy (include all pregnancies)	When? (Year)	How long to conceive	Gender	Is current Partner the Father (Y/N)	Outcome (spontaneous miscarriage, abortion, or terminations, ectopic pregnancy, vaginal delivery, cesarean section, fetal demise or stillbirth) and list complications, if any.
First					
Second					
Third					
Fourth					
Fifth					

Male: Pregnancies from previous marriage(s) or partner(s), if any:

Pregnancy (include all pregnancies)	When? (Year)	How long to conceive	Gender	Outcome (spontaneous miscarriage, abortion, or terminations, ectopic pregnancy, vaginal delivery, cesarean section, fetal demise or stillbirth) and list complications, if any
First				
Second				
Third				
Fourth				

Comprehensive History Form

Female History

Menstrual History

Age at first menstrual period_____ last menstrual period_____
How often do menses occur _____ duration of menstrual flow _____
Amount/severity of menstrual flow _____
Medication taken for cramps _____ amount _____ frequency _____

Midcycle: spotting _____ pelvic pain _____ increase mucus _____

When was your last pap smear: _____ When was your last mammogram: _____
Any abnormal pap smears: _____
Do you have or have you ever had (Place a "Check Mark" by any that apply):

Infectious Problems		**Gynecologic Problems**		**Medical Problems**			
Chicken Pox (varicella)		Chlamydia		Anemia		Kidney disease	
Chicken Pox vaccine		Gonorrhea		Bleeding disorders		Kidney infection	
Hepatitis A, B, or C		Syphilis		Blood clots		Liver problems	
German measles-rubella		Pelvic infection (PID)		Blood transfusion		Lost > 15 pounds last year	
Rubella immunization		Mycoplasma/Ureaplasma		Diabetes		Lung disease	
Rheumatic fever		Condyloma-venereal warts		Cancer		Asthma	
Chronic bronchitis		Herpes: genital		Appendicitis		Recurrent urinary infections	
		Abnormal mammogram		Heart disease		Thyroid problems	
Neurological Problems		Abnormal pap smear		High blood pressure		Arthritis	
Migraine headaches		Blocked fallopian tubes		Mitral valve prolapse			
Seizures (epilepsy)		Pelvic adhesions		Excess hair growth		Other Problems:	
		Endometriosis		Hot flashes or night sweats			
		Uterine anomalies		Rh sensitized			
		Cervical Stenosis		Breast discharge			
		DES exposure					

Comments _____

Toxicant Exposure:	(yes)	(no)	(date)	
Alcohol				
none	____	____	_____	
weekend	____	____	_____	
daily	____	____	_____	
Smoking	____	____	_____	
Pesticides	____	____	_____	
Radiation	____	____	_____	
Coffee/caffeine	____	____	_____	(amount)
Other chemicals	____	____	_____	

Comprehensive History Form

Female History

List all medication you take now (prescription, vitamin, over-the-counter, alternative therapies):

(drug)	(date)	(dose)
(drug)	(date)	(dose)

Are you taking prenatal vitamins? _____

List all allergic reactions you have had:

(drug or allergen)	(date)

List all surgery you have had (cervix, uterus, ovarian cysts, tubes, endometriosis, appendix, etc.):

(type of surgery)	(date)
(type of surgery)	(date)
(type of surgery)	(date)

List all other serious illnesses for which you have been under the care of a physician:

(illness)	(date)
(illness)	(date)

Weight _____ Height _____

Special dietary habits: _____

How much do you exercise? _____

Comprehensive History Form

Family History of Female

Country of origin: Mother _____ Father _____

Ethnic background (circle): African/American Asian Asian-Indian Caucasian Hispanic Jewish American/Indian Mediterranean Middle Eastern Other:_____

Ethnic group (Circle all that apply)	Have you been tested for:	Yes	No	Date	Result
African, African/American	Sickle cell trait				
Asian, Mediterranean or Hispanic	Thalassemia				
Caucasian, Jewish	Cystic fibrosis				
Jewish	Tay Sachs				
Jewish	Gaucher				

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

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

	Yes	Who		Yes	Who
Endometriosis			Infertility		
Excess body hair			Mental retardation		
Genital abnormalities			Early menopause < 40 yrs old		
Breast cancer			Miscarriages (2 or more)		
Chromosomal disorders			Ovarian cancer		
Delayed development					
Early puberty			Hormone disorders		
Birth defects			Metabolic disorders		
Bleeding disorders			Genetic (inherited) disorders		

Comments _____

Comprehensive History Form

Male History

Growth and development:	(yes)	(no)
Undescended testicles		
Delayed puberty		
Breast enlargement		

Testicular injury:	(yes)	(no)	(date)
Varicocele			
Torsion (twisted)			
Painful swelling			
Severe trauma			

Toxicant exposure:	(yes)	(no)	(date)
Alcohol			
none			
weekend			
daily			
Smoking			
Pesticides			
Radiation			
Other chemicals			

Sexually transmitted diseases:

Chlamydia			
Genital warts (HPV)			
Gonorrhea			
Herpes			
Syphilis			
Other			

Urinary tract:

Bladder/kidney infection			
Prostatitis			
Other			

Frequency of hot tub use: _____

Comprehensive History Form

Male History

List all medication you take now (prescription, vitamin, over-the-counter, alternative therapies):

(drug)	(date)	(dose)
(drug)	(date)	(dose)

List all allergic reactions you have had:

(drug or allergen)	(date)

List all surgery or blood transfusions you have had:

(type of surgery)	(date)
(type of surgery)	(date)

List all other serious illnesses for which you have been under the care of a physician:

(illness)	(date)
(illness)	(date)

	(yes)	(no)
Difficulty with sexual function (male): (please explain)	_____	_____

Comprehensive History Form

Male Family History

Country of origin: Mother _____ Father _____

Ethnic background (circle): African/American Asian Asian-Indian Caucasian
Hispanic Jewish American Indian Mediterranean Middle Eastern Other:_____

Ethnic group (Circle all that apply)	Have you been tested for:	Yes	No	Date	Result
African, African/American	Sickle cell trait				
Asian, Mediterranean or Hispanic	Thalassemia				
Caucasian, Jewish	Cystic fibrosis				
Jewish	Tay Sachs				
Jewish	Gaucher				

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

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

	Yes	Who		Yes	Who
Infertility			Learning problems		
Genital abnormalities			Mental retardation		
Birth defects			Metabolic disorders		
Chromosomal disorders			Miscarriages (2 or more)		
Delayed development			Short stature		
Early puberty			Testicular cancer		
Hormone disorders			Undescended testicles		
Pituitary tumor			Abnormal breasts		
Lack of sense of smell			Genetic (inherited) disorders		

Comments _____

Comprehensive History Form

Previous female infertility tests:	(result)	(date)
Basal body temperature		
Ovulation predictor kits		
Endometrial biopsy		
Post-coital test		
HSG		
Chromosome studies		
Hysteroscopy		
Laparoscopy		
Antisperm antibodies		
Pelvic ultrasound		
Other		

Immunologic screening tests:	(result)	(date)
ANA (antinuclear antibodies)		
Antiphospholipid antibodies		
Lupus anticoagulant		
Leukocyte antibody detection		
Thyroid antibodies		
Other immunologic testing		

Previous male infertility tests:	(result)	(date)
Semen analyses		
Post-coital test		
Antisperm antibodies (semen & serum)		
Hamster test (SPA)		
Chromosomes		
Other (SCSA, EFT, etc.)		

Previous hormonal tests:	Female		Male	
	Result	Date	Result	Date
Testosterone				
Prolactin				
TSH				
FSH (random)				
FSH (day 3)				
Estradiol (day 3)				
DHEA-S				
Progesterone				

Comprehensive History Form

Previous Treatments:

	Yes/No	# cycles	Comments (dose, # days/cycle)
Inseminations (IUIs, without medication)			
Clomiphene (Clomid, Serophene) (with intercourse only)			
Clomiphene with inseminations (IUI)			
FSH * with intercourse only			
FSH * with inseminations (IUI)			
Progesterone supplements			
Dexamethasone, prednisone			
Aspirin			
Heparin			
Parlodel** - dopamine agonist			
IVIG			
Leukocyte immunization			
Other			

Comments _____

Prior in-vitro fertilization (IVF), GIFT, or intracytoplasmic sperm injection (ICSI) results, if applicable

Date of procedure	Procedure	Protocol	# of eggs obtained	# of eggs mature	# of eggs fertilized	# embryos transferred	# embryos frozen	Pregnancy outcome

Comments

*FSH - Pergonal, Humegon, Repronex, Metrodin, Fertinex, HMG, Gonal-F and/or Follistim
** - Parlodel, dopamine agonists - bromocriptine (Parlodel), cabergoline (Dostinex)