Advanced Reproductive Center
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Reproductive Health and Fertility Center

Female History

Name: _____ Age:_____ Date: _____

Current OB/GYN? _____

What is the reason for your appointment today? _____

How did you hear about our clinic? _____

Check any of the below that apply to you:

_____Irregular menstrual periods
_____LEEP, cone biopsy or any surgery on your cervix
_____Chlamydia, gonorrhea or other sexually transmitted disease
_____Uterine problems such as polyps
_____Breast masses or lumps
_____Endometriosis
_____Urinary problems
_____Fibroids

_____Abnormal pap smear
_____Surgery or problems with your fallopian tubes
_____Pelvic inflammatory disease
_____Bleeding between periods
_____Bleeding with intercourse
_____Nipple discharge
_____Heavy menstrual periods
_____Hot flashes
_____Vaginal discharge or infections

Any additional information regarding the above:

_____
_____
_____
_____

Menstrual History

Day one of you last menstrual period_____ Date of last pap_____
Age at onset of first menstrual period_____
Frequency of menstrual periods (e.g. every 26-30 days) _____
Duration of bleeding (e.g. 3-4 days) _____
Do you experience pain with your menstrual cycles? _____
Do you experience pain with intercourse? _____

Relationship History

Are you legally married?_____
How long have you been trying to get pregnant?_____
Any difficulty conceiving with prior pregnancies?_____
Frequency of intercourse (per month) _____

Name_____

Pregnancy History

Previous pregnancies:

Date	Outcome (e.g. vaginal delivery, c section, ectopic, miscarriage, termination)	Male or female	Any complications or health issues with the pregnancy or delivery?	Any health issues with the child?	Was the pregnancy with your current partner?

Any additional information about your past pregnancies:

_____

_____

_____

_____

Previous infertility testing and/or treatment

Have you had any previous infertility testing and/or treatment?_____

If you have had previous infertility testing and/or treatment please have those records forward to our office before your appointment.

Infertility Testing:

Test	Date(s)	Normal or abnormal	If abnormal, describe result
Hormone levels (usually FSH, LH and estrogen)			
AMH level			
HSG (tube test)			
Pelvic ultrasound			
Hysteroscopy (uterine evaluation with a camera)			
SIS (saline contrast ultrasound)			
Any other fertility testing:			

Name:_____

Infertility treatment:

Treatment type (e.g. clomid, injectables, insemination, IVF, etc.)	Number of cycles (months)	Medication dose	Cycle outcomes

Additional details regarding previous infertility testing and/or treatment:

_____

_____

_____

Surgical history

Previous surgeries:

Surgery	Date	Surgical findings	Complications, if any

Any additional details regarding previous surgeries:

_____

_____

_____

Medical History

List any medical problems such as high blood pressure, cancer, diabetes, asthma, arthritis, migraine headaches, thyroid problems, heart disease etc.

_____

_____

_____

_____

Name:_____

Family History

Family members' medical history including high blood pressure, cancer, diabetes, asthma, arthritis, mental retardation, etc.

Medical Problem	Family member(s) affected (e.g. mom, maternal grandmother, sister etc.)

Is there a history of infertility or multiple miscarriages in your family? _____

Describe any additional details regarding a family history of medical problems:

_____
_____
_____

Medications

Medications currently taking including vitamins and herbal medications:

Medication	Dose and frequency (e.g. 20 mg 3 times a day)	Reason

Allergies:

_____

Any additional details regarding current medications or allergies:

_____

Social History

Do you smoke?_____
If so, how many years have you smoked? _____ and
How many cigarettes do you smoke a day?_____

Do you drink alcohol? _____
If so how many alcoholic beverages do you drink per day? _____

Do you drink caffeinated beverages? _____
If so what type of beverages? _____ and
How many caffeinated beverages do you drink a day? _____

Do you use any recreational drugs? _____
If so what drugs do you use?_____ and
How often do you use them?_____

Name:_____

Background and Ethnicity

The American College of Obstetrics and Gynecology (ACOG) recommends evaluating women, depending on their ethnicity/background, for specific genetic diseases that they may be at higher risk for carrying and/or passing on to an offspring.

ACOG recommends a cystic fibrosis screen on all women who are trying to conceive. As with all tests the cystic fibrosis test is not perfect. Even if a woman tests negative, it is still possible (but unlikely) to have a child with cystic fibrosis.

In order to help individually tailor genetic screening, please answer the following questions:

Are there any genetic diseases that you or a family member are affected by or carry the trait for?_____
If so what disease(s)? _____

Do you have a family history of mental retardation or fragile X syndrome?_____

Are you of Jewish Eastern European origin?_____

Are you of French Canadian and/or Cajun origin?_____

Are you of Mediterranean or Southeast Asian origin?_____

Are you of African or African American Origin?_____

Any additional details regarding genetic diseases:

_____
_____
_____

Additional Information

Provide any additional information you want to share:

_____
_____
_____
_____

Signature:_____ Date:_____

To be completed by our Staff

Blood Pressure:_____Height:_____Weight:_____BMI:_____