# The New Hope Center *for* Reproductive Medicine

*1181 First Colonial Rd., Suite 100, Virginia Beach, VA 23454 . Phone: (757) 496-5370 . Fax: (757) 481-3354 . www.thenewhopecenter.com*

# *Female Patient History*

## 1. Identifying Information

*Please read all questions carefully and answer as thoroughly as possible.*
*Infertility patients, please complete ALL sections.*
*All other patients, complete sections 1 through 5.*

*Date:* ______________________

*Name:* ______________________ *Partner's Name:* ______________________

*Address:* ______________________

*Home Phone:* ( ) __________ *Cell Phone:* ( ) __________ *Work Phone:* ( ) __________

*Does your home phone have an answering machine?* ❍Yes/❍No *May we call you at work?* ❍Yes/❍No

*Date of Birth:* __________ *Age:* ______ *SS#:* __________ *Partner's Date of Birth:* __________ *Age:* ______

*Duration of Relationship:* __________ *Duration of Infertility:* __________

*Nature of Employment (title and brief job description):* ______________________

## 2. Medical History

*Height:* __________ *Weight:* __________ *Blood Type (if known):* __________

*Have you gained or lost greater than 20 pounds of weight in the past year?* ❍Yes/❍No

*Do you follow a particular food diet or have any special dietary habits?* ❍Yes/❍No
*If yes, please specify:* ______________________

*Have you ever received x-rays in the pelvic area for therapy or diagnosis?* ❍Yes/❍No
*If yes, please specify:* ______________________

*Within the past year, have you taken any prescription medicines?* ❍Yes/❍No
*If yes, list all prescriptions and problems for which you were using them:* ______________________

*Are you taking any over-the-counter medications regularly?* ❍Yes/❍No
*If yes, list medications and conditions for taking them:* ______________________

*Do you use or have you ever used the following? (check all that apply)*
- ❍Alcohol-How many glasses per week on average? ______ Wine ______ Beer ______ Cocktails
- ❍Cigarettes-Number of packs per day ______________________
- ❍Recreational Drugs-(marijuana, cocaine, etc.) current or past ______________________

*(continued on page two)*

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PATIENT NAME ______________________ PHONE NUMBER ______________

## 2. MEDICAL HISTORY *(continued from page one)*

*List all forms of vigorous exercise (swimming, cycling, running, etc.)*

| *Exercise* | *Hours Per Week* |
|---|---|
| | |
| | |
| | |
| | |

*Do you have or have you ever been diagnosed and treated for: (check all that apply)*

❍ *Allergies (please list and describe reaction)* ______________________

❍ *Anemia*
❍ *Appendicitis*
❍ *Arthritis*
❍ *Blood Transfusions*
❍ *Breast Milky Discharge*
❍ *Breast Tenderness*
❍ *Cancer (specify)* ______________
❍ *Chlamydia*
❍ *Chronic Bronchitis*
❍ *Chronic Headaches*
❍ *Colitis*
❍ *Color Blindness*
❍ *Diabetes*
❍ *Dizziness*
❍ *Eating Disorder*
❍ *Endometriosis*
❍ *Epilepsy*
❍ *Gallbladder Problems*
❍ *Gonorrhea*
❍ *Heart Disease*
❍ *Hepatitis*
❍ *Herpes*
❍ *Hirsutism (excessive hair growth)*
❍ *High Blood Pressure*
❍ *Immunization for German Measles (rubella)*
❍ *Kidney Infection*
❍ *Liver Problems*
❍ *Loss of Balance*
❍ *Measles: German*
❍ *Measles: Regular*
❍ *Neurological Problems*
❍ *Ovarian Cysts*
❍ *Parasitic Infection*
❍ *Pelvic Infection*
❍ *Pneumonia*
❍ *Poor Sense of Smell*
❍ *Rhuematic Fever*
❍ *Scarlett Fever*
❍ *Seizures*
❍ *Syphilis*
❍ *Thyroid Problems*
❍ *Tuberculosis*
❍ *Ulcers*
❍ *Vaginitis (Trichomoniasis, Gardnerella, Yeast)-number of episodes* ________
❍ *Visual Disturbances*

## 3. SURGICAL HISTORY

*Have you ever had any pelvic surgery?* ❍ *Yes* / ❍ *No*
*Have you ever had surgery for endometriosis?* ❍ *Yes* / ❍ *No*
*Have you ever had surgery for lysis of adhesions?* ❍ *Yes* / ❍ *No*
*Have you ever had a tubal ligation?* ❍ *Yes* / ❍ *No*
*Have you ever had surgery to re-anastomose your tubes?* ❍ *Yes* / ❍ *No*
*Have you ever had cervical conization or cautery?* ❍ *Yes* / ❍ *No*
*Have you ever had any other surgery?* ❍ *Yes* / ❍ *No*
*(D&C, Thyroid, Appendectomy, etc.)*
*If yes, please specify* ______________________

*(continued on page three)*

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PATIENT NAME ______________________ PHONE NUMBER ______________

## 4. MENSTRUAL AND PREGNANCY HISTORY

*Age at your first period* ______________ *Date of the first day of your last period* ______________

*Are your periods regular?* ❍ *Yes* / ❍ *No*

*If yes, what is the usual length? (from onset of menses to onset of next menses)* ______________

*If no, how many times per year do you menstruate?* ______________

*Is progesterone or Provera needed to initiate bleeding?* ❍ *Yes* / ❍ *No*

*Do you bleed or spot between periods?* ❍ *Yes* / ❍ *No*

*Are cramps present before, during or after your period?* ❍ *Yes* / ❍ *No*

*If yes, check all that apply:* ❍ *Before* / ❍ *During* / ❍ *After*

*Please specify the severity of your cramps:* ❍ *Mild* / ❍ *Moderate* / ❍ *Severe*

*What is the usual duration of your period?* ______________ *Days*

*How many pregnancies (including elective terminations) have you had?* ______________

*Did you have any complications during or after your pregnancies?* ❍ *Yes* / ❍ *No*

*Did your mother have any difficulties with her pregnancies?* ❍ *Yes* / ❍ *No*

*If yes, please specify* ______________

*Did your mother take DES (diethylstilbesterol) while she was pregnant with you?* ❍ *Yes* / ❍ *No*

*Please complete the following table as it pertains to each of your pregnancies:*

| Pregnancy | Year Conceived | How Long Did it Take Conceive? | Was Infertility Therapy Required? | choose one: Elective Termination / Miscarriage / Ectopic / Stillborn? | Date Of Baby's Birth | Vaginal Delivery or C-Section? | Male or Female? | Is Your Current Partner the Father? |
|---|---|---|---|---|---|---|---|---|
| First | | | ❍ Yes / ❍ No | | | | ❍ M / ❍ F | ❍ Yes / ❍ No |
| Second | | | ❍ Yes / ❍ No | | | | ❍ M / ❍ F | ❍ Yes / ❍ No |
| Third | | | ❍ Yes / ❍ No | | | | ❍ M / ❍ F | ❍ Yes / ❍ No |
| Fourth | | | ❍ Yes / ❍ No | | | | ❍ M / ❍ F | ❍ Yes / ❍ No |
| Fifth | | | ❍ Yes / ❍ No | | | | ❍ M / ❍ F | ❍ Yes / ❍ No |

## 5. CONTRACEPTIVE / SEXUAL HISTORY

*What forms of contraception have you used in the past? (check all that apply)*

- ❍ *Pills-(name)* ______________
- ❍ *Diaphragm*
- ❍ *Foams / Jellies*
- ❍ *Rhythm*
- ❍ *Other-(specify)* ______________
- ❍ *IUD-(name)*
- ❍ *Withdrawal*
- ❍ *Condom*
- ❍ *None*

*For each contraceptive method used, specify length of use and reason for discontinuation:*

| Method | Year and Length of Use | Reason for Discontinuation |
|---|---|---|
| | | |
| | | |
| | | |

*(continued on page four)*

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PATIENT NAME ____________________ PHONE NUMBER ____________________

## 5. CONTRACEPTIVE/SEXUAL HISTORY *(continued from page three)*

*How many times per week do you and your partner have intercourse?* ____________________
*How many times do you have intercourse around ovulation?* ____________________
*Is intercourse painful or difficult for you?* ❍ *Yes*/❍ *No*
*Do you use lubricants for intercourse?* ❍ *Yes*/❍ *No*
*Do you douche before or after intercourse?* ❍ *Yes*/❍ *No*

## 6. INFERTILITY HISTORY

*How long have you been trying to get pregnant?* ____________________

*Which of the following tests have you had performed? (check all that apply)*

| Test | When? | Results? |
|---|---|---|
| ❍ *Antibodies* | *When?* ______ | *Results?* ______ |
| ❍ *BBT* | *When?* ______ | *Results?* ______ |
| ❍ *Postcoital Test* | *When?* ______ | *Results?* ______ |
| ❍ *Hormonal Assays (FSH, prolactin, estrogen, DHEA-S, testosterone, progesterone)* | *When?* ______ | *Results?* ______ |
| ❍ *Endometrial Biopsy* | *When?* | *Results?* |
| ❍ *Hysteroscopy* | *When?* ______ | *Results?* ______ |
| ❍ *Mycoplasma/Chlamydia Cultures* | *When?* ______ | *Results?* ______ |
| ❍ *Thyroid Tests* | *When?* ______ | *Results?* ______ |
| ❍ *Rubella Immunity* | *When?* ______ | *Results?* ______ |
| ❍ *Pap Smear* | *When?* ______ | *Results?* ______ |
| ❍ *Other (specify)* ______ | *When?* ______ | *Results?* ______ |

*Which of the following have you taken for infertility? (check all that apply)*

- ❍ *antibiotics*
- ❍ *bromocriptine (Parlodel®)*
- ❍ *clomiphene citrate (Serophene®, Clomid®)*
- ❍ *danazol (Danocrine®)*
- ❍ *Depo-Lupron® (one injection per month, intramuscular)*
- ❍ *estrogens*
- ❍ *None*
- ❍ *Other (specify)* ____________________
- ❍ *GnRH agonist (Lupron®, Synarel®)*
- ❍ *GnRH antagonist*
- ❍ *hCG (Profasi®, Pregnyl®)*
- ❍ *hMG (Repronex®, Menopur®)*
- ❍ *prednisone (or cortisone-like drugs)*
- ❍ *progesterone*
- ❍ *urofollitrophin of FSH (Follistim®, Gonal F®, Bravelle®)*

*Have you ever undergone ovulation induction therapy?* ❍ *Yes*/❍ *No*

*If yes, how many cycles?* ____________________

______ *Clomid®*

______ *Combination of Clomid® and Repronex®, Follistim®, Gonal F®, or Menopur®*

*If yes, specify the average number of mature follicles (> or = 16mm bilaterally) noted at time of ultrasound.* ____________________

____________________

____________________

____________________

*(continued on page five)*

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Patient Name ______________________ Phone Number ______________________

## 6. Infertility History *(continued from page four)*

*Have you ever undergone artificial insemination or in vitro fertilization?* ❍ Yes / ❍ No

*If yes, using partner or donor sperm?* ❍ Partner Sperm / ❍ Donor Sperm

*Is your partner seeing a doctor for evaluation of infertility?* ❍ Yes / ❍ No

*If yes, please list doctor's name and address* ______________________

______________________

*Does this doctor feel that your partner has an infertility problem?* ❍ Yes / ❍ No

*If yes, what is the diagnosis and current treatment?* ______________________

______________________

*Has your partner ever fathered a child with another partner?* ❍ Yes / ❍ No

*If yes, when?* ______________________

______________________

***Thank you for taking the time to complete this form in advance of your first appointment.***

*Please make sure your name and phone number are listed at the top of each page, and fax it to us at: (757) 481-3354.*

*If you prefer, you may mail it to:*

*The New Hope Center for Reproductive Medicine*
*1181 First Colonial Rd., Suite 100,*
*Virginia Beach, VA 23454*

*If you have any questions, please call: (757) 496-5370.*