Diamond Institute for Infertility & Menopause
89 Millburn Avenue◦ Millburn, NJ 07041

FEMALE PATIENT HISTORY

I. IDENTIFYING INFORMATION

DATE____

NAME______________________________________PARTNER'S NAME______________________________________

ADDRESS____

TELEPHONE NUMBER –DAY ___________________________EVENING______________________________________

D.O.B._________PARTNER'S D.O.B_______DURATION OF RELATIONSHIP_____DURATION OF INFERTILITY_________

INSURANCE COMPANY____INSURANCE ID#________________________

NATURE OF PRESENT EMPLOYMENT (TITLE, BRIEF DESCRIPTION____

____

II. MEDICAL HISTORY

YES NO

WEIGHT__________HEIGHT_________BLOOD TYPE IF KNOWN____________________________________

HAVE YOU LOST GREATER THAN 20 POUNDS OF WEIGHT IN THE LAST YEAR?...................................... . ☐ ☐

DO YOU FOLLOW A PATRICULAR FOOD DIET OR HAVE ANY SPECIAL DIETARY HABITS?.................................. ☐ ☐
IF YES, SPECIFY: ____

LIST THE FORMS & FREQUENCY OF REGULAR VIGOROUS EXERCISE (SWIMMING, CYCLING, RUNNING & AGE YOU BEGAN:

EXERCISE:_____________HRS/WK_____AGE____EXERCISE;_____________HRS/WK__________AGE_____

HAVE YOU EVERY HAD ANY SURGERY?.. ☐ ☐
IF YES, SPECIFY DATE & TYPE ____

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

- ☐ Anemia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Blood Transfusions
- ☐ Breast Milky Discharge
- ☐ Herpes
- ☐ Breast Tenderness
- ☐ Cancer? Specify_____________
  ____
- ☐ Chlamydia
- ☐ Chronic Bronchitis
- ☐ Chronic Headaches
- ☐ Colitis
- ☐ Color Blind
- ☐ Diabetes
- ☐ Dizziness
- ☐ Endometriosis
- ☐ Epilepsy
- ☐ Gallbladder problems
- ☐ Gonorrhea
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Scarlet Fever
- ☐ Hirsutism (Excess Hair Growth)
- ☐ High Blood Pressure
- ☐ Immunization: German Measles
- ☐ Kidney Infection
- ☐ Liver Infection
- ☐ Loss of Balance
- ☐ Measles: German
- ☐ Measles: Regular
- ☐ Neurological Problems
- ☐ Nongonococcal Urethritis
- ☐ Ovarian Cysts
- ☐ Parasitic Infection
- ☐ Pelvic Infection
- ☐ Pneumonia
- ☐ Poor Sense of Smell
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Syphilis
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Vaginitis (Trichomoniasis, yeast)
  # of episodes___________
- ☐ Visual Disturbances

☐ Any Allergies____

____

	YES	NO
HAVE YOU EVER BEEN TREATED FOR CANCER?........	☐	☐
IF YES, EXPLAIN THERAPY________________		
HAVE YOU EVER RECEIVED X-RAYS TO THE PELVIC AREA FOR THERAPY OR DIAGNOSIS?........	☐	☐
IF YES, SPECIFY: ________________		
WITHIN THE LAST YEAR, HAVE YOU TAKEN ANY PRESCRIPTION MEDICATIONS?........	☐	☐
IF YES, LIST ALL PRESCRIPTIONS AND PROBLEMS FOR WHICH YOU WERE TAKING THEM________________		
ARE YOU TAKING ANY OVER-THE- COUNTER MEDICATIONS ON A REGULAR BASIS?........	☐	☐
IF YES, LIST ALL MEDICATIONS AND DIAGNOSES:________________		

DO YOU OR HAVE YOU EVER USED (CHECK ALL THAT APPLY):
☐ ALCOHOL – HOW MANY GLASSES PER WK DO YOU USUALLY DRINK? WINE____BEER____COCKTAIL___
☐ CIGARETTES -# PACKS PER DAY ____________
☐ ILLICIT OR RECREATIONAL DRUGS (MARIJUANA, COCAINE, ETC.)
____

III. MENSTRUAL AND PREGNANCY HISTORY

AGE AT FIRST PERIOD?______________WHEN WAS YOUR LAST PERIOD?________________

ARE YOUR PERIODS REGULAR?........ ☐ ☐
IF YES WHAT ARE THE USUAL # OF DAYS BETWEEN PERIODS________________

WHAT IS THE USUAL DRATION OF YOUR PERIOD?______________________
ARE CRAMPS PRESENT BEFORE, DURING OR AFTER YOUR PERIOD?________________
ARE CRAMPS : ☐ MILD ☐ MODERATE ☐ SEVERE

DO YOU HAVE TO TAKE PAIN MEDIATION FOR CRAMPS?........ ☐ ☐
IF YES, SPECIFY MEDICATION:________________

DO YOU BLEED OR SPOT BETWEEN PERIODS?........ ☐ ☐
HOW MANY PREGNANCIES (INCLUDING ABORTIONS) HAVE YOU HAD?________________

	WHEN? (YEAR)	END IN ABORTION	END IN MISCAR.	ECTOPIC PREG.	INFERTILITY THERAPY REQUIRED TO CONCEIVE	HOW LONG TO CONCEIVE	BABY BORN ALIVE	DID YOU CONCIEVE WITH CURRENT PARTNER
1st pregnancy								
2nd pregnancy								
3rd pregnancy								
4th pregnancy								
5th pregnancy								
MORE THAN 5								

	YES	NO
WHERE THERE ANY COMPLICATIONS DURING OR AFTER YOUR FREGNANCIES?........	☐	☐
IF YES EXPLAIN:________________		
DID YOU MOTHER HAVE ANY DIFFCULTY WITH CONCEPTION OR PREGNANCY?........	☐	☐
IF YES EXPLAIN:________________		

HOW LONG HAVE YOU BEEN TRYING TO GET PREGNANT?________________
DID YOUR MOTHER TAKE DIETHYLSTILBESTROL (DES) WHEN SHE WAS PREGNANT WITH YOU........ ☐ ☐

IV. CONTRACEPTIVE/SEXUAL HISTORY

WHAT FORM OF CONTRACEPTION DO YOU USE NOW OR HAVE YOU USED IN THE PAST? CHECK ALL THAT APPLY
☐ PILLS NAME:______________ ☐ IUD NAME:________________ ☐DIAPHRAGM ☐WITHDRAWL ☐ FOAMS/JELLIES

☐ CONDOM ☐ RHYTHM ☐ NONE ☐ OTHER____

FOR EACH CONTRACEPTIVE METHOD USED SPECIFY LENGTH OF USE AND REASO N FOR DISCONTINUATION:

METHOD	LENGTH	COMPLICATIONS	REASON FOR DISCONTINUATION
____________	_________	_________	____
____________	_________	_________	____
____________	_________	_________	____
____________	_________	_________	____

	YES	NO
IS SEXUAL INTERCOURSE PAINFUL?	☐	☐
HOW MANY TIMES PER WEEK DO YOU AND YOUR PARTNER HAVE SEXUAL INTERCOURSE?____________________		
DO YOU USE LUBRICANTS FOR INTERCOURSE?.......... IF YES WHICH ONES____________________	☐	☐
DO YOU DOUCHE BEFORE OR AFTER INTERCOURSE..........	☐	☐

V. FAMILY HISTORY

	YES	NO
IS THER A FAMILY HISTORY OF INFERTILITY?.......... IF YES, WHO LIST ALL MEMBERS AND RELATIONSHIPS TO YOU____________________	☐	☐
IS THERE HISTORY OF HORMONAL DISORDERS IN YOUR FAMILY?.......... IF YES WHAT TYPE:____________________	☐	☐

VI. HISTORY OF FERTILITY THERAPY

	YES	NO
HAVE YOU BEEN TREATED FOR INFERTILITY BEFORE?.......... IF YES, KWHO WAS YOUR PHYSICIAN?____________________	☐	☐

WHAT CAUSE OF INFERTILITY WAS DIAGNOSED?____

WHAT DRUGS HAVE YOU TAKEN FOR INFERTILITY? CHECK ALL THAT APPLY:

- ☐ CLOMIP0HENE CITRATE (SEPOPHENE ®, COMID®)
- ☐ hMG (PERGONAL®)
- ☐ ESTROGEN
- ☐ PROGESTERONE
- ☐ PREDNISONE (OR CORTISONE-LIKE DRUGS)
- ☐ ANTIBIOTICS
- ☐ GnRH or LHRH (FACTREL ®)
- ☐ hCG (PROFASI ®, A.P.I. ®)
- ☐ BROMOCRIPTINE (PARLODEL®)
- ☐ DANAZOL (DANOCRINE ®)
- ☐ UROFOLLITROPIN OR FSH (METRODIN®)
- ☐ OTHER – SPECIFY________________________
- ☐ NONE

WHICH OF THE FOLLOWING TESTS HAVE YOU HAD PERFORMED? CHECK ALL THAT APPLY AND THE RESULTS IF KNOWN:

TEST	WHEN?	RESULTS
☐ BBT	WHEN?__________	RESULTS____________________
☐ POSTCOITAL TEST	WHEN?__________	RESULTS____________________
☐ HORMONAL ASSAYS (FSH, LHJ, PROLACTIN, ESTROGEN	WHEN?__________	RESULTS____________________
DHEA-S, TESTOSTERONE, PROGESTERONE)	WHEN?__________	RESULTS____________________
☐ ENDOMETRIAL BIOPSY	WHEN?__________	RESULTS____________________
☐ HYSTEROSALPINGOGRAM	WHEN?__________	RESULTS____________________
☐ ULTRASOUND	WHEN?__________	RESULTS____________________
☐ ANTIBODIES	WHEN?__________	RESULTS____________________
☐ LAPAROSCOPY, HYSTEROSCOPY	WHEN?__________	RESULTS____________________
☐ MYCOPLASMA/CHALMYDIA CULTURES	WHEN?__________	RESULTS____________________
☐ THYROID TESTS	WHEN?__________	RESULTS____________________
☐ OTHER – SPECIFY________________________	WHEN?__________	RESULTS____________________

	YES	NO
HAVE YOU EVER HAD SURGERY FOR TUBAL REVERSAL? IF YES SPECIFY DATES___	☐	☐
HAVE YOU EVER HAD SURGERY FOR LYSIS OF ADHESIONS?	☐	☐
HAVE YOU EVER HAD CERVICAL CONIZATON OF CAUTERY?	☐	☐
HAVE YOU EVER HAD ANY OTHER SURGERY? IF YES SPECIFY:___ ___	☐	☐
HAVE YOU EVER UNDERGONE ARTIFICIAL INSEMINATION OR IN VITRO FERTILIZATION? IF YES, USING PARTNER OR DONOR SPERM?___	☐	☐
IS YOUR PARTNER SEEING A DOCTOR FOR EVALUATION OF INFERTILITY? IF YES, SPECIFY PHYSICIAN NAME AND LOCATION:___	☐	☐
DOES THE DOCTOR FEEL THAT YOUR PARTNER HAS AN INFERTILITY PROBLEM? IF YES, WHAT IS THE DIAGNOSIS AND HOW IS HE BEING TREATED?___ ___	☐	☐
HAS HE EVER FATHERED A CHILD WITH A NOTHER WOMAN? IF YES, WHEN___	☐	☐

FOR PHYSICIAN USE ONLY

VII. PHYSICAL FINDINGS

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VII. SURGERY

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IX. OTHER COMMENTS

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X. COURSE OF ACTION

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