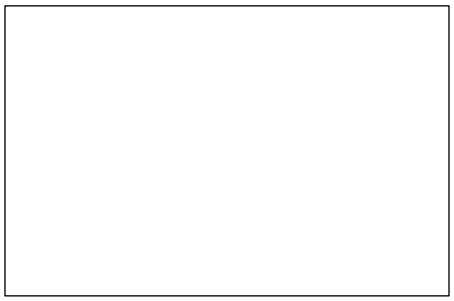
University of Washington Medical Center
University Reproductive Care



FERTILITY HISTORY FORM

Please complete this form and bring it with you to your scheduled appointment.

CONTACT INFORMATION:

First name: _____ Middle Initial: ____ Last Name:_____

Date of Birth: ____/____/____ Age: _____ Occupation:_____

Home Street Address:_____

City: _____ State: _____ Zip/Postal Code: _____

Indicate which number to call or leave messages

☐Home Phone: (___) _____ ☐Cell Phone: (___)_____☐Work Phone:(___)_____

Do you feel safe at home? ☐ Yes ☐No

Are you married? ☐Yes ☐No ☐Divorced ☐Other_____

Spouse/Partner:☐ Not Applicable

First name: _____ Middle Initial: ____ Last Name:_____

Date of Birth: ____/____/____ Age: _____ Occupation:_____

Home Street Address:_____

City: _____ State: _____ Zip/Postal Code: _____

Indicate which number to call or leave messages

☐Home Phone: (___) _____ ☐Cell Phone: (___)_____☐Work Phone:(___)_____

Who Referred you?

☐ Physician Name: _____Clinic: _____

Phone: (___)_____Address: _____

☐ Former Patient/Friend: _____

☐ Website/Advertisement: _____

☐ Insurance Carrier: _____

Who is your Ob/Gyn?

Name: _____Clinic: _____ Phone: (___) _____

Address: _____

FEMALE MEDICAL HISTORY AND INFORMATION:

Reason for visit? ☐ Fertility evaluation ☐ Sperm insemination
☐ Other_____
What is your primary goal for this visit?_____
_____

Do you have any personal, ethical or religious objections to any of our tests or treatments, such as insemination, in vitro fertilization, egg donation, sperm donation, masturbation to collect a semen sample, etc.?
☐ No ☐ Yes _____

Menstrual History:
Age when you had your first period: _____
Age when you first noticed breast development: _____ pubic hair: _____underarm hair: _____

Current menstrual cycle pattern: ☐ Regular ☐ Irregular (if irregular check all that apply)
☐ <25 days ☐ >35 days ☐ No periods ☐ Heavy ☐ Light ☐ Bleed between periods ☐ Bleed after sex

Number of days between the start of one period to the start of the next period: _____
How many periods do you have a year? _____ How many days of bleeding do you have?_____
Dates of the 1st day of your last 2 periods (month/day/year): ____/____/____ , ____/____/____
If you do not have periods, at what age did you stop having them? _____
Do you have severe menstrual cramps/pain? ☐ **No** ☐ Yes: Always __Sometimes __ In the Past___

Contraceptive History: (please check all that apply and provide dates of use) ☐ N/A ☐
☐ Condoms: _____ ☐ Diaphragm____ ☐ IUD_____
☐ Implanon/Nexplanon_____ ☐ Birth control pills_____
☐ Patch _____ ☐ Nuva-ring _____
☐ Injectable (Depo-Provera, Lunelle etc.) _____
☐ Tubal sterilization (tubes tied, cut, burned, Essure, etc.) date ____/____/____ Type:_____
☐ Tubes untied – date ____/____/____

Sexual History:
☐ Have you used over-the-counter ovulation kits to time intercourse? ☐ Yes ☐ No
☐ Do you have pain with intercourse? ☐ No ☐ Yes
☐ Do you use lubricants (K-Y Jelly, etc.) during intercourse? ☐ Yes What type? _____ ☐ No

Have you been treated for or diagnosed with one of the following sexually transmitted infections?
☐ **No** ☐ Yes (Please check all that apply and provide the date of diagnosis)
☐ Chlamydia _____ ☐ Gonorrhea _____ ☐ Herpes _____ ☐ Hepatitis B _____
☐ Genital warts (HPV) _____ ☐ Syphilis _____ ☐ HIV/AIDS _____

Have you been treated for or diagnosed with one of the following problems?
☐ **No** ☐ Yes (Please check all that apply and provide the date of diagnosis)
☐ Ovarian failure_____ ☐ Ovarian cysts (specify type)_____ ☐ Fibroids_____
☐ Endometriosis_____ ☐ Tubal disease_____ ☐ Uterine polyps _____ ☐ Adrenal disease
☐ Pelvic inflammatory disease (PID)_____ ☐ PCOS_____ ☐ Thyroid disease_____

Pap Smear History:
When was your last pap smear (month and year)? ____/____
Have you ever had an abnormal pap smear □ **No** □ Yes
If yes, when was your last abnormal pap smear?____/____
Have you had any of the following treatments for abnormal pap smear? (please check all that apply)
□ Colposcopy □ Cryosurgery (freezing) □ Laser treatment
□ Conization □ LEEP procedure

Breast Screening History:
Do you perform breast self-exams? □ No □ Yes
Have you ever had a mammogram? □ No □ Yes – date ___/___/___ Result: □ Normal
□ Abnormal – explain _____

Pregnancy Summary:
□Total Number of ALL pregnancies: _____ □Number of living children _____
□Miscarriages (less than 20 weeks): _____ □Ectopic/Tubal Pregnancies: _____
□Elective Terminations (Abortions): _____
□Full Term Deliveries:_____ □Premature Deliveries (less than 37 weeks): _____
□Any Pregnancies with birth defects? ☐ No ☐Yes _____

Date Pregnancy Ended or Delivered	Months to Conception	Treatment to Conceive	Delivery Type D&C/Complications	Current Partner?
1.				☐ Yes ☐No
2.				☐ Yes ☐No
3.				☐ Yes ☐No
4.				☐ Yes ☐No
5.				☐ Yes ☐No
6.				☐ Yes ☐No

Medical History:
Are you allergic to any medications or foods? □ **No** □ Yes (list allergies and describe reactions)

Drug or food	Reaction

List all medications, including over-the-counter medicines, herbal remedies, and vitamins

Medication	Dose	Why are you taking this medication

Do you have any medical problem(s)? ☐ **No** ☐ Yes (please list type, dates and treatments)

Medical problem	Diagnosis date	Treatments

Surgical History: Have you had any surgeries? ☐ **No** ☐ Yes

Any anesthesia problems? ☐ **No** ☐ Yes (describe)_____

Year	Reason and Type of Surgery
1.	
2.	
3.	
4.	

Social History:

Number of caffeinated beverages (coffee, tea, soda) per day? _____

Do you smoke cigarettes? ☐ **No** ☐ Quit/when_____ ☐ Yes

Number of years_____ Number of cigarettes per day _____

Do you drink alcohol? ☐ **No** ☐ Yes

Number of drinks per week: Beer ____ Wine ____ Liquor _____

Do you use recreational drugs (i.e. marijuana)? ☐ **No**

☐ Yes (describe) _____

Do you Exercise? ☐ No ☐ **Yes**-- Number of hours per week _____

Type_____

Review of Physical Symptoms:

General
- ☐ Fever/chills
- ☐ Recent weight gain or loss
- ☐ Anorexia/bulimia
- ☐ Lack of energy
- ☐ Other:_____
- ☐ **None**

Head, Eyes, Ears, Nose and Throat
- ☐ Hearing loss/deafness
- ☐ Loss of sense of smell
- ☐ Chronic nasal congestion
- ☐ Blurred vision ☐ Ringing ears
- ☐ Other:_____
- ☐ **None**

Respiratory
- ☐ Shortness of breath
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia ☐Tuberculosis
- ☐ Other_____
- ☐ **None**

Endocrine/Hormonal
- ☐ Thyroid gland problems
- ☐ Diabetes
- ☐ Frequently hot or cold
- ☐ Rapid weight gain/loss
- ☐ Hot flashes
- ☐ Increased hunger/thirst
- ☐ Adrenal disorder
- ☐ Other_____
- ☐ **None**

Breasts
- ☐ Surgery (Type:_____)
- ☐ Discharge (Type:_____)
- ☐ Lumps
- ☐ Pain
- ☐ Cancer
- ☐ Other_____
- ☐ **None**

Neurological
- ☐ Dizziness
- ☐ Weakness or loss of balance
- ☐ Seizures/Epilepsy
- ☐ Stress headaches
- ☐ Migraine headaches
- ☐ Numbness
- ☐ Memory Loss
- ☐Other_____
- ☐ **None**

Mental Health
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar depression disorder
- ☐ Personality disorder
- ☐ Eating disorder
- ☐ Suicidal
- ☐ Other_____
- ☐ **None**

Kidney/Urinary
- ☐ Kidney cysts
- ☐ Frequent bladder infections
- ☐ Kidney stones
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Other_____
- ☐ **None**

Cardiovascular
- ☐ Murmurs
- ☐ Chest pain
- ☐ Heart attack
- ☐ High blood pressure
- ☐ Mitral valve prolapse (antibiotics are required with dental procedures ☐ No ☐Yes)
- ☐ Other:_____
- ☐ None

Hematologic
- ☐ Blood clots
- ☐ Sickle cell anemia
- ☐ Easy bruising
- ☐ Swollen glands/lymph nodes
- ☐ Stroke
- ☐ Blood Transfusion date and reason:_____
- ☐ Other_____
- ☐ None

Skin/Extremities
- ☐ Hair loss
- ☐ Rash
- ☐ Acne
- ☐ Skin cancer
- ☐ Excessive facial or body hair
- ☐ Eczema
- ☐ Other_____
- ☐ **None**

Gastrointestinal
- ☐ Ulcers
- ☐ Nausea/Vomiting
- ☐ Diarrhea ☐ Constipation
- ☐ Blood in stool
- ☐ Irritable bowel disease
- ☐ Colitis (Ulcerative or Crohn's)
- ☐ Other:_____
- ☐ **None**

Musculoskeletal/Immune
- ☐ Osteoporosis
- ☐ Decreased energy/fatigue
- ☐ Rheumatoid arthritis
- ☐ Lupus erythematosus
- ☐ Myasthenia gravis
- ☐ Other_____
- ☐ **None**

Family History	**Living**	**Age and Cause of Death**
Mother	☐ Yes-age: ☐ No	
Father	☐ Yes –age: ☐ No	
Brothers (number=___)	☐ Yes- ages: ☐ No	
Sisters (number=____)	☐ Yes – ages: ☐ No	
Maternal Grandmother	☐ Yes – age: ☐ No	
Maternal Grandfather	☐ Yes – age: ☐ No	
Paternal Grandmother	☐ Yes – age: ☐ No	
Paternal Grandfather	☐ Yes – age: ☐ No	

☐Did your mother take DES during pregnancy to prevent miscarriage? ☐ Yes ☐ No ☐ Don't know

Disorders in Your Family		**Relationship to you**		
Breast Cancer	☐ Yes	_____	☐ No	☐ Don't Know
Ovarian Cancer	☐ Yes	_____	☐ No	☐ Don't Know
Colon Cancer	☐ Yes	_____	☐ No	☐ Don't Know
Other Cancer_____	☐ Yes	_____	☐ No	☐ Don't Know
Diabetes	☐ Yes	_____	☐ No	☐ Don't Know
Thyroid Problems	☐ Yes	_____	☐ No	☐ Don't Know
Heart Disease	☐ Yes	_____	☐ No	☐ Don't Know
Blood Clots	☐ Yes	_____	☐ No	☐ Don't Know

Psychiatric Problems	□ Yes	_____	□ No	□ Don't Know
Tuberculosis	□ Yes	_____	□ No	□ Don't Know
Endometriosis	□ Yes	_____	□ No	□ Don't Know
Menopause before age 40	□ Yes	_____	□ No	□ Don't Know
Birth Defects	□ Yes	_____	□ No	□ Don't Know
Cystic Fibrosis	□ Yes	_____	□ No	□ Don't Know
Tay-Sachs Disease	□ Yes	_____	□ No	□ Don't Know
Canavan Disease	□ Yes	_____	□ No	□ Don't Know
Bloom Syndrome	□Yes	_____	□ No	□ Don't Know
Gaucher Disease	□Yes	_____	□ No	□ Don't Know
Niemann-Pick Disease	□ Yes	_____	□ No	□ Don't Know
Fanconi Anemia	□ Yes	_____	□ No	□ Don't Know
Familial Dysautonia	□ Yes	_____	□ No	□ Don't Know
Muscular Dystrophy	□ Yes	_____	□ No	□ Don't Know
Neurologic (brain/spine)	□ Yes	_____	□ No	□ Don't Know
Neural Tube Defects	□ Yes	_____	□ No	□ Don't Know
Bone/Skeletal Defects	□ Yes	_____	□ No	□ Don't Know
Dwarfism	□ Yes	_____	□ No	□ Don't Know
Developmental Delays	□ Yes	_____	□ No	□ Don't Know
Learning Problems	□ Yes	_____	□ No	□ Don't Know
Polycystic Kidneys	□ Yes	_____	□ No	□ Don't Know
Heart defect from birth	□ Yes	_____	□ No	□ Don't Know
Down Syndrome	□ Yes	_____	□ No	□ Don't Know
Other Chromosome defects	□ Yes	_____	□ No	□ Don't Know
Marfan Syndrome	□ Yes	_____	□ No	□ Don't Know
Hemophilia	□ Yes	_____	□ No	□ Don't Know
Sickle Cell Anemia	□ Yes	_____	□ No	□ Don't Know
Thalassemia	□ Yes	_____	□ No	□ Don't Know
Galactosemia	□ Yes	_____	□ No	□ Don't Know
Deafness/Blindness	□ Yes	_____	□ No	□ Don't Know
Color Blindness	□ Yes	_____	□ No	□ Don't Know
Hemochromatosis	□ Yes	_____	□ No	□ Don't Know

□ Other-Specify _____

What is Your Race/Ethnicity?

☐ African American
☐ American Indian/Native American
☐ Ashkenazi Jewish
☐ Asian American
☐ Cajun/French Canadian
☐ Caucasian
☐ Eastern European
☐ Hispanic/Caribbean
☐ Northern European
☐ Southern European
☐ Other: _____

Would you like to be screened for?

Cystic Fibrosis	☐ Yes	☐No
Sickle Cell Anemia	☐ Yes	☐No
Tay - Sachs disease	☐ Yes	☐No
Thalassemia	☐ Yes	☐No

□ Other_____

Emotional Status: Please rate on a scale of 1-10 (1 is best and 10 is worst)

How do you estimate your average level of stress to be? 1 2 3 4 5 6 7 8 9 10
Over the last two weeks have you felt little pleasure in doing things?
❑Not at all ❑Several days ❑More than half the days ❑Nearly every day
Over the last two weeks have you felt down, depressed or hopeless?
❑Not at all ❑Several days ❑More than half the days ❑Nearly every day
Do you see a counselor?
□ **No** □Yes- for how long? _____ How often?_____
Do you feel safe at home? ❑**Yes** ❑No

Vaccinations:

Chickenpox (Varicella)	□ No	□ **Yes** (dates _____)	□ Don't know
MMR-Measles, Mumps and Rubella	□ No	□ **Yes** (dates _____)	□ Don't know
BCG (Tuberculosis)	□ No	□ **Yes** (dates _____)	□ Don't know
Hepatitis B	□ No	□ **Yes** (dates _____)	□ Don't know
Polio	□ No	□ **Yes** (dates _____)	□ Don't know
Hepatitis A	□ No	□ **Yes** (dates _____)	□ Don't know
Tetanus	□ No	□ **Yes** (dates _____)	□ Don't know
Influenza	□ No	□ **Yes** (dates _____)	□ Don't know
Human papilloma virus (HPV)	□ No	□ **Yes** (dates _____)	□ Don't know

Prior Infertility Testing and Treatment:

☐Have you had prior infertility testing or treatment ? ☐ No ☐ Yes

Prior Tests: (check all that apply):

☐ Basil body temperature chart (date_____/results_____)
☐ Thyroid blood test (date_____/results_____
☐ Ovulation test kit (date_____/results_____)
☐Day 3 blood test FSH level (date_____/results_____)
☐AMH blood test (date_____/results_____)
☐ Prolactin blood test (date_____/results_____
☐ Hysterosalpingogram (date_____/results_____)
☐ Laparoscopy surgery (date_____/results_____)
☐ Hysteroscopy surgery (date_____/results_____)

Prior Treatments: (check all that apply):

❑ Intrauterine insemination	**# of cycles** _____	**Dates** (mo/year) From___/___to___/___	**Outcome** ❑Pregnant ❑Delivered ❑Ectopic ❑Miscarriage ❑Not Pregnant
❑ Clomiphene citrate or Letrozole with timed intercourse: Maximum # tablets per day___	_____	From___/___to___/___	❑Pregnant ❑Delivered ❑Ectopic ❑Miscarriage ❑Not Pregnant
❑ Clomiphene citrate or Letrozole with insemination: Maximum # tablets per day___	_____	From___/___to___/___	❑Pregnant ❑Delivered ❑Ectopic ❑Miscarriage ❑Not Pregnant
❑ Fertility drug injections with insemination:	_____	From___/___to___/___	❑Pregnant ❑Delivered ❑Ectopic ❑Miscarriage ❑Not Pregnant
❑ Complete in vitro fertilization cycle(s):	_____		
1. #eggs ___ #embryos transferred ___ #frozen ___		From___/___to___/___	❑Pregnant ❑Delivered ❑Ectopic ❑Miscarriage ❑Not Pregnant
2. #eggs ___ #embryos transferred ___ #frozen ___		From___/___to___/___	❑Pregnant ❑Delivered ❑Ectopic ❑Miscarriage ❑Not Pregnant
3. #eggs ___ #embryos transferred ___ #frozen ___		From___/___to___/___	❑Pregnant ❑Delivered ❑Ectopic ❑Miscarriage ❑Not Pregnant
4. #eggs ___ #embryos transferred ___ #frozen ___		From___/___to___/___	❑Pregnant ❑Delivered ❑Ectopic ❑Miscarriage ❑Not Pregnant
❑ Frozen embryo transfers:	_____		
1. #embryos transferred ___		From___/___to___/___	❑Pregnant ❑Delivered ❑Ectopic ❑Miscarriage ❑Not Pregnant
2. #embryos transferred ___		From___/___to___/___	❑Pregnant ❑Delivered ❑Ectopic ❑Miscarriage ❑Not Pregnant
3. #embryos transferred ___		From___/___to___/___	❑Pregnant ❑Delivered ❑Ectopic ❑Miscarriage ❑Not Pregnant
4. #embryos transferred ___		From___/___to___/___	❑Pregnant ❑Delivered ❑Ectopic ❑Miscarriage ❑Not Pregnant
❑ Cancelled in vitro fertilization attempts:	_____	From___/___to___/___	❑Pregnant ❑Delivered ❑Ectopic ❑Miscarriage ❑Not Pregnant
❑ Any other prior treatment (describe): _____ _____			

Additional information:_____
_____
_____

PATIENT SIGNATURE _____ DATE___/___/_____
I confirm that I have reviewed the information above.

PROVIDER SIGNATURE _____DATE ___/___/____