University of Washington Medical Center
University Reproductive Care

FERTILITY HISTORY

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

CONTACT INFORMATION:

First name: _____ Middle initial: ____ Last name:_____

Preferred name: _____ Self-declared gender: _____

Preferred pronoun (he/him, she/her etc) _____

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:(___)_____

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: _____

PLACE PATIENT LABEL HERE

Phone: (___)_____Address: _____

□ Former Patient/Friend: _____

□ Website/Advertisement: _____ □ Insurance Carrier_____

Who is your Ob/Gyn?

Name: _____Clinic: _____ Phone: (___) _____

Address: _____

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** □ None
□ 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 assess for ovulation? □ Yes □ No
□ Do you have pain with sex? ☐ No □ Yes
□ Do you use lubricants (K-Y Jelly, etc.) during sex? □ 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 _____

ZIKA and West Nile exposure
Have you (or your partner) traveled to a Zika Virus Zone?**:** □ **No** □ Yes
Have you (or your partner) traveled to a West Nile Zone?: □ **No** □ Yes
Do you (or your partner) plan to travel to a Zika virus or West Nile zone?**:** □ **No** □ Yes

Have you (or your partner) experienced any of the following in the last 6 months?:
Fever: □ **No** □ Yes Rash: □ **No** □ Yes Joint pain or body aches: □ **No** □ Yes
Conjunctivitis: □ **No** □ Yes Headache: □ **No** □ Yes

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?

PLACE PATIENT LABEL HERE

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

Breasts
□ Surgery (Type:_____)
□ Discharge (Type:_____)
□ Lumps

Neurological
□ Dizziness
□ Weakness or loss of balance
□ Seizures/Epilepsy

☐ Rapid weight gain/loss
☐ Hot flashes
☐ Increased hunger/thirst
☐ Adrenal disorder
☐ Other_____
☐ **None**

☐ Pain
☐ Cancer
☐ Other_____
☐ **None**

☐ 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	

PLACE PATIENT LABEL HERE

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

What is Your Race/Ethnicity?

☐ African American
☐ American Indian/Native American
☐ Ashkenazi Jewish
☐ Asian American
☐ Cajun/French Canadian
☐ Caucasian/ White
☐ 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_____

PLACE PATIENT LABEL HERE

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 _____		

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?_____ Name of counselor: _____
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 Fertility Testing and Treatment:

□ Have you had prior fertility testing or treatment ? ☐ No ☐ Yes

Prior Tests: (check all that apply):

□ Basal 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	PRINT NAME	DATE	TIME

I confirm that I have reviewed the information above.

PROVIDER SIGNATURE	PRINT NAME AND TITLE	DATE	TIME

PLACE PATIENT LABEL HERE