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University of Washington Medical Center University Reproductive Care

FEMALE SINGLE OR SS COUPLE NEW PATIENT 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: _____

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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 ____/____/____

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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

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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.				<input type="checkbox"/> Yes <input type="checkbox"/> No
2.				<input type="checkbox"/> Yes <input type="checkbox"/> No
3.				<input type="checkbox"/> Yes <input type="checkbox"/> No
4.				<input type="checkbox"/> Yes <input type="checkbox"/> No
5.				<input type="checkbox"/> Yes <input type="checkbox"/> No
6.				<input type="checkbox"/> Yes <input type="checkbox"/> 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)

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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
- CPAP machine
- Other _____
- None**

Endocrine/Hormonal

- Thyroid gland problems
- Diabetes
- Frequently hot or cold
- Rapid weight gain/loss

Breasts

- Surgery (Type: _____)
- Discharge (Type: _____)
- Lumps
- Pain

Neurological

- Dizziness
- Weakness or loss of balance
- Seizures/Epilepsy
- Stress headaches

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- Hot flashes
- Increased hunger/thirst
- Adrenal disorder
- Other_____
- None**

- Cancer
- Other_____
- None**

- 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	<input type="checkbox"/> Yes – age: <input type="checkbox"/> No	
Father	<input type="checkbox"/> Yes – age: <input type="checkbox"/> No	
Brothers (number=____)	<input type="checkbox"/> Yes – ages: <input type="checkbox"/> No	
Sisters (number=____)	<input type="checkbox"/> Yes – ages: <input type="checkbox"/> No	

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Maternal Grandmother	<input type="checkbox"/> Yes – age: _____	<input type="checkbox"/> No	
Maternal Grandfather	<input type="checkbox"/> Yes – age: _____	<input type="checkbox"/> No	
Paternal Grandmother	<input type="checkbox"/> Yes – age: _____	<input type="checkbox"/> No	
Paternal Grandfather	<input type="checkbox"/> Yes – age: _____	<input type="checkbox"/> 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 | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Ovarian Cancer | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Colon Cancer | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Other Cancer _____ | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Diabetes | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Thyroid Problems | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Heart Disease | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Blood Clots | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Psychiatric Problems | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Tuberculosis | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Endometriosis | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Menopause before age 40 | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Birth Defects | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Cystic Fibrosis | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Tay-Sachs Disease | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Canavan Disease | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Bloom Syndrome | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Gaucher Disease | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Niemann-Pick Disease | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Fanconi Anemia | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Familial Dysautonia | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Muscular Dystrophy | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Neurologic (brain/spine) | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Neural Tube Defects | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Bone/Skeletal Defects | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Dwarfism | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Developmental Delays | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Learning Problems | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Polycystic Kidneys | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Heart defect from birth | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Down Syndrome | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Other Chromosome defects | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Marfan Syndrome | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Hemophilia | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Sickle Cell Anemia | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Thalassemia | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> 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 _____

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- 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_____)

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Prior Treatments: (check all that apply):

<input type="checkbox"/> Intrauterine insemination	# of cycles _____	Dates (mo/year) From ___/___ to ___/___	Outcome <input type="checkbox"/> Pregnant <input type="checkbox"/> Delivered <input type="checkbox"/> Ectopic <input type="checkbox"/> Miscarriage <input type="checkbox"/> Not Pregnant
<input type="checkbox"/> Clomiphene citrate or Letrozole with timed intercourse: Maximum # tablets per day ___	_____	From ___/___ to ___/___	<input type="checkbox"/> Pregnant <input type="checkbox"/> Delivered <input type="checkbox"/> Ectopic <input type="checkbox"/> Miscarriage <input type="checkbox"/> Not Pregnant
<input type="checkbox"/> Clomiphene citrate or Letrozole with insemination: Maximum # tablets per day ___	_____	From ___/___ to ___/___	<input type="checkbox"/> Pregnant <input type="checkbox"/> Delivered <input type="checkbox"/> Ectopic <input type="checkbox"/> Miscarriage <input type="checkbox"/> Not Pregnant
<input type="checkbox"/> Fertility drug injections with insemination:	_____	From ___/___ to ___/___	<input type="checkbox"/> Pregnant <input type="checkbox"/> Delivered <input type="checkbox"/> Ectopic <input type="checkbox"/> Miscarriage <input type="checkbox"/> Not Pregnant
<input type="checkbox"/> Complete in vitro fertilization cycle(s): 1. #eggs ___ #embryos transferred ___ #frozen ___ 2. #eggs ___ #embryos transferred ___ #frozen ___ 3. #eggs ___ #embryos transferred ___ #frozen ___ 4. #eggs ___ #embryos transferred ___ #frozen ___	_____	From ___/___ to ___/___ From ___/___ to ___/___ From ___/___ to ___/___ From ___/___ to ___/___	<input type="checkbox"/> Pregnant <input type="checkbox"/> Delivered <input type="checkbox"/> Ectopic <input type="checkbox"/> Miscarriage <input type="checkbox"/> Not Pregnant <input type="checkbox"/> Pregnant <input type="checkbox"/> Delivered <input type="checkbox"/> Ectopic <input type="checkbox"/> Miscarriage <input type="checkbox"/> Not Pregnant <input type="checkbox"/> Pregnant <input type="checkbox"/> Delivered <input type="checkbox"/> Ectopic <input type="checkbox"/> Miscarriage <input type="checkbox"/> Not Pregnant <input type="checkbox"/> Pregnant <input type="checkbox"/> Delivered <input type="checkbox"/> Ectopic <input type="checkbox"/> Miscarriage <input type="checkbox"/> Not Pregnant
<input type="checkbox"/> Frozen embryo transfers: 1. #embryos transferred ___ 2. #embryos transferred ___ 3. #embryos transferred ___ 4. #embryos transferred ___	_____	From ___/___ to ___/___ From ___/___ to ___/___ From ___/___ to ___/___ From ___/___ to ___/___	<input type="checkbox"/> Pregnant <input type="checkbox"/> Delivered <input type="checkbox"/> Ectopic <input type="checkbox"/> Miscarriage <input type="checkbox"/> Not Pregnant <input type="checkbox"/> Pregnant <input type="checkbox"/> Delivered <input type="checkbox"/> Ectopic <input type="checkbox"/> Miscarriage <input type="checkbox"/> Not Pregnant <input type="checkbox"/> Pregnant <input type="checkbox"/> Delivered <input type="checkbox"/> Ectopic <input type="checkbox"/> Miscarriage <input type="checkbox"/> Not Pregnant <input type="checkbox"/> Pregnant <input type="checkbox"/> Delivered <input type="checkbox"/> Ectopic <input type="checkbox"/> Miscarriage <input type="checkbox"/> Not Pregnant
<input type="checkbox"/> Cancelled in vitro fertilization attempts:	_____	From ___/___ to ___/___	<input type="checkbox"/> Pregnant <input type="checkbox"/> Delivered <input type="checkbox"/> Ectopic <input type="checkbox"/> Miscarriage <input type="checkbox"/> Not Pregnant
<input type="checkbox"/> Any other prior treatment (describe): _____ _____			

Additional information: _____

PATIENT SIGNATURE	PRINT NAME	DATE	TIME
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I confirm that I have reviewed the information above.

PROVIDER SIGNATURE	PRINT NAME AND TITLE	DATE	TIME
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