

**HEARTLAND CENTER FOR REPRODUCTIVE MEDICINE
ENDOCRINOLOGY – FERTILITY
FEMALE**

PERSONAL DATA

Name _____ Age _____ Date of birth _____
Address _____ Home phone _____
_____ Cell phone _____
Employer _____ Work phone _____
Race _____ Ethnic Background _____ Height _____ Weight _____ Education level _____

OCCUPATION/HABITS

Current Occupation _____

Past Occupations (list most recent first): _____

If you have any exposures to substances or chemicals please specify: _____

Current nicotine usage: _____ If no, have you smoked previously? _____

Smoker for how long? _____ (years) Cigarette per day? _____ Cigars per day? _____ Smokeless tobacco _____

Caffeine usage: _____ Type _____ Average daily caffeine consumption _____

Alcohol use: _____ Type _____ Average weekly alcohol consumption _____

Current drugs or medications, including vitamins and nonprescription medications:

_____ Stimulants _____ Antibiotics _____ Hormones (specify: _____)

_____ Tranquilizers _____ Aspirin _____ Other specify: (1) _____

_____ Decongestants _____ Vitamins _____ (2) _____

_____ Narcotics (frequency of use: _____) _____ (3) _____

_____ Marijuana (frequency of use: _____)

Do you exercise regularly? _____ Activity _____ Frequency _____

MARITAL AND SEX HISTORY:

Present marriage: _____ Years Contraception _____ # years Type _____

Sexual intercourse frequency: Per month _____ Douches _____

Adequate penetration? _____ Ejaculation (normal or premature) _____ Orgasm _____

Difficulties _____

Coital positions _____ Pain or discomfort _____

Use of Lubricants _____ Pain or discomfort _____

Marital Problems _____

Previous marriages(s): _____ Number of years _____ Contraception _____ Type _____ Years _____

Reason for divorce: _____

Number of natural children _____ Number of adopted children _____

Pregnancies: (list in order all pregnancies giving dates, outcome including miscarriage and elective terminations, weight, sex, complications, etc., begin with most recent pregnancy first)

PAST INFERTILITY TREATMENT OR TESTING:

Please list tests performed, dates, results and name of physician: _____

MENSTRUAL HISTORY

Age at onset of sexual development _____ Age at onset of menstruation _____

Present menstrual cycles: Length (in days from start to start) _____ Duration of bleeding _____

Any spotting before or after periods? _____ Any spotting between periods _____.

Past menstrual cycles: _____ Start date of last menstrual period _____

Pains or cramps with periods? _____ Every cycle? _____ Age at onset? _____

Are the pains worse now than three years ago? _____ Pain between periods? _____ Ovulation pain? _____

Can you tell when your period is approaching? _____ What are the symptoms? _____

Is there anything else you can tell us about your cycles? _____

MEDICAL HISTORY

Have you had any of the following illnesses? (Check box for yes)

| | | | |
|-----------------|-------------------|---------------------------|--------------------|
| Allergies | Inguinal hernia | Psychiatric disorder | Phlebitis |
| Hypertension | Blood transfusion | Syphilis | Migraines |
| Injuries | Kidney disease | Gonorrhea | Congenital disease |
| Operations | Liver disease | Birth defect or birthmark | Cystitis |
| Prolonged fever | Diabetes | Tubal infection | Other (specify): |

Was your mother taking any medications or hormones during her pregnancy with you? _____

If you answered yes to any of the above questions please elaborate. Include dates of hospitalization, etc.: _____

FAMILY HISTORY

Have there been any of the following diseases in your family?

| | | | |
|----------------|---------------------|------------------------|---------------------------------------|
| Diabetes | Down's Syndrome | Deafness | Schizophrenia or depressive psychoses |
| Heart Disease | Spina Bifida | Early deaths | Children with birth defects |
| Hypertension | Muscular Dystrophy | Recurrent miscarriages | Mental retardation |
| Kidney disease | Cleft lip or palate | Cystic Fibrosis | Other congenital anomalies (specify): |
| Tuberculosis | Limb deformities | Infertility | |
| Cancer | Blindness | Sickle Cell Disease | |

If the answer to any of the above is yes, please elaborate: _____

Is there anything else you would like to add to what we have asked? _____