

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

PERSONAL DATA

Name _____ Age _____ SSN# _____
Address _____ Date of birth _____
Home phone _____
Cell phone _____
Employer _____ Work phone _____
Race _____ Hispanic Yes No 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 marriage(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? _____

