MOUNT SINAI HOSPITAL
Joseph and Wolf Lebovic Health Complex

Female Fertility History Form

IMPORTANT: Please complete this form and bring it with you to your scheduled visit

This form was adapted by the Centre for Fertility and Reproductive Health at Mount Sinai Hospital to assist health care providers and patients in obtaining a complete fertility history. It consists of two parts:

Part I: Contact information
Part II: Your medical history

FOR OFFICE USE ONLY

PART I: CONTACT INFORMATION

First Name _____ **Middle Initial** ____ **Last Name** _____ **Age**

Date of Birth (MM/DD/YY) _____ Occupation _____

Home Street Address _____

City _____ Prov. _____ Postal Code _____ Country _____

Indicate which number to call or leave messages.

☐ Home Telephone _____ ☐ Work Telephone _____ ☐ Cell Phone ( ) _____

Are you married? ☐ Yes ☐ No ☐ Divorced ☐ Other _____

Spouse/Partner's First Name _____ **Middle Initial** ____ **Last Name** _____ **Age**

☐ Not Applicable

Date of Birth (MM/DD/YY) _____ Occupation _____

Home Street Address _____

City _____ State _____ Zip/Postal Code _____ Country _____

Indicate which number to call or leave messages.

☐ Home Telephone _____ ☐ Work Telephone _____ ☐ Cell Phone _____

Who referred you?

☐ Physician
Name _____ Phone _____
Address _____

☐ Former Patient / Friend _____

☐ Web Site _____

☐ Insurance (Name of Insurance) _____

Who is your Ob/Gyn? (If applicable)

Name _____ Phone _____
Address _____

Who is your Primary Care Physician?

Name _____ Phone _____
Address _____

Physician Notes
(for office use only)

PART II: MEDICAL HISTORY AND INFORMATION

Reason for Visit: ☐ Infertility Evaluation ☐ Sperm Insemination ☐ Other _____

If you are in a same-sex relationship, are you hoping to carry the pregnancy? _____

What questions would you like answered at this visit? _____

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

If applicable, how many months have you been having intercourse without using any form of birth control? _____

Pregnancy Summary

Total Number of ALL Pregnancies: _____ Number of Miscarriages (less than 20 weeks) _____

Number of Ectopic/Tubal Pregnancies: _____ Number of Elective Terminations (Abortions): _____

Number of Full Term Deliveries: _____ Of these, how many were live births? _____ How many were still born? _____

Number of Premature (< 37 weeks) Deliveries: _____ Of these, how many were live births _____ How many were still born? _____

Any Pregnancies with Birth Defects? ☐ No ☐ Yes - explain _____

	Date Pregnancy Ended or Delivered	Months to Conception	Treatments to Conceive	Delivery Type / D&C / Complications	Current Partner?
1					☐ Y ☐ N
2					☐ Y ☐ N
3					☐ Y ☐ N
4					☐ Y ☐ N
5					☐ Y ☐ N
6					☐ Y ☐ N

Menstrual History

Menstrual cycle pattern: ☐ Regular periods ☐ Irregular periods ☐ Spotting before periods ☐ No periods

(check all that apply) ☐ Heavy periods ☐ Light periods ☐ Bleeding between periods

Number of days between the start of one period to the start of the next period _____ days

How many days of bleeding do you have? _____ Days

Dates of the 1st day of your last 2 menstrual periods: _____ ; _____

Age when you had your first period: _____ years old

How many periods do you have per year? _____

Do you need medication to bring on a period? ☐ Yes – what type? _____ ☐ No

If you do not have periods, at what age did you stop having them? _____ years old

Do you have severe cramping/pelvic pain with your periods? ☐ Yes ___ Always ___ Sometimes ___ Recently ___ In past ☐ No

Sexual History

How many times do you have intercourse per week? _____ times per week ☐ None ☐ Not Applicable

If applicable, have you used over-the-counter ovulation kits to time intercourse? ☐ Yes ☐ No

Do you have pain with intercourse/vaginal penetration? ☐ Yes ☐ No

Do you ever use lubricants (K-Y Jelly®, etc.)? ☐ Yes – what types? _____ ☐ No

Have you had any of the following sexually transmitted diseases or pelvic infections? ☐ Yes – check all that apply ☐ No

☐ Chlamydia - date _____ ☐ Gonorrhea-date _____ ☐ Herpes-date _____ Genital warts/HPV-date _____

☐ Syphilis –date _____ ☐ HIV/AIDS-date _____ ☐ Hepatitis-date _____ Other-date _____

Contraceptive History

☐ Contraception not necessary (i.e. same-sex relationship)

☐ None ☐ Condoms-dates of use _____ ☐ Diaphragm- dates of use _____ ☐ IUD-dates of use _____

☐ Birth control pills - dates of use _____ - complications? _____ ☐ Never used birth control pills

☐ Injectable contraception (i.e. Depo-Provera®) - dates of use _____ - complications? _____

☐ Skin patch - dates of use _____ - complications? _____ ☐ Foam or Jelly?

☐ Tubal sterilization procedure (tubes tied) - date (month/year) _____ ☐ Tubes untied - date (month/year) _____

Did your mother take DES when she was pregnant with you? ☐ Yes ☐ No ☐ Don't know

Pap Test History

When was your last Pap test (month and year)? _____ ☐ Normal ☐ Abnormal

When was your last abnormal Pap Test? _____ ☐ Not Applicable

Have you undergone any procedures as a result of an abnormal Pap test?

☐ Yes (check all that apply) ☐ No

☐ Colposcopy ☐ Cryosurgery (freezing) ☐ Laser Treatment ☐ Conization ☐ LEEP

Breast Screening History

Have you ever had a mammogram? ☐ No ☐ Yes - date _____ Result: ☐ Normal ☐ Abnormal - explain _____

Do you perform breast self-exams? ☐ Yes ☐ No

Medical History

Are you allergic to any medications? ☐ No ☐ Yes (please list and describe reactions)

Are you allergic to any foods (peanuts, eggs, etc.)? ☐ No ☐ Yes (please list and describe reactions)

List any medications you are currently taking, including over-the-counter medicines. _____

Do you take any herbal medicines/vitamins or health food store supplements? ☐ No ☐ Yes (please list) _____

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

(1)

(2)

(3)

(4)

(5)

Did you have either of these childhood illnesses? ☐ Chickenpox (Varicella) ☐ German Measles (Rubella) ☐ Don't know

Other childhood diseases: _____

Vaccinations

Chickenpox (Varicella)	☐ No	☐ Yes (dates _____)	☐ Don't know
MMR – Measles, Mumps, and Rubella (German Measles)	☐ No	☐ Yes (dates _____)	☐ Don't know
BCG (Tubercolosis)	☐ 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

Social History

How many caffeinated beverages (coffee, tea, soda) do you drink per day? _____ ☐ None

Do you smoke cigarettes? ☐ No ☐ Yes – How many/day? _____ How many years? _____ ☐ Quit-when? _____

Do you drink alcohol? ☐ No ☐ Yes

☐ Beer - # per week _____ ☐ Wine - # per week _____ ☐ Liquor - # per week _____

Do you use marijuana, cocaine, or any other similar drug? ☐ No ☐ Yes - describe _____

Do you exercise? ☐ No ☐ Yes (describe) _____

Are you aware of any radiation exposures other than X-rays? ☐ No ☐ Yes (describe) _____

Physician Notes (for office use only)

Surgical History

Have you had any surgeries ☐ No ☐ Yes (List all surgeries in chronological order)

Year		Reason and Type of Surgery
_____	(1)	_____
_____	(2)	_____
_____	(3)	_____
_____	(4)	_____
_____	(5)	_____
_____	(6)	_____
_____	(7)	_____

Did you have any anesthesia problems? ☐ No ☐ Yes (describe) _____

Physical Symptoms

General:
- ☐ Recent weight gain or loss
- ☐ Anorexia/Bulimia
- ☐ Lack of energy
- ☐ Fever/Chills
- ☐ Other _____
- ☐ None

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

Respiratory:
- ☐ Shortness of breath
- ☐ Asthma ☐ Bronchitis
- ☐ Pneumonia ☐ Tubercolosis
- ☐ Bloody cough
- ☐ Other _____
- ☐ None

Endocrine/Hormonal:
- ☐ Diabetes ☐ Hair loss
- ☐ Thyroid gland problems
- ☐ Rapid weight gain or loss
- ☐ Excessive hunger/thirst
- ☐ Temperature intolerance - hot flashes or feeling cold
- ☐ Other _____
- ☐ None

Breasts:
- ☐ Discharge Clear ___ Bloody ___ milky ___
- ☐ Lumps ☐ Pain ☐ Cancer
- ☐ Abnormal mammogram
- ☐ Reduction
- ☐ Augmentation/Breast implants Saline? _____ Silicone? _____
- ☐ Other _____
- ☐ None

Neurological Issues:
- ☐ Weakness/Loss of Balance
- ☐ Seizures/Epilepsy
- ☐ Headaches
- ☐ Migraine headaches
- ☐ Numbness
- ☐ Memory loss
- ☐ Other _____
- ☐ None

Gastrointestinal:
- ☐ Nausea/Vomiting ☐ Diarrhea
- ☐ Hepatitis ☐ Ulcers
- ☐ Blood in stool ☐ Constipation
- ☐ Irritable Bowel Syndrome
- ☐ Change in bowel habits
- ☐ Colitis (ulcerative or Crohn's)
- ☐ Other _____
- ☐ None

Genito-Urinary:
- ☐ Bladder infections
- ☐ Kidney infections
- ☐ Vaginal infections
- ☐ Frequent urination ☐ Leaking urine
- ☐ Blood in urine
- ☐ Herpes
- ☐ Other _____
- ☐ None

Skin/Extremities:
- ☐ Unexplained rash/inflammation
- ☐ Acne
- ☐ Skin cancer
- ☐ Burn injury
- ☐ Moles changing in appearance
- ☐ Excess hair growth
- ☐ Other _____
- ☐ None

Musculoskeletal:
- ☐ Unusual muscle weakness
- ☐ Decreased energy/stamina
- ☐ Rheumatoid arthritis
- ☐ Lupus Erythematosus
- ☐ Myasthenia gravis
- ☐ Other _____
- ☐ None

Hematologic:
- ☐ Blood clotting disorder/Blood clot
- ☐ Sickle cell anemia ☐ Thrombophlebitis
- ☐ Easy bruising
- ☐ Swollen glands/lymph nodes
- ☐ Blood transfusions (dates/reasons)
- ☐ Other _____
- ☐ None

Cardiovascular:
- ☐ Palpitations/skipped beats
- ☐ Chest pain ☐ Heart attack
- ☐ Stroke ☐ Murmurs
- ☐ High blood pressure
- ☐ Rheumatic fever
- ☐ Mitral valve prolapse (Require antibiotics before dental procedures?)
- ☐ Other _____
- ☐ None

Mental Illnesses:
- ☐ Depression ☐ Anxiety disorder
- ☐ Schizophrenia
- ☐ Other _____
- ☐ None

Physician Notes (for office use only) _____

Family History

	Living		Cause of Death/Age at Death	
Mother	☐ Yes – age	____	☐ No	____
Father	☐ Yes – age	____	☐ No	____
Brother(s)	☐ Yes – age	____	☐ No	____
	☐ Yes – age	____	☐ No	____
Sister(s)	☐ Yes – age	____	☐ No	____
	☐ Yes – age	____	☐ No	____
Maternal Grandmother	☐ Yes – age	____	☐ No	____
Maternal Grandfather	☐ Yes – age	____	☐ No	____
Paternal Grandmother	☐ Yes – age	____	☐ No	____
Paternal Grandfather	☐ Yes – age	____	☐ No	____
Paternal Grandfather	☐ Yes – age	____	☐ No	____

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 issues	☐ Yes	____	☐ No	☐ Don't Know
Heart disease	☐ Yes	____	☐ No	☐ Don't Know
Blood clots	☐ Yes	____	☐ No	☐ Don't Know
Obesity	☐ Yes	____	☐ No	☐ Don't Know
Mental illness	☐ Yes	____	☐ No	☐ Don't Know
Tuberculosis (TB)	☐ Yes	____	☐ No	☐ Don't Know
Infertility/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 dysautonomia	☐ 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 delay	☐ Yes	____	☐ No	☐ Don't Know
Polycystic kidney disease	☐ Yes	____	☐ No	☐ Don't Know
Down syndrome	☐ Yes	____	☐ No	☐ Don't Know
Other chromosome defect	☐ 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
Deaf/Blind/Colour Blind	☐ Yes	____	☐ No	☐ Don't Know
Hemochromatosis	☐ Yes	____	☐ No	☐ Don't Know

☐ None of the above ☐ Others (specify) ____

What is your Ancestry?

- ☐ African-American
- ☐ Aboriginal/First Nations/ Native American
- ☐ Ashkenazi Jewish
- ☐ Asian-American
- ☐ Cajun/French Canadian
- ☐ Caucasian
- ☐ Eastern European
- ☐ Hispanic/Caribbean
- ☐ Northern European
- ☐ Southern European
- ☐ Others (specify) ____

Indicate what you would like to be screened for:

- ☐ Cystic fibrosis ___ Y ___ N
- ☐ Sickle cell anemia ___ Y ___ N
- ☐ Tay-Sachs ___ Y ___ N
- ☐ Thalassemia ___ Y ___ N

PRIOR INFERTILITY TESTING AND TREATMENT

If applicable, have you had prior infertility testing or treatment elsewhere? ☐ Yes ☐ No

Prior Tests (check all that apply) ☐ Basal body temperature chart (date _____ results _____

☐ Thyroid test (date) _____ result _____ ☐ Ovulation test kit (dates from-to) _____ result - Pos / Neg

☐ Day 3 FSH blood test (date) _____ result _____ ☐ Hysterosalpingogram (HSG) (date) _____ result _____

☐ Prolactin blood test (date) _____ result _____ ☐ Hysteroscopy (date) _____ result _____

☐ Progesterone blood test (date) _____ result _____ ☐ Laparoscopy (date) _____ result _____

Prior Treatment (check all that apply)

	# of cycles	Dates From - To	Outcome
☐ Intrauterine insemination			___ Pregnant ___ Delivered ___ Ectopic ___ Miscarriage ___ Not preg
☐ Clomiphene citrate with timed intercourse Maximum # of tablets per day _____			___ Pregnant ___ Delivered ___ Ectopic ___ Miscarriage ___ Not preg
☐ Clomiphene citrate with insemination Maximum # of tablets per day _____			___ Pregnant ___ Delivered ___ Ectopic ___ Miscarriage ___ Not preg
☐ Daily fertility drug injections with insemination			___ Pregnant ___ Delivered ___ Ectopic ___ Miscarriage ___ Not preg
☐ Completed in-vitro fertilization cycle(s) 1 eggs ___ embryos transferred ___ frozen ___	_____	_____	___ Pregnant ___ Delivered ___ Ectopic ___ Miscarriage ___ Not preg
2 eggs ___ embryos transferred ___ frozen ___		_____	___ Pregnant ___ Delivered ___ Ectopic ___ Miscarriage ___ Not preg
3 eggs ___ embryos transferred ___ frozen ___		_____	___ Pregnant ___ Delivered ___ Ectopic ___ Miscarriage ___ Not preg
4 eggs ___ embryos transferred ___ frozen ___		_____	___ Pregnant ___ Delivered ___ Ectopic ___ Miscarriage ___ Not preg
☐ Frozen embryo transfer(s) 1 #embryos transferred _____	_____	_____	___ Pregnant ___ Delivered ___ Ectopic ___ Miscarriage ___ Not preg
2 #embryos transferred _____		_____	___ Pregnant ___ Delivered ___ Ectopic ___ Miscarriage ___ Not preg
3 #embryos transferred _____		_____	___ Pregnant ___ Delivered ___ Ectopic ___ Miscarriage ___ Not preg
4 #embryos transferred _____		_____	___ Pregnant ___ Delivered ___ Ectopic ___ Miscarriage ___ Not preg
Cancelled in-vitro fertilization attempt(s):			
☐ Any other prior treatment (describe) _____			

Additional Information/Complications: _____

EMOTIONAL STATUS

On a scale of 1-10 (10 being the worst), estimate the level of stress you feel due to infertility and other pressures _____

Do you see a counselor? ☐ No ☐ Yes – For how long? _____ How often? _____

List any antidepressant/antianxiety medications you are currently taking: _____

Describe any emotional, marital or sexual problems caused by your infertility: _____

PATIENT'S SIGNATURE _____ DATE _____

I confirm that I have reviewed the information above.

PHYSICIAN'S SIGNATURE _____ DATE _____