Northwestern Medicine®
Fertility and Reproductive Medicine

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HEALTH HISTORY

If you need help filling out this form, please contact us and we will have someone help you. You may be asked to come in ½ hour earlier than your scheduled appointment to answer your questions.

IDENTIFYING INFORMATION

Date: _____

Patient Legal Name: Last name: _____ First Name: _____ Middle Initial: _____

Partner Legal Name (if applicable): Last name: _____ First Name: _____ Middle Initial: _____

PATIENT:

Patient Age: _____

Date of Birth: _____

Sex Assigned at Birth: Male Female Intersex Decline to state

Gender Identity: Male Female Other: _____

Name by which you wish to be addressed: _____

Height: Feet: _____ Inches: _____

Current Weight (lbs): _____

Cell Phone: _____

Work Phone: _____

E-mail Address: _____

PARTNER (IF APPLICABLE):

Partner Age: _____

Date of Birth: _____

Sex Assigned at Birth: Male Female Intersex Decline to state

Gender Identity: Male Female Other: _____

Name by which you wish to be addressed: _____

Height: Feet: _____ Inches: _____

Current Weight (lbs): _____

Cell Phone: _____

Work Phone: _____

E-mail Address: _____

ETHNICITY (PLEASE MARK ALL THAT APPLY)

PATIENT

- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black/African American
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White/Caucasian
- ☐ Other: _____
- ☐ Unknown

PARTNER (IF APPLICABLE)

- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black/African American
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White/Caucasian
- ☐ Other: _____
- ☐ Unknown

Additional identity information:

Pharmacy Name and Phone Number: _____

( ) _____

Chief Complaint (reason for visit): _____

***If* Infertility, duration (years):** _____

Brief Menstrual/Obstetrical history of the intended mother (if applicable):

Menstrual Cycles: Age of first menses: _____ Cycles are: Regular Irregular Cycle occurs every _____ days

Obstetrical History: Number of total pregnancies: _____ Number of live births: (<37 weeks): _____ (=/>37 weeks): _____

Number of living children: _____ Number of induced abortions: _____ Number of miscarriages: ___

Number of ectopic pregnancies: ____ Number of biochemical pregnancies: ____ Number of still births: _____

Number of total previously completed IVF cycles: Fresh: _____ Thaw/Frozen: _____

Form Completed By: _____

BASIC INFORMATION

Who referred you? _____

Who is your gynecologist (if applicable)? _____

What is your occupation? _____

Are you
- ❒ married (date)_____
- ❒ single
- ❒ long-term relationship
- ❒ other:_____

How many years have you been with your present partner? _____

What is your partner's occupation? _____

HEALTH STATUS

Do you have any allergies to any medicines? _____

What are the allergic reactions to the medications? _____

Do you take any current medications? _____

PAST MEDICAL HISTORY

Do you have antibiotic therapy before dental work or a surgical procedure to protect your heart? ❒ yes ❒ no

Do you have a history of clots in your legs or lungs? ❒ yes ❒ no

Have you had a stroke or heart attack? ❒ yes ❒ no

Have you ever taken gender affirming hormones? ❒ yes ❒ no

Have you ever been told you had any of the following?

Anemia ❒ yes ❒ no

Bleeding tendency ❒ yes ❒ no

Prior blood transfusion ❒ yes ❒ no

Lung disease ❒ yes ❒ no

Heart disease ❒ yes ❒ no

High blood pressure ❒ yes ❒ no

Cancer ❒ yes ❒ no

If yes, type and treatment _____

Chronic headaches ❒ yes ❒ no

Seizures ❒ yes ❒ no

Depression ❒ yes ❒ no

Diabetes ❒ yes ❒ no

Thyroid disease ❒ yes ❒ no

Gall bladder disease ❒ yes ❒ no

Stomach reflux (GERD) ❒ yes ❒ no

Irritable bowel syndrome ❒ yes ❒ no

Liver disease/Hepatitis ❒ yes ❒ no

Infection in your kidneys/bladder ❒ yes ❒ no

PREVIOUS HOSPITALIZATIONS OR SURGERIES

Please list any time you were in the hospital, the reason, and the year; list all your surgeries as well.

_____

SOCIAL HISTORY

Do you smoke? ..... ❒ yes ❒ no

If yes, how many cigarettes per day? _____

Do you drink caffeine? ..... ❒ yes ❒ no

If yes, how many cups per day? _____

Do you drink alcohol? ..... ❒ yes ❒ no

If yes, how many drinks per week? _____

Do you take recreational drugs? ..... ❒ yes ❒ no

Do you exercise? ..... ❒ yes ❒ no

If yes, how many hours per week? _____

FAMILY HISTORY

	Age	Living	# of miscarriages	Cancer	Chromosomal	Diabetes	High blood pressure
Mother		❒ yes ❒ no		❒ yes ❒ no	❒ yes ❒ no	❒ yes ❒ no	❒ yes ❒ no
Father		❒ yes ❒ no		❒ yes ❒ no	❒ yes ❒ no	❒ yes ❒ no	❒ yes ❒ no
Sister		❒ yes ❒ no		❒ yes ❒ no	❒ yes ❒ no	❒ yes ❒ no	❒ yes ❒ no
Sister		❒ yes ❒ no		❒ yes ❒ no	❒ yes ❒ no	❒ yes ❒ no	❒ yes ❒ no
Brother		❒ yes ❒ no		❒ yes ❒ no	❒ yes ❒ no	❒ yes ❒ no	❒ yes ❒ no
Brother		❒ yes ❒ no		❒ yes ❒ no	❒ yes ❒ no	❒ yes ❒ no	❒ yes ❒ no

PARTNER'S HISTORY (if applicable)

Has your partner had any pregnancies with another partner? ..... ❒ yes ❒ no

Does your partner use recreational drugs? ..... ❒ yes ❒ no

Does your partner smoke or use tobacco? ..... ❒ yes ❒ no

Does your partner drink alcohol? ..... ❒ yes ❒ no

Drinks per week: ..... _____

Drinks per month: ..... _____

Has your partner ever had a sexually transmitted disease? ..... ❒ yes ❒ no

Is your partner allergic to any medications? ..... ❒ yes ❒ no

What medicines does your partner now take? ..... _____

REVIEW OF SYSTEMS

Do you have any of the following:

Fever	❒ yes	❒ no	Cough	❒ yes	❒ no
Chills	❒ yes	❒ no	Coughing up phlegm	❒ yes	❒ no
Sweats	❒ yes	❒ no	Coughing up blood	❒ yes	❒ no
Loss of appetite	❒ yes	❒ no	Wheezing	❒ yes	❒ no
Tiredness	❒ yes	❒ no	Nausea	❒ yes	❒ no
Weight change	❒ yes	❒ no	Vomiting	❒ yes	❒ no
Blurred vision	❒ yes	❒ no	Diarrhea	❒ yes	❒ no
Double vision	❒ yes	❒ no	Constipation	❒ yes	❒ no
Burning eyes	❒ yes	❒ no	Change in bowel habits	❒ yes	❒ no
Discharge from your eyes	❒ yes	❒ no	Abdominal pain	❒ yes	❒ no
Loss of vision	❒ yes	❒ no	Blood in your stools	❒ yes	❒ no
Eye pain	❒ yes	❒ no	Black stools	❒ yes	❒ no
Pain with bright lights	❒ yes	❒ no	Yellow skin	❒ yes	❒ no
Ear pain	❒ yes	❒ no	Yellow eyes	❒ yes	❒ no
Ear discharge	❒ yes	❒ no	Vaginal discharge	❒ yes	❒ no
Ringing in your ears	❒ yes	❒ no	Loss of urine	❒ yes	❒ no
Decreased hearing	❒ yes	❒ no	Painful urine	❒ yes	❒ no
Blockage of your nose	❒ yes	❒ no	Blood in your urine	❒ yes	❒ no
Nosebleeds	❒ yes	❒ no	Frequent/excessive urination	❒ yes	❒ no
Sore throat	❒ yes	❒ no	No menstrual periods	❒ yes	❒ no
Hoarseness	❒ yes	❒ no	Abnormal vaginal bleeding	❒ yes	❒ no
Difficulty swallowing	❒ yes	❒ no	Pelvic pain	❒ yes	❒ no
Chest pain	❒ yes	❒ no	Back pain	❒ yes	❒ no
Fast heartbeat	❒ yes	❒ no	Joint pain	❒ yes	❒ no
Fainting	❒ yes	❒ no	Joint swelling	❒ yes	❒ no
Difficulty breathing	❒ yes	❒ no	Muscle cramps	❒ yes	❒ no
Difficulty breathing while you're laying down	❒ yes	❒ no	Muscle weakness	❒ yes	❒ no
Swelling of your feet or hands	❒ yes	❒ no	Stiffness or pain in your joints	❒ yes	❒ no
Itching	❒ yes	❒ no	Paranoia	❒ yes	❒ no
Rash	❒ yes	❒ no	Cold intolerance	❒ yes	❒ no
Dryness	❒ yes	❒ no	Heat intolerance	❒ yes	❒ no
Suspicious lesions on skin	❒ yes	❒ no	Excessive drinking	❒ yes	❒ no
Unable to move arms or legs	❒ yes	❒ no	Excessive eating	❒ yes	❒ no
Seizures	❒ yes	❒ no	Abnormal bruising	❒ yes	❒ no
Shaking	❒ yes	❒ no	Enlarged lymph nodes	❒ yes	❒ no
Dizziness	❒ yes	❒ no	Hives	❒ yes	❒ no
Depression	❒ yes	❒ no	Hayfever	❒ yes	❒ no
Anxiety/nervous condition	❒ yes	❒ no	Persistent infections	❒ yes	❒ no
Memory loss	❒ yes	❒ no	HIV exposure	❒ yes	❒ no

Mental illness…….. ❒ yes ❒ no | Hallucinations……. ❒ yes ❒ no

Suicidal thoughts……. ❒ yes ❒ no

BACKGROUND INFORMATION

1. Have you ever **had** or **been vaccinated** for Chicken Pox? ..... ❒ yes ❒ no
2. Have you ever **had** or **been vaccinated** for Hepatitis? ..... ❒ yes ❒ no
3. Have you ever **had** or **been vaccinated** for Rubella (German measles)?..... ❒ yes ❒ no
4. Do you or your partner or any family member have a birth defect? ..... ❒ yes ❒ no

   If yes, who has the defect and what is it? _____
5. Have any of your or your partner's previous pregnancies, if any, resulted in a birth defect? . ❒ yes ❒ no

   If yes, what was the defect? _____
6. Do you or your partner or any family member have Cystic Fibrosis? ❒ yes ❒ no

   If yes, who has cystic fibrosis? _____
7. Do you or your partner or any family member have Down Syndrome? ❒ yes ❒ no

   If yes, who has Down Syndrome? _____
8. Do you or your partner or any family member have hemophilia? ❒ yes ❒ no

   If yes, who has hemophilia? _____
9. Do you or your partner or any family member have Muscular Dystrophy? ❒ yes ❒ no

   If yes, who has Muscular Dystrophy? _____
10. Do you or your partner or any family member have a neural tube defect? ❒ yes ❒ no

    If yes, who has the defect and what is it? _____
11. Do you or your partner or any family member have any other chromosomal abnormalities? ❒ yes ❒ no

    If yes, who has the abnormality and what is it? _____
12. Do you or your partner or any family member have mental retardation? ❒ yes ❒ no

    If yes, who has mental retardation? _____
13. Are you or your partner of Ashkenazi Jewish ancestry? ❒ myself ❒ partner ❒ both

    If yes, have you/partner been screened for Tay-Sachs disease? ❒ yes ❒ no

    Cystic Fibrosis? ❒ yes ❒ no

    If yes, indicate who and the results: _____
14. Are you or your partner black? ❒ myself ❒ partner ❒ both

    If yes, have you/partner been screened for sickle cell? ❒ yes ❒ no

    If yes, indicate who and the results: _____
15. Are you or your partner of French-Canadian ancestry? ❒ myself ❒ partner ❒ both

    If yes, have you/partner been screened for Tay-Sachs disease? ❒ yes ❒ no

    Cystic Fibrosis? ❒ yes ❒ no

    If yes, indicate who and the results: _____
16. Are you or your partner of Italian, Greek, Portuguese or Mediterranean background? ❒ myself ❒ partner ❒ both

    If yes, have you/partner been tested for ß-thalaseemia? ❒ yes ❒ no

    If yes, indicate who and the results: _____
17. Are you or your partner of Philippine, Southeast Asian, or Indian ancestry? ❒ myself ❒ partner ❒ both

    If yes, have you/partner been screened for α-thalaseemia? ❒ yes ❒ no

    If yes, indicate who and the results: _____

PLEASE COMPLETE THIS SECTION IF YOUR ASSIGNED SEX AT BIRTH WAS FEMALE
(Please skip to the next section if your assigned sex at birth was male**):**

MENSTRUAL HISTORY

What was your last menstrual period? _____

How many days are there typically between the first day of one period and the first day of the next period? _____

Would you describe your periods as: ..... ❒ heavy ❒ moderate ❒ light

Are your periods: ..... ❒ regular ❒ irregular

Are your periods painful? ..... ❒ yes ❒ no

Would you describe that pain as:..... ❒ moderate ❒ severe ❒ mild

GYNECOLOGIC HISTORY

Do you have hair on your face that is concerning? ..... ❒ yes ❒ no

Do you have acne? ..... ❒ yes ❒ no

Do you use lubricants for vaginal sex? ..... ❒ yes ❒ no

Do you have pain with intercourse? ..... ❒ yes ❒ no

Have you ever had an abnormal pap smear? ..... ❒ yes ❒ no

Have you had a pelvic infection? ..... ❒ yes ❒ no

Have you had any sexually transmitted diseases? ..... ❒ yes ❒ no

Have you ever used any contraception? ..... ❒ yes ❒ no

If yes, please check: ❒ oral contraceptives ❒ IUD ❒ condoms ❒ other: _____

How often do you have sex?

OBSTETRICAL HISTORY

How many times have you been pregnant? _____

For each pregnancy, please fill in the following chart:

	#1	#2	**#3**	**#4**
Month/year pregnancy ended				
Pregnancy outcome (circle)	Vaginal delivery C-section Miscarriage (# of weeks: __) Termination Ectopic/Tubal	Vaginal delivery C-section Miscarriage (# of weeks: __) Termination Ectopic/Tubal	Vaginal delivery C-section Miscarriage (# of weeks: __) Termination Ectopic/Tubal	Vaginal delivery C-section Miscarriage (# of weeks: __) Termination Ectopic/Tubal
With current partner?	❒ yes ❒ no	❒ yes ❒ no	❒ yes ❒ no	❒ yes ❒ no
Time it took to get pregnant?				
Used Fertility Treatment?				
Sex of Baby	❒ male ❒ female	❒ male ❒ female	❒ male ❒ female	❒ male ❒ female
Weight of Baby				
Pregnancy complications	❒ yes ❒ no	❒ yes ❒ no	❒ yes ❒ no	❒ yes ❒ no

Have you used any of the following, please check:

❒ Basal body temp monitoring ❒ Ovulation predictor kit ❒ Clomiphene ❒ Femara/Letrozole ❒ Gonadotropins (fertility shots)

❒ In Vitro Fertilization ❒ Artificial insemination: ❒ partner sperm ❒ donor sperm

Have you ever had an x-ray (HSG) of your uterus and tubes? ..... ❒ yes ❒ no

If yes, where was it done? _____

What were the results? _____

Have you ever had a sonohysterogram (ultrasound with saline) of your uterus and tubes?

If yes, where was it done? _____

What were the results? _____

Has your partner had a semen analysis? ❒ yes ❒ no ❒ N/A

If yes, what were the results? _____

GYNECOLOGIC SURGERY

If you have had any of the following, please list the dates:		**Date**
Tubes and ovaries removed	❒ yes ❒ no	
D&C; cone	❒ yes ❒ no	
D&C, Leep	❒ yes ❒ no	
Treatment of endometriosis, medical or surgical	❒ yes ❒ no	
Hysteroscopy (view inside of uterus)	❒ yes ❒ no	
Laparoscopy (view inside abdominal cavity and pelvis)	❒ yes ❒ no	
Lysis of adhesions (scar tissue removal)	❒ yes ❒ no	
Fibroid removal	❒ yes ❒ no	
Hysterectomy (uterus removal)	❒ yes ❒ no	
Cutting of a uterine septum	❒ yes ❒ no	
Tubal ligation	❒ yes ❒ no	
Tubal ligation reversal	❒ yes ❒ no	

PLEASE COMPLETE THIS SECTION IF YOUR ASSIGNED SEX AT BIRTH WAS MALE

UROLOGICAL/FERTILITY HISTORY

At what age did you begin shaving? ☐ Under 12 ☐ 12-14 ☐ 15-17 ☐ 18-20 ☐ over 20

How would you describe your beard growth? ☐ Light ☐ Medium ☐ Heavy

Compared to other men in your family? ☐ Light ☐ Medium ☐ Heavy

Type of Underwear Worn: ☐ Boxer Shorts ☐ Jockeys ☐ Other:_____

Are you circumcised? ❒ yes ❒ no If NO, does the foreskin retract easily? ❒ yes ❒ no

Have you ever been treated for gonorrhea, syphilis, prostatitis or infection of the testicles and/or seminal vesicles? ❒ yes ❒ no

Any history of hernia repair (including shortly after birth)? ..... ❒ yes ❒ no

If YES, when? _____

History of Mumps? ..... ❒ yes ❒ no

If YES, when? _____

History of undescended testes? ..... ❒ yes ❒ no

History of injury to the testes? ..... ❒ yes ❒ no

History or diagnosis of varicocele (varicose vein in scrotum)? ..... ❒ yes ❒ no

☐ If YES, has this been treated? If so, when? _____

History of genitourinary infection? ..... ❒ yes ❒ no

Has there been a recent change in libido or sexual drive? ..... ❒ yes ❒ no

Do you have difficulty maintaining an erection? ..... ❒ yes ❒ no

If applicable, do have difficulty ejaculating in the vagina? ..... ❒ yes ❒ no

Has a doctor ever told you that you were infertile? ..... ❒ yes ❒ no

Has a semen analysis ever been performed? ..... ❒ yes ❒ no

☐ If YES – When?_____ Where? _____ Results? _____

Have fathered a child outside this relationship? ..... ❒ yes ❒ no

Have you ever doubted your fertility outside this relationship? ..... ❒ yes ❒ no

Any history of treatment to promote fertility in the past? ..... ❒ yes ❒ no

☐ If YES, please explain: _____

Has artificial insemination ever been suggested to achieve pregnancy? ..... ❒ yes ❒ no

☐ If YES, ☐ with YOUR Sperm? ☐ with DONOR Sperm?

Have you ever been employed in an occupation with sustained high temperatures? ..... ❒ yes ❒ no

Have you ever been a professional driver or do you drive long distances as part of your job? ..... ❒ yes ❒ no

History of recent hospitalization or prolonged bed rest? ..... ❒ yes ❒ no

History of hot baths, sauna or steam baths? ..... ❒ yes ❒ no

Are you an IV drug user? ..... ❒ yes ❒ no

Have you ever had sex with an IV drug user? ..... ❒ yes ❒ no

Have you ever had sex with a homosexual or bisexual person? ..... ❒ yes ❒ no

Are you at risk for AIDS? ..... ❒ yes ❒ no

Total number of sexual partners: _____