Northwestern Medicine®
Fertility and Reproductive Medicine

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HEALTH HISTORY - WOMEN

Date:___________________

Last Name | First Name | Middle Initial | Age | Date of Birth

Street Address | City | State | Zip

Home Phone | Work Phone | Cell Phone

Referring Physician | Office Phone | Your Religion

MEDICAL HISTORY (CURRENT & PAST)

Height:______________ Current Weight:_________ Highest Weight:______________ Lowest Weight:__________

Allergies:____ Reaction:____________________________

Current Medications/Vitamins/Supplements (Please include dose):

____

____

Surgical History (Please include name of surgery, date and where it was performed):

____

____

Current Use of Complementary Medicine (i.e. herbs, acupuncture, etc.):

____

____

Any history of blood transfusion? ....No Yes

HISTORY OF:

Anemia	No	Yes	Diarrhea	No	Yes	Kidney/Urine Infections	No	Yes
Anxiety	No	Yes	Eating Disorder	No	Yes	Lupus	No	Yes
Asthma	No	Yes	Emphysema	No	Yes	Pituitary Disease	No	Yes
Bipolar Disorder	No	Yes	Gallbladder Disease	No	Yes	Pneumonia	No	Yes
Blood Clot (in lung or leg)	No	Yes	Headaches	No	Yes	Psychosis	No	Yes
Cancer	No	Yes	Hepatitis A / B / C	No	Yes	Reflux/Indigestion	No	Yes
Colitis	No	Yes	Heart Murmur	No	Yes	Rheumatoid Arthritis	No	Yes
Constipation	No	Yes	High Blood Pressure	No	Yes	Seizures	No	Yes
Chickenpox/Vaccine	No	Yes	HIV/AIDS	No	Yes	Sleep Apnea	No	Yes
Depression	No	Yes	Hyper/Hypothyroid	No	Yes	Tuberculosis	No	Yes
Diabetes	No	Yes	Irritable Bowel Syndrome	No	Yes	Other	No	Yes

If you answered **YES**, please explain:

____

____

____

Continued on the other side →

FAMILY HISTORY

Breast Cancer	No	Yes	Early Menopause	No	Yes	Obesity	No	Yes
Colon Cancer	No	Yes	Heart Disease	No	Yes	Ovarian Cancer	No	Yes
Diabetes	No	Yes	High Blood Pressure	No	Yes	Other	No	Yes

If you answered **YES**, please explain:

____

____

GENETIC HISTORY

Your Ethnic Background:______________________ Your Partner's Ethnic Background:___________________________

Is there a history in your family or your partner's family of:

Bleeding Disorder	No	Yes	Hydrocephaly	No	Yes
Bone Disorder/Short Stature (<5ft)	No	Yes	Limb Defect	No	Yes
Chromosomal Abnormality	No	Yes	Mental Retardation	No	Yes
Cleft Lip/Palate	No	Yes	Muscular Dystrophy	No	Yes
Cystic Fibrosis	No	Yes	Sickle Cell	No	Yes
Down Syndrome	No	Yes	Spinal Bifida/Anencephaly	No	Yes
Fragile X Syndrome	No	Yes	Tay-Sachs	No	Yes
Genital Abnormality	No	Yes	Thalassemia	No	Yes
Heart Defect (as a child)	No	Yes	Other	No	Yes

FERTILITY HISTORY

If Partnered:

- Name of Partner:_________________________________
- Duration of marriage/relationship:____________________ (months/years)
- Duration of unprotected intercourse:__________________ (months/years)

Frequency of intercourse (per week):___________________ More during Midcycle/Ovulation? ....No Yes

Do you achieve orgasm? ☐Never ☐Sometimes ☐Usually ☐Always

Is intercourse painful to either you or your partner? ☐No ☐Yes – Self ☐Yes – Partner

*For a **MALE** partner – does he ejaculate during intercourse? .... ☐No ☐Yes

Are lubricants used?.......... ☐No ☐Yes (please specify:_________________________________)

Children from prior relationship? .... ☐No ☐Yes – Self ☐Yes - Partner

- How long to conceive?.......... ☐Self____________ ☐Partner____________

Do you have a history of:

Appendicitis	No	Yes	Excessive Hair Growth	No	Yes	Infertility Evaluation	No	Yes
Breast discharge	No	Yes	Gonorrhea	No	Yes	Infertility Treatment	No	Yes
Chlamydia Endometriosis	No	Yes	Hot Flashes	No	Yes			

OBSTETRIC & GYNECOLOGIC HISTORY

Total # of Pregnancies:_______ Term:______ Premature:______ Miscarriage:______ Abortion:_______ Living:_______

Complications of Pregnancy:____

Contraception: ☐Oral Pills ☐IUD ☐Other:________________ *Total # of months/years:_____________________

Menstrual History:

First Day of Last Period:________________ Duration of Flow:___________ Length of Cycle:____________

Heavy/Irregular Bleeding? .... No Yes | Pain with Menses? .... No Yes | Other Pelvic Pain? .... No Yes

Date of Last Pap:_________ Result?:__________ History of Abnormal Pap?:___________ Last Mammogram:______________

SOCIAL HISTORY

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐Domestic Partnership

Occupation: ☐Student ☐Retired ☐Disabled ☐Employed ☐Unemployed

- Name of occupation or school:____

Exercise (how often, duration, types of exercise):____

Dietary Habits (# of meals daily, # of fruit/vegetable servings, daily caloric intake):______________________

____

Do you smoke cigarettes/cigars? ☐Never ☐Current (packs per day:_________) ☐Past History (packs per day:________)

Do you drink alcohol?☐Never ☐Current (# of drinks weekly:______) ☐Past History (# of drinks weekly:_____)

Any History of:

☐IV Drug Use ☐Sex with IV Drug User ☐Sex with a homosexual/bisexual person ☐At Risk for HIV/AIDS

Total number of Lifetime Partners:___________________

If you have any history of or currently use Marijuana/Cocaine or other addictive drugs – Please tell the physician verbally