Northwestern Medicine®
Center for Fertility and Reproductive Medicine

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NEW PATIENT HEALTH HISTORY FORM

If you need help filling out this form, please contact us and we will have someone help you.

PATIENT INFORMATION

DATE: _____

Patient's Legal Name: _____

Preferred Name: _____

Pronoun (he/she/they): _____

Birth date (mm/dd/yyyy): _____ Age: _____

Biological Sex: _____

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

Height: Feet: _____ Inches: _____ Weight (lbs): _____

Home address: _____

City: _____ State: _____ Zip Code: _____

Indicate best number to call or leave messages:
Preferred phone: _____

Email Address: _____

Who referred you to us? _____

Who is your obstetrician/gynecologist (if applicable)? _____

PARTNER INFORMATION *(if applicable)*

Partner's Legal Name: _____

Preferred Name: _____

Pronoun (he/she/they): _____

Birth date (mm/dd/yyyy): _____ Age: _____

Biological Sex: _____

Ethnicity: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American

☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander ☐ White/Caucasion

☐ Other: _____ ☐ Unknown

Height: Feet: _____ Inches: _____ Weight (lbs): _____

Home address: _____

City: _____ State: _____ Zip Code: _____

Indicate best number to call or leave messages:
Preferred phone: _____

What are the goals of your visit today?

_____

_____

Have you been treated at another fertility practice? ☐ Yes ☐ No

Reason for leaving past practice: _____

What can we do differently at Northwestern? _____

INFERTILITY HISTORY

How long have you been trying to get pregnant? _____years _____months

Have you attempted pregnancy prior to this relationship? ☐ Yes ☐ No

PATIENT REPRODUCTIVE & SEXUAL HISTORY

MENSTRUAL HISTORY

Age of first period: _____ Date of first day of last menstrual period: _____

How many days does bleeding last? _____

Cycle length (Number of days between day 1 of one cycle and day 1 of next cycle: _____

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: ☐ Mild ☐ Moderate ☐ Severe

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

Do you bleed between periods? ☐ Yes ☐ No

GYNECOLOGIC HISTORY

Do you have hair on your face? ☐ Yes ☐ No

Do you have acne? ☐ Yes ☐ No

Do you use lubricants for vaginal sex? ☐ Yes ☐ No

Do you have pain during or after intercourse? ☐ Yes ☐ No

Do you bleed during or after intercourse? ☐ Yes ☐ No

Have you had an abnormal Pap Smear? ☐ Yes – When?_____ ☐ No

Have you had an abnormal mammogram? ☐ Yes – When?_____ ☐ No

Have you had any sexually transmitted infections? ☐ Yes ☐ No

If yes, which and when?_____

Have you had a pelvic infection? ☐ Yes ☐ No

Have you ever used any contraception? ☐ Yes ☐ No

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

Are you currently sexually active? ☐ Yes ☐ No

What is the frequency of intercourse per week?_____

Have you experienced physical/sexual abuse? ☐ Yes ☐ No

If you answered, do you wish to discuss this? ☐ Yes ☐ No

PREGNANCY HISTORY *(if applicable)*

Pregnancy	Year	Time to conceive	Length of pregnancy (weeks)	Sex	Baby's name	Birth weight	Outcome (e.g. miscarriage, ectopic, abortion, vaginal delivery, C-section)	Pregnancy Complications
1								

2								
3								
4								

PRIOR FERTILITY EVALUATION *(if applicable)*

Semen Analysis	☐ Yes ☐ No	Result/date:
HSG (X-ray of tubes)	☐ Yes ☐ No	Result/date:
Ovulation Predictor	☐ Yes ☐ No	Result/date:
Pelvic Ultrasounds	☐ Yes ☐ No	Result/date:
TSH	☐ Yes ☐ No	Result/date:
Day 3 FSH, Estradiol	☐ Yes ☐ No	Result/date:
AMH	☐ Yes ☐ No	Result/date:

GYNECOLOGIC SURGERY

Year	Physician	Hospital	Surgery and Findings

MEDICATION REVIEW *(including prescriptions, supplements, herbs, vitamins)*

Name of medication	Strength/dose	Frequency taken	Reason for taking

ALLERGIES TO MEDICATIONS

Medication	Reaction

PAST MEDICAL HISTORY

Have you ever had or been diagnosed with any of the following?

Anemia	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Bleeding tendency	☐ Yes ☐ No	Thyroid disease	☐ Yes ☐ No
Blood transfusion	☐ Yes ☐ No	Lung disease	☐ Yes ☐ No
High blood pressure	☐ Yes ☐ No	Irritable bowel syndrome	☐ Yes ☐ No
Migraines with aura	☐ Yes ☐ No	Liver disease/Hepatitis	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Blood clots	☐ Yes ☐ No
Anxiety	☐ Yes ☐ No	Heart disease	☐ Yes ☐ No
Obesity	☐ Yes ☐ No	Cancer:	☐ Yes ☐ No
Eating disorder	☐ Yes ☐ No	Other:	

SURGICAL HISTORY (*non gynecologic)*

Year	Type of surgery	Reason for surgery

Did you have any problems with anesthesia? ☐ Yes ☐ No

FAMILY HISTORY

	Self	Father	Mother	Brothers	Sisters	Sons	Daughters	Grandparents	Partner
Birth Defect	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cystic Fibrosis	☐	☐	☐	☐	☐	☐	☐	☐	☐
Down Syndrome	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hemophilia	☐	☐	☐	☐	☐	☐	☐	☐	☐
Muscular Dystrophy	☐	☐	☐	☐	☐	☐	☐	☐	☐
Neural Tube Defect	☐	☐	☐	☐	☐	☐	☐	☐	☐
Chromosomal Abnormalities	☐	☐	☐	☐	☐	☐	☐	☐	☐
Miscarriages	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mental Retardation	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid problems	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Blood clots	☐	☐	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychiatric conditions	☐	☐	☐	☐	☐	☐	☐	☐	☐

Infertility	☐	☐	☐	☐	☐	☐	☐	☐	☐
Menopause before age 40	☐	☐	☐	☐	☐	☐	☐	☐	☐
Neurologic (brain/spine)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	☐	☐	☐
Gallstones	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐	☐	☐	☐
Endometriosis	☐	☐	☐	☐	☐	☐	☐	☐	☐
Genetic Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Irritable Bowel Syndrome	☐	☐	☐	☐	☐	☐	☐	☐	☐

Are you or your partner of Ashkenazi Jewish ancestry? ☐ Myself ☐ Partner ☐ Both

If yes, have you/partner had genetic carrier screening? ☐ Yes ☐ No

If yes, indicate who and the results: _____

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: _____

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

If yes, indicate who and the results: _____

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: _____

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: _____

SOCIAL HISTORY

How many caffeinated beverages (coffee, tea, soda) do you drink per day?

☐ Yes – How many/day? _____ ☐ None

Do you smoke cigarettes? ☐ Yes – How many/day? ____ ☐ Quit, year: ____ ☐ No

Do you drink alcohol? ☐ Yes – How many drinks per week? _____ ☐ No

Do you take recreational drugs? ☐ Yes ☐ No

Do you exercise? ☐ Yes – How many hours per week? _____ ☐ No

Do you feel safe in your own home? ☐ Yes ☐ No – Explain _____

Do you have a therapist/counselor who provides you with support? _____

REVIEW OF SYSTEMS (check any that you are experiencing currently)

General ☐None	**Head, Eyes, Ears, Nose, & Throat** ☐None	**Respiratory** ☐None
☐Recent weight changes (☐gain ☐loss) ☐Anorexia/Bulimia ☐Lack of energy ☐Fever/Chills ☐Other:	☐Dizziness ☐Loss of sense of smell ☐Headaches ☐Ringing ears ☐Chronic nasal congestion ☐Blurred vision ☐Hearing loss/deafness ☐Other:	☐Shortness of breath ☐Bronchitis ☐Bloody cough ☐Other:
Endocrine/Hormonal ☐None	**Breasts** ☐None	**Neurological Problems** ☐None
☐Hair loss ☐Thyroid gland problems ☐Rapid weight change ☐Excessive hunger/thirst ☐Temperature intolerance (hot flashes or feeling cold) ☐Other:	☐Discharge (☐clear ☐bloody ☐milky) ☐Lumps ☐Pain ☐Cancer ☐Abnormal mammogram ☐Reduction ☐Augmentation/Breast implants (☐saline ☐silicone) ☐Other:	☐Weakness/Loss of balance ☐Seizures/Epilepsy ☐Headaches ☐Migraine headaches ☐Numbness ☐Memory loss ☐Other:
Gastrointestinal ☐None	**Genito-Urinary** ☐None	**Skin/Extremities** ☐None
☐Nausea/Vomiting ☐Ulcers ☐Blood in your stools ☐Constipation ☐Diarrhea ☐Change in bowel habits ☐Colitis (ulcerative or Crohn's) ☐Other:	☐Bladder infections ☐Kidney infections ☐Vaginal infections ☐Frequent urination ☐Leaking urine ☐Blood in the urine ☐Herpes ☐Other:	☐Unexplained rash/inflammation ☐Acne ☐Skin cancer ☐Burn injury ☐Moles changing in appearance ☐Excess hair growth ☐Other:
Musculoskeletal ☐None	**Hematologic** ☐None	**Cardiovascular** ☐None
☐Unusual muscle weakness ☐Decreased energy/stamina ☐Other:	☐Blood clotting disorder/Blood clot ☐Sickle Cell Anemia ☐Easy bruising ☐Thrombophlebitis ☐Swollen glands/lymph nodes ☐Blood transfusions (dates/reasons) ☐Other:	☐Palpitations/Skipped beats ☐Chest pain ☐Heart attack ☐Murmurs ☐Rheumatic fever
Mental Health Problems ☐None	**Other** ☐	
☐Depression ☐Anxiety ☐Schizophrenia ☐Other:		

PARTNER MEDICAL HISTORY

MEDICATION REVIEW *(including prescriptions, supplements, herbs, vitamins)*

Name of medication	Strength/dose	Frequency taken	Reason for taking

ALLERGIES TO MEDICATIONS

Medication	Reaction

PAST MEDICAL HISTORY **Have you ever had or been diagnosed with any of the following?**

Anemia	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Bleeding tendency	☐ Yes ☐ No	Thyroid disease	☐ Yes ☐ No
Blood transfusion	☐ Yes ☐ No	Lung disease	☐ Yes ☐ No
High blood pressure	☐ Yes ☐ No	Irritable bowel syndrome	☐ Yes ☐ No
Migraines with aura	☐ Yes ☐ No	Liver disease/Hepatitis	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Blood clots	☐ Yes ☐ No
Anxiety	☐ Yes ☐ No	Heart disease	☐ Yes ☐ No
Obesity	☐ Yes ☐ No	Cancer:	☐ Yes ☐ No
Eating disorder	☐ Yes ☐ No	Other:	

SURGICAL HISTORY

Year	Type of surgery	Reason for surgery

SOCIAL HISTORY

How many caffeinated beverages (coffee, tea, soda) do you drink per day?

☐ Yes – How many/day?_____ ☐ None

Do you smoke cigarettes? ☐ Yes – How many/day?____ ☐ Quit, year:____ ☐ No

Do you drink alcohol? ☐ Yes – How many drinks per week?_____ ☐ No

Do you use marijuana? ☐ Yes ☐ No

Do you use other drugs? ☐ Yes ☐ No

Do you have a therapist/counselor who provides you with support?

FOR MALE PARTNERS

PREGNANCY SUMMARY

Have you been responsible for a previous pregnancy? ☐ No ☐ Yes – Total # of pregnancies: _____

List dates: _____

Has a doctor ever told you that you were infertile? ☐ Yes ☐ No

Have you had a semen analysis? ☐ Yes (if yes, please answer below) ☐ No

Prior test results (volume, count, motility, morphology): _____

Prior treatment & results: _____

SEXUAL HISTORY

Do you have difficulty achieving or sustaining an erection? ☐ Yes ☐ No

Do you have difficulty ejaculating? ☐ Yes ☐ No

Do you have (or have you had) a loss/change of libido (sex drive)? ☐ Yes ☐ No

Do you have or have you had any of the following? ☐ Yes (check all that apply) ☐ No

☐ Mumps ☐ Varicocele ☐ Undescended testes ☐ Genital surgery

☐ Testicular torsion/trauma

UROLOGICAL HISTORY

At what age did you begin shaving? _____

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 ☐ Briefs Boxer Briefs: _____

Are you circumcised? ☐ Yes ☐ No

Any history of the following?

Prostatitis	☐ Yes	☐ No
Epididymitis	☐ Yes	☐ No
Orchitis	☐ Yes	☐ No
Previous vasectomy	☐ Yes	☐ No
Testicular tumor	☐ Yes	☐ No
Gonorrhea	☐ Yes	☐ No
Chlamydia	☐ Yes	☐ No
Syphilis	☐ Yes	☐ No
Exposure to chemicals	☐ Yes	☐ No
Exposure to toxic substances	☐ Yes	☐ No
Exposure to high temperatures	☐ Yes	☐ No

FOR FEMALE PARTNERS

PREGNANCY HISTORY *(if applicable)*

Pregnancy	Year	Time to Conceive	Length of Pregnancy (weeks)	Sex	Baby Name	Birth weight	Outcome (e.g. miscarriage, ectopic, abortion, vaginal delivery, C-section)	Pregnancy Complications
1								
2								
3								
4								

MENSTRUAL HISTORY

Age of first periods: _____

Date of first day of last menstrual period: _____

How many days does bleeding last? _____

Cycle length (Number of days between day 1 of one cycle and day 1 of next cycle: _____

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: ☐ Mild ☐ Moderate ☐ Severe

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

Do you bleed between periods? ☐ Yes ☐ No

GYNECOLOGIC HISTORY

Do you have hair on your face? ☐ Yes ☐ No

Do you have acne? ☐ Yes ☐ No

Do you use lubricants for vaginal sex? ☐ Yes ☐ No

Do you have pain during or after intercourse? ☐ Yes ☐ No

Do you bleed during or after intercourse? ☐ Yes ☐ No

Have you had an abnormal Pap Smear? ☐ Yes – When?_____ ☐ No

Have you had an abnormal mammogram? ☐ Yes – When?_____ ☐ No

Have you had any sexually transmitted infections? ☐ Yes ☐ No

If yes, which and when?_____

Have you had a pelvic infection? ☐ Yes ☐ No

Have you ever used any contraception? ☐ Yes ☐ No

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

Are you currently sexually active? ☐ Yes ☐ No

What is the frequency of intercourse per week?_____

Have you experienced physical/sexual abuse? ☐ Yes ☐ No

If you answered, do you wish to discuss this? ☐ Yes ☐ No

Is there anything else you would like us to know?

_____

_____

_____