Advanced Reproductive Center

Medical History (Female / Female Gender at Birth)

Please fill in as completely as possible

Name: _____ Age:_____ Date: _____

Current OB/GYN? (or indicate n/a) _____

What is the reason for your appointment today? _____

How did you hear about our clinic? _____

Check any of the below that apply to you:

- ☐ Irregular menstrual periods LEEP, cone biopsy or any surgery on your cervix
- ☐ Chlamydia, gonorrhea or other sexually transmitted disease
- ☐ Uterine problems such as polyps
- ☐ Breast masses or lumps
- ☐ Endometriosis
- ☐ Urinary problems
- ☐ Fibroids
- ☐ Abnormal pap smear
- ☐ Surgery or problems with your fallopian tubes
- ☐ Pelvic inflammatory disease
- ☐ Bleeding between periods
- ☐ Bleeding with intercourse
- ☐ Nipple discharge
- ☐ Heavy menstrual periods
- ☐ Hot flashes
- ☐ Vaginal discharge or infections

Any additional information regarding the above:

Menstrual History

Day one of you last menstrual period_____ Date of last pap_____
Age at onset of first menstrual period_____
Frequency of menstrual periods (e.g. every 26-30 days) _____
Duration of bleeding (e.g. 3-4 days) _____
Do you experience pain with your menstrual cycles? _____
Do you experience pain with intercourse? _____

Relationship History

Are you legally married? ◯ Y ◯ N
How long have you been trying to get pregnant?_____
Any difficulty conceiving with prior pregnancies? _____
Frequency of intercourse (per month) _____

Name_____

Pregnancy History

Have you had a previous pregnancy? ◯ Y ◯ N

Date	Outcome (e.g. vaginal delivery, c section, ectopic, miscarriage, termination)	Male or female	Any complications or health issues with the pregnancy or delivery?	Any health issues with the child?	Was the pregnancy with your current partner?

Any additional information about your past pregnancies:

Previous infertility testing and/or treatment

If you have had previous infertility testing and/or treatment please have those records forward to our office before your appointment.

Have you had any previous infertility testing and/or treatment? ◯ Y ◯ N

Test	Date(s)	Normal or abnormal	If abnormal, describe result
Hormone levels (usually FSH, LH and estrogen)			
AMH level			
HSG (tube test)			
Pelvic ultrasound			
Hysteroscopy (uterine evaluation with a camera)			
SIS (saline contrast ultrasound)			
Any other fertility testing:			

Name:_____

Infertility treatment:

Treatment type (e.g. clomid, injectables, insemination, IVF, etc.)	Number of cycles (months)	Medication dose	Cycle outcomes

Additional details regarding previous infertility testing and/or treatment:

Surgical history

Have you had any previous surgeries? ◯ Y ◯ N

Surgery	Date	Surgical findings	Complications, if any

Any additional details regarding previous surgeries:

Medical History

List any medical problems such as high blood pressure, cancer, diabetes, asthma, arthritis, migraine headaches, thyroid problems, heart disease etc. or indicate N/A

Name:_____

Family History

Do you have any known family medical history, such as, high blood pressure, cancer, diabetes, asthma, arthritis, etc. ◯ Y ◯ N

Medical Problem	Family member(s) affected (e.g. mom, maternal grandmother, sister etc.)

Is there a history of infertility or multiple miscarriages in your family? ◯ Y ◯ N

Describe any additional details regarding a family history of medical problems:

Medications

Are you currently taking medications, including vitamins/herbal? ◯ Y ◯ N

Medication	Dose and frequency (e.g. 20 mg 3 times a day)	Reason
	medications:	

Allergies:

_____

Any additional details regarding current medications or allergies:

_____

Social History

Do you smoke? ◯ Y ◯ N
If so, how many years have you smoked? _____ and
How many cigarettes do you smoke a day?_____

Do you drink alcohol? ◯ Y ◯ N
If so how many alcoholic beverages do you drink per day? _____

Do you drink caffeinated beverages? ◯ Y ◯ N
If so what type of beverages? _____ and
How many caffeinated beverages do you drink a day? _____

Do you use any recreational drugs? ◯ Y ◯ N
If so what drugs do you use?_____ and
How often do you use them?_____

Name:_____

Background and Ethnicity

The American College of Obstetrics and Gynecology (ACOG) recommends evaluating women, depending on their ethnicity/background, for specific genetic diseases that they may be at higher risk for carrying and/or passing on to an offspring.

ACOG recommends a cystic fibrosis screen on all women who are trying to conceive. As with all tests the cystic fibrosis test is not perfect. Even if a woman tests negative, it is still possible (but unlikely) to have a child with cystic fibrosis.

In order to help individually tailor genetic screening, please answer the following questions:

Are there any genetic diseases that you or a family member are affected by or carry the trait for? ◯ Y ◯ N

If so what disease(s)? _____

Do you have a family history of intellectual disability or fragile X syndrome? ◯ Y ◯ N

Are you of Jewish Eastern European origin?_____

Are you of French Canadian and/or Cajun origin?_____

Are you of Mediterranean or Southeast Asian origin?_____

Are you of African or African American Origin?_____

Any additional details regarding genetic diseases:

Additional Information

Provide any additional information you want to share:

Signature:_____ Date:_____

To be completed by our Staff

Blood Pressure:_____Height:_____Weight:_____BMI:_____