Name ____Date of Birth______________ Age________

Obstetrical History

1. Have you ever been pregnant? ____
2. If yes, please give dates ____

Gynecological History

1. At what approximate age did you start menstruating? ________________________
2. How often do you have your menstrual cycle? _________________________________
3. If variable please give range from shortest time to longest time between menstrual cycles ____
4. How many days does your menstrual cycle last? ______________________________
5. Do you have any symptoms prior to your menstrual cycle? ___________________
6. Do you have any pain with your menstrual cycle? _____________________________
7. Have you ever checked to see if you ovulate? _________________________________
8. Have you used urine ovulation predictor kits? ________________________________
9. Have you ever used basal temperature charting? ______________________________
10. When was your last Pap smear? ____
11. Have you ever had an abnormal Pap smear that required treatment? If yes, what treatment did you have? ____
12. Have you ever been told you had a uterine infection? __________________________
13. Have you ever had surgery on your uterus? ___________________________________

Sexual History

1. How often on average do you have intercourse on a monthly basis? __________
2. Do you group intercourse according to your cycle? ___________________________
3. Have you ever experienced pain with intercourse? ____________________________
4. Do you lie flat after intercourse? ____
5. Do you use any lubricants with intercourse? __________________________________

Past Medical History

1. Do you have any medical problems? ____
   ____

Past Surgical History

1. Have you ever had any surgery? ____

   ____

Medications ____

Allergies to drugs/medications? ____

Social History

1. What is your occupation? ____
2. Does your job or life cause you stress? ______________________________________
3. Do you have problems sleeping? ____
4. Do you eat/drink caffeinated products? ____
5. Do you smoke and if so, how much? ____
6. Do you drink alcohol? ____
7. Do you exercise? ____
8. Have you ever had a significant change in weight, gain or loss? ________________

Family History

1. What medical problems exist in your family? ___________________________________

   ____

2. Did any of the women in your family have a hysterectomy (removal of the uterus)? ____
3. Did any of the women in your family have a problem getting pregnant? _______

   ____

4. Did any of the women in your family have a miscarriage? ______________________

   ____

Is there anything else that you think might be significant in your or your family history? ____

____

____

Partner Name ____ DOB ______________ Age _____

Past Medical History

1. Do you have any medical problems? ____

   ____

Past Surgical History

1. Have you ever had any surgery? ____

   ____

Medications ____

Allergies to drugs/medications? ____

Social History

1. What is your occupation? ____
2. Do you eat/drink caffeinated products? ______________________________________
3. Do you smoke and if so, how much? ____
4. Do you drink alcohol? ____
5. Do you exercise? ____
6. Have you ever had a significant change in weight, gain or loss? _______________

Family History

1. What medical problems exist in your family? ___________________________________

   ____

2. Did any of the men in your family have problems getting their partner pregnant? ____

Testicular Exposures

1. Any history of a testicular injury? ____
2. Did you have mumps after puberty? ____
3. Any toxin/chemical/radiation exposure? _______________________________________
4. Do you use a Jacuzzi/hot tub/sauna? ____
5. Do you wear boxers or briefs? ____
6. Do you place a laptop on your lap? ____
7. Do you use a car seat warmer? ____

8. Have you ever had a semen analysis and if so when and what was the result?
____
____
9. Have you ever seen an urologist? ____

Have you or your partner had any diagnostic procedure or treatment for infertility?

____
____
____
____
____
____
____

Thank you for taking the time to fill out this form. Please bring with you to your appointment.