

**Women's Clinic, Ltd.
Female History**

Patient: _____ Age: _____ Today's Date: _____

If married, which marriage for you? _____ Marriage date? _____

How long have you been sexually active with your current partner? _____

How long have you not prevented pregnancy? _____ Intercourse frequency? _____

Previous contraception used? _____

Please review the following questions. Give details for all positive responses.

Questions		Details of positive responses
Ever pregnant	<input type="checkbox"/> No	_____
How many times	<input type="checkbox"/> No	_____
Difficulty conceiving	<input type="checkbox"/> No	_____
Due to infertility treatment	<input type="checkbox"/> No	_____
Deliveries	<input type="checkbox"/> No	_____
Miscarriages	<input type="checkbox"/> No	_____
Tubal / ectopic pregnancy	<input type="checkbox"/> No	_____
Pregnancies by current partner	<input type="checkbox"/> No	_____
Children adopted out	<input type="checkbox"/> No	_____
Infertility in a previous relationship	<input type="checkbox"/> No	_____
Any adopted children	<input type="checkbox"/> No	_____
Change in menstrual periods	<input type="checkbox"/> No	_____
Spotting before &/or after periods	<input type="checkbox"/> No	_____
Worsening menstrual cramps	<input type="checkbox"/> No	_____
Cramps several days before period	<input type="checkbox"/> No	_____
Pain with intercourse	<input type="checkbox"/> No	_____
Bleeding after intercourse	<input type="checkbox"/> No	_____
Lubrication used with intercourse	<input type="checkbox"/> No	_____
Douche after intercourse	<input type="checkbox"/> No	_____
Sexual problems	<input type="checkbox"/> No	_____
Acne problem	<input type="checkbox"/> No	_____
Excessive hair growth	<input type="checkbox"/> No	_____
Significant weight gain or loss	<input type="checkbox"/> No	_____
More than occasional alcohol intake	<input type="checkbox"/> No	_____
Past / present recreational drug use	<input type="checkbox"/> No	_____
Previous partner who used drugs	<input type="checkbox"/> No	_____
Sexually Transmitted Diseases	<input type="checkbox"/> No	{Gonorrhea, Chlamydia, Warts, Herpes, Urethritis, etc.} _____
Hepatitis or HIV	<input type="checkbox"/> No	_____
Exposure to STD / Hepatitis / HIV	<input type="checkbox"/> No	_____
Age at first intercourse	_____	
Number of sexual partners	_____	

Have you had any of these fertility studies?

Details of positive responses

- Basal body temperature charts (BBT) No
- Hysterosalpingogram (HSG) No
- Post-Coital test (PK) No
- Endometrial biopsy No
- Hormonal blood tests No
- Ultrasound No
- Laparoscopy No
- Hysteroscopy No
- Semen Analysis No
- Other No

What infertility problems have been diagnosed already?

Details of positive responses

- Endometriosis No
- Pelvic adhesions No
- Blocked or damaged tubes No
- Irregular or absent ovulation No
- Corpus luteal defect No
- Uterine fibroids No
- Hostile cervical mucus No
- Male infertility No
- Other No

What infertility treatments have you and / or your partner been through?

Treatment:	Doctor:	When:	# of cycles:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Physician notes: