FERTILITY CENTER OF THE CAROLINAS

PATIENT HISTORY: GYNECOLOGY

GREENVILLE HEALTH SYSTEM
Department of Obstetrics & Gynecology

I. Identifying Information

Date: ____________________________________

Name: ____ Partner's Name: ____

Age: ________ Date of Birth: ____________________ Partner's Age: ________ Date of Birth: ____________________

Address: ____

City: ____ State: ____________ Zip Code: ________________________

Telephone Number: Day (_____) ___________________________ Evening (_____) ______________________________

Referring Physician: Name ____

Address ____

II. Pregnancy History

How many pregnancies (including abortions) have you had: _________________________________

	When (Year)	How Long to Conceive (Months)	Fertility Therapy Used (Yes / No)	Is Current Partner the Father (Yes / No)	Duration of Pregnancy (Months)	Outcome*	Complications
1st Pregnancy							
2nd Pregnancy							
3rd Pregnancy							
4th Pregnancy							
5th Pregnancy							

*Outcomes: Vaginal Deliver = VD; Cesarean Section = CS; Abortion = AB; Miscarriage = MS; Ectopic = EP

III. Fertility History

How long have you and your present partner been trying to conceive: ____

Have you ever been infertile with a past partner: ☐ YES ☐ NO If so, how long: ____________________

Have you had any of the following tests performed: (Check all that apply and the results)

	Test	Date	Results
☐	Anti-Sperm Antibodies	________________	________________________________
☐	Antibody Screen	________________	________________________________
☐	Basal Body Temperature	________________	________________________________
☐	Blood type and Rh	________________	________________________________
☐	Endometrial Biopsy	________________	________________________________
☐	Gonorrhea/Chlamydia Cultures	________________	________________________________
☐	Hepatitis B or C	________________	________________________________
☐	HIV	________________	________________________________
☐	Hormone Tests	________________	________________________________

Fertility History CONTINUED	Date	Results
☐ Hysterosalpingogram (HSG)	______	______
☐ Hysteroscopy	______	______
☐ Laparoscopy	______	______
☐ Post-coital Test	______	______
☐ RPR (Syphilis)	______	______
☐ Rubella (German Measles)	______	______
☐ Sonohysterogram	______	______
☐ Ultrasound	______	______
☐ Urinary LH (Ovulation) Predictor Kits	______	______

What types of fertility therapy have you previously received:

Drug / Treatment	Dosage	How Long or How Many Cycles	When
Clomiphene Citrate (Clomid, Seraphene) Letrozole (Femara)			
Gonadotropins (Pergonal, Repronex, Gonal-F, Follistim, Menopur)			
HCG (Profasi, Pregnyl, Ovidrel)			
Progesterone			
Prednisone or Dexamethasone			
Bromocriptine (Parlodel, Dostinex)			
Artificial Insemination			
Donor Insemination			
In Vitro Fertilization = ICSI			

IV. Gynecological History

How old were you when you started having periods: __________ Date your last period started: ______________________

Are your periods regular: ☐ YES ☐ NO

If yes, how many days between periods (start until start): ______________________

If no, how many periods per year do you have: ______________________

How many days do your periods last: __________ Do you have cramps with your periods: ☐ YES ☐ NO

If yes, are they: ☐ Mild ☐ Moderate ☐ Severe

Have you ever missed work or school due to menstrual pain: ☐ YES ☐ NO

Do you have pain with intercourse: ☐ YES ☐ NO

Were you ever diagnosed with endometriosis: ☐ YES ☐ NO

Have you ever been told you have/had fibroid tumors in your uterus: ☐ YES ☐ NO

How often do you and your partner have intercourse: ______________________

What type of contraception have you used in the past or are using now: (Check all that apply)

☐ Birth Control ☐ IUD ☐ Depo Provera (birth control shots)
☐ Condoms ☐ Diaphragm ☐ Foams/Jellies
☐ Withdrawal ☐ Rhythm ☐ Tubal Ligation

History of contraceptive complications: ______________________

____

When did you last use contraception: ______________________

Have you ever had an abnormal Pap smear: ☐ YES ☐ NO If so, when: ______________________

What was done about it: ______________________

When was your last Pap smear: ______________________

Have you ever had any of the following: (Check all that apply)

☐ Conorrhea	☐ Venereal Warts	☐ Syphilis
☐ Ghlamydia	☐ Genital Herpes	☐ Pelvic Inflammatory Disease (PID)

V. Medical History

Do you have or have you ever had: (Check all that apply)

☐ Anemia	☐ Diabetes	☐ Ovarian Cysts
☐ Appendicitis	☐ Gallbladder Problems	☐ Pneumonia
☐ Arthritis	☐ Heart Disease	☐ Rheumatic Fever
☐ Blood Transfusions	☐ Hepatitis	☐ Rubella (German Measles)
☐ Breast Discharge	☐ Hirsutism (excess facial hair)	☐ Scarlet Fever
☐ Breast Pain	☐ High Blood Pressure	☐ Seizures
☐ Chicken Pox	☐ Kidney Infections	☐ Thyroid Problems
☐ Chronic Bronchitis	☐ Liver Problems	☐ Tuberculosis (TB)
☐ Chronic Headaches	☐ Migraine Headaches	☐ Ulcers
☐ Colitis	☐ Neurological Problems	☐ Vision Problems

Current Medications: ______________________

____

Are you allergic to any medications: ☐ YES ☐ NO What: ______________________

Have you ever had surgery before: ` ☐ YES ☐ NO

Date and type: ______________________

VI. Social History

Current or Recent Employer/Position: ______________________

Do you drink alcohol: ☐ YES ☐ NO Number of drinks per week: ____________

Do you smoke: ☐ YES ☐ NO

Number of cigarettes per day: ______________________ Number of years smoking: ____________

Do you now, or have you ever, used illicit drugs (marijuana, cocaine, etc.): ☐ YES ☐ NO

If yes, please specify: ______________________

Do you have a special exercise program: ☐ YES ☐ NO

If yes, type: ______________________ Number of hours per week: ____________

Are you on a special diet: ☐ YES ☐ NO If yes, type: ______________________

VII. Family History

Do any family members have significant health problems or inherited diseases: (Check all that apply)

☐ Birth Defects	☐ Down Syndrome	☐ Muscular Dystrophy
☐ Brain/Spinal Defects	☐ Fragile X Syndrome	☐ Sickle Cell Disease
☐ Cancer	☐ Heart Disease	☐ Tay-Sachs Disease
☐ Cystic Fibrosis	☐ Hemophilia	☐ Thalassemia
☐ Diabetes	☐ High Blood Pressure	☐ Thyroid Disease

Who: ______________________

VIII. Review of Systems

What is your usual height: ____________ Current weight: _____________ Ideal weight: ______________

Have you had more than a 10-pound weight gain or loss in the past 12 months: ☐ YES ☐ NO

If yes, how much: ____________ Was this intentional: ☐ YES ☐ NO

Please check the following that apply to you:

Breast	☐ Discharge ☐ Masses ☐ Pain ☐ Other
Cardiovascular	☐ Chest pain ☐ Difficulty breathing on exertion ☐ Palpitations ☐ Swelling ☐ Other
Constitutional	☐ Fatigue ☐ Fever ☐ Sleep problems ☐ Other
Ear, Nose, Throat	☐ Headache ☐ Hearing loss ☐ Sinusitis ☐ Ulcers
Endocrine	☐ Abnormal hair growth ☐ Diabetes ☐ Hair loss ☐ Heat/cold intolerance ☐ Other
Eyes	☐ Glasses/contacts ☐ Vision changes ☐ Other
Gastrointestinal	☐ Bloody stool ☐ Constipation ☐ Diarrhea ☐ Nausea/vomiting ☐ Pain ☐ Other
Genitourinary	☐ Blood in urine ☐ Incontinence ☐ Urinary frequency/burning ☐ Other
Hematologic/Lymph	☐ Bleeding ☐ Blood clots ☐ Bruising ☐ Swollen lymph nodes ☐ Other
Musculoskeletal	☐ Muscle or joint pain ☐ Muscle swelling ☐ Muscle weakness ☐ Other
Neurologic	☐ Fainting spells ☐ Memory loss ☐ Numbness ☐ Seizures ☐ Other
Psychiatric	☐ Anxiety ☐ Crying spells ☐ Depression Other
Respiratory	☐ Asthma ☐ Cough ☐ Shortness of breath ☐ Wheezing ☐ Other
Skin	☐ Dry skin ☐ Moles ☐ Rash ☐ Ulcers ☐ Other

Please bring this form with you to your first appointment. Ensure that records from your current or previous physician have been sent or faxed to the address below at least one week in advance of your visit. We look forward to meeting you.

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