Female MEDICAL HISTORY INFORMATION SHEET **Today's date_____ Age_____**

Name_____

Any concerns/issues you would like to discuss today?

GYNECOLOGY HISTORY

First day of last menstrual period?	
Age at 1st period	
# of days between periods (from 1st day of period to 1st day of next period)	
Length of period (# of days of bleeding)	
Heavy bleeding?	Y / N
Cramps?	Y / N

Birth control method ☐ N/A	
Number of sexual partners in last year	
Are you currently sexually active?	Y / N
With whom do you have sex? Males only Both Males and Females	Females only
Have you had any sexually transmitted diseases? If yes, which ones?	Y / N
Would you like to be tested today?	Y / N

When was your last pap smear?	
Any history of abnormal pap smears? When was this? What treatment was performed?	Y / N
When was your last mammogram? ☐ N/A	
Any history of abnormal mammograms?	Y / N
Do you do self-breast exams?	Y / N

Any history of sexual abuse or domestic violence?	Y / N
Do you feel safe in your current relationship?	Y / N
Would you like to talk about this today?	Y / N

If you are in menopause:

When did this begin?	
Which hormone replacement therapy are you taking? ☐ N/A	

What symptoms are you having? Please circle

Hot flashes	Vaginal dryness	Night sweats
Vaginal bleeding	Low libido	
Mood changes	Difficulty sleeping	

OBSTETRIC HISTORY
Please list all previous pregnancies

PAST MEDICAL HISTORY
Please list all medical problems

PAST SURGICAL HISTORY
Please list all previous surgeries

MEDICATIONS
List all medications, **herbs or supplements**

MEDICATION ALLERGIES

SOCIAL HISTORY

Occupation?			
With whom do you live?			
Smoke/Vape?	Y/ N	How many packs a day?	
Drink alcohol?	Y/ N	How many drinks a week?	
Do drugs?	Y/ N	Which drugs?	
International travel in the last 6-months?	Y/ N	Where and when	

FAMILY HISTORY-Please circle if you have any family members with the following:

Breast cancer	Uterine cancer	Ovarian cancer
Colon cancer	Stroke	High blood pressure
Heart attacks	Blood clots	Diabetes
Osteoporosis	Birth defects	High cholesterol

PREVENTATIVE What kind and how often?

Do you exercise?	Y / N		
Calcium in your diet?	Y / N		
Use sunscreen	Y / N	Seatbelt use?	Y / N

Have you had the following test?		When was this test last done?
Cholesterol	Y / N	
Diabetes screen	Y / N	
Thyroid test	Y / N	
Colonoscopy	Y / N	
Bone density test	Y / N	

REVIEW OF SYSTEMS- Please circle if you have any of the following:

Fever/Cough	Feeling hot/cold
Fatigue	Shortness of breath
Hair loss	Chest pain/ Palpitations
Weight loss/gain	Nausea/vomiting
Breast pain/lump	Rashes/skin lesions
Nipple discharge	Sleep difficulties
Blood in urine/stools	Depression/anxiety
Pain with urination	Excessive bleeding
Loss of urine/incontinence	Constipation/Diarrhea

NONE OF THE ABOVE

**********IF DESIRING FERTILITY, PLEASE COMPLETE THE NEXT PAGE**********

NAME:_____ Date of Birth:_____

Past Fertility Testing and Treatments: Please complete with dates and results:

History of chicken pox or chicken pox immunization?	Y / N	
History of Hyserosalpingogram (HSG)	Y / N	
History of Saline Infusion Sonohysterogram or hysteroscopy	Y / N	
Previous day-3 FSH level	Y / N	
Other day-3 hormone tests?	Y / N	
History of AMH level	Y / N	
Semen Analysis results	Y / N	
Ovulation predictor kit to predict ovulation	Y / N	
Other means to detect ovulation?	Y / N	
Genetic Carrier screening test?	Y / N	
Other fertility testing?	Y / N	

For All Treatment Cycles below, please list the date, number of cycles started, dose of meds, outcomes, and where the cycle was performed.
Ovulation induction cycle(s) with Clomid? Dose?
Ovulation induction cycle(s) with Femara/letrozole? Dose?
Intrauterine inseminations (IUIs) with a natural cycle, Clomid, Femara/letrozole, or injectable meds?
IVF cycle(s)
Fresh embryo transfer (list dates and number of embryos and embryo stage)?
Frozen embryo transfer (list dates and number of embryos and embryo stage)?
Other treatments: