

Woman's History

1. **Patient Name** _____ 2. _____
LAST FIRST
3. Birthdate ___ / ___ / ___ 4. Age ___ 5. Height ___ 6. Weight ___ 7. Occupation _____

8. **Medical problems** Please circle as many as are appropriate:

- | | |
|-------------------------------|---|
| a. never had periods | i. have never been pregnant |
| b. stopped having periods | j. have been pregnant before, but cannot now |
| c. irregular periods | k. can get pregnant, but lose the pregnancy |
| d. pelvic pain | l. have had tubes tied or cut or burned, and want them reversed |
| e. bleeding between periods | m. breast problems (discharge, lumps, or pain) |
| f. heavy periods (usually so) | n. overweight |
| g. usually light periods | o. underweight (according to your relatives or friends) |
| h. cannot get pregnant | p. excess hair on face and/or body |
| | q. other gynecologic problems (list below) |

9. If you circled "q," please give details.

Other relevant history Please circle any appropriate letters:

10. Do you exercise (a) not at all (b) occasionally (c) moderately (d) strenuously and regularly?
11. Do you train strenuously for competitive sports (including dance) (Y/N)?
12. Do you (a) smoke tobacco? (b) use marijuana? (c) drink at least one alcoholic beverage per day?
13. Medications that you are currently taking (including vitamins): _____
- _____
14. List other physicians you see, along with their specialty.
- _____
- _____
15. List any known allergies
- _____
16. Age you first noticed breast development ()
17. Age you first noticed pubic hair ()
18. Age when you had first period ()
19. Did your mother take any hormones when she was pregnant with you? (Y/N)?
- If "Y" which hormone? _____

20. How many days from the beginning of one period to the next? (usually)? _____
21. Can you tell a period is coming? (Y/N)? ()
22. If so, how? (circle all that are appropriate)
- a. breast tenderness
 - b. personality changes
 - c. pelvic fullness
 - d. swelling of ankles or wrists
 - e. headaches
23. Do you have (a) bleeding between periods, (b) heavy flow, making you weak, (c) scanty, almost absent flow.
24. Date of last menstrual period (month/day/year) / /
25. If your periods are irregular, how many months can you go without one?
26. If you have pain, is it worse (a) before the period? (b) during, or (c) after? (circle the appropriate letter).
27. What medication do you take to help the pain? _____ Does it help? (yes/no/sometimes).
28. If your problem is lack of periods, do you have,
- a. hot flashes
 - b. vaginal dryness (discomfort with intercourse)
 - c. vaginal spotting
29. Do you take hormones? (Y/N)? () if so, which hormone(s)? _____
30. Other comments on your periods, not covered above : _____

31. Name of regular gynecologist? _____
32. Have you had an abnormal "Pap" smear? (Y/N)
If "Y" was this treated by (a) biopsy (b) antibiotics (c) freezing of cervix (d) cautery of cervix (e) other surgery
33. Date of last "Pap" smear (/ /) Normal? (Y/N)
34. Have you ever had a tubal infection? (Y/N)
35. If more than once, how many times? ()
36. Were you treated with antibiotics? (Y/N)
37. Were you ever hospitalized for a tubal infection(s)? (Y/N)
38. How old were you when you had the infection(s)? ()
39. Have you had gonorrhea? (Y/N) If (Y), at what age? ()
40. Have you had syphilis? (Y/N) If (Y), at what age? ()

Previous pregnancies Please list all, including miscarriages and abortions. List the date of delivery or abortion, the number of months pregnant, circle the outcome, (vaginal, cesarean section, miscarriage or voluntary abortion) and whether or not there were postpartum complications, such as infection or fever.

DATE	MOS.	OUTCOME	COMPLICATIONS
41. / /	42. ____	43. normal, C/sect/mis/abort	44. yes/no
45. / /	46. ____	47. normal, C/sect/mis/abort	48. yes/no
49. / /	50. ____	51. normal, C/sect/mis/abort	52. yes/no

53. Comments, if not able to list above _____

54. Pills, if used, were taken:
- less than 1 year
 - 1-2 years
 - 2-5 years
 - greater than 5 years
55. Did you have complications attributed to the pill?
- irregular or absent periods
 - stroke or heart disease
 - high blood pressure
 - diabetes
 - other (list)
56. IUD, if used, was in place from
 / / to / / and;
 / / to / / and;
57. Problems with IUD included:
- abnormal bleeding requiring removal of IUD
 - perforation of the uterus, requiring surgery
 - pregnancy with the IUD, carried to term (delivery)
 - infection requiring removal of IUD
 - pregnancy with the IUD with subsequent abortion
 - none
58. Other methods of contraception used include: (a) diaphragm, (b) condom, (c) foam, (d) cervical cap, (e) rhythm
59. Previous abdominal surgery (circle any appropriate letter and fill in the date)
- tuboplasty / /
 - removal of fibroids / /
 - hysterectomy / /
 - removal of biopsy of ovary(s) / /
 - appendectomy / /
 - intestinal surgery / /
 - removal of tube / /
 - clearing of adhesions (scar tissue) / /
 - sterilization by laparoscopy / /
 - sterilization by other technique / /
60. Other surgery, not listed above _____
61. List all medications you take, prescription or non-prescription. _____
62. List any significant medical condition for which you are being or have been treated. _____
63. If you have problems with any of the following, please circle the appropriate letters.
- headache, convulsions, stroke
 - sinus problems, nosebleed, hearing problems
 - difficulty swallowing or talking
 - asthma, TB, coughing blood, pneumonia, chronic cough
 - heart problems, murmurs, irregular beats, rheumatic fever
 - digestion problems, nausea, vomiting, ulcers, jaundice, diarrhea, black bowel movements, constipation
 - kidney infections, bladder infections, kidney stones, blood in urine
 - loss of urine (incontinence)
 - bone or joint pain (arthritis)
 - skin problems, (acne, excess hair)
 - nervous problem (anxiety, depression)
 - easy bruising, bleeding doesn't stop easily
 - diabetes, thyroid problems
64. How many times a week do you have intercourse (on the average)
65. Intercourse is painful (a) never, (b) occasionally, (c) frequently, (d) usually.
66. If you have pain, is it: (a) in the vagina, (b) deeper, inside, toward the front, (c) inside, toward the back (near the rectum).
67. The pain has been present (a) less than one year, (b) 1-3 years, (c) 4-5 years, (d) greater than 5 years.
68. Have you been treated with medicine or surgery for the pain? (Y/N) is so what?
69. Percent of time you have orgasm with intercourse (a) 0% (b) 25% (c) 50% (d) 75% (e) greater than 75%.
- Other issues you wish to discuss _____

Infertility History (couple)

1. If your problem is INFERTILITY, how long have you been trying to become pregnant? () years.
2. Have you been diagnosed or treated by another doctor? (Y/N) () If yes, what tests have you had?

(Circle the appropriate letters)

- | | |
|-------------------------|----------------------|
| a. temperature charts | e. post coital tests |
| b. endometrial biopsy | f. Rubin's test |
| c. HSG (x-ray of tubes) | g. laparoscopy |
| d. sperm analysis | |

3. List the letter(s) of the above tests which were abnormal.

_____, _____, _____, _____, _____, _____

4. What treatments have you previously undergone for infertility:

- | | |
|--|-----------------------|
| a. Clomid | Number of Cycles_____ |
| b. Gonadotropins (Fertinex, Gonal F, etc.) | Number of Cycles_____ |
| c. ART (IVF, GIFT) | Number of Cycles_____ |

Genetic/Ethnic History

Some inherited genetic conditions can be detected by performing laboratory testing.

Please check below if any of the following categories are included in your family history:

Wife/Female Partner:

- Afro-American
 Latin/Italian (Mediterranean)
 Jewish

Husband/Male Partner:

- Afro-American
 Latin/Italian (Mediterranean)
 Jewish



ARLINGTON

Suite 301
46 S. Glebe Road
(703) 920-3890

SIBLEY HOSPITAL

Suite 500
5255 Loughboro Road NW
(202) 537-4591

RESTON

Suite 120
1800 Town Center Drive
(703) 920-3890

LOUDOUN

Suite 220
44055 Riverside Parkway
(703) 920-3890