FEMALE PATIENT HISTORY **GYFT CLINIC, LLC**

Patient Name:_______________ Partner's Name:_______________

Date of Birth:_______________ Partner's Date of Birth:_______________

Duration of Relationship:_______________ Duration of Infertility:_______________

Nature of Employment:_______________

MEDICAL HISTORY

Height: __________ Weight __________ Blood Type (If known)_______________

Have you lost or gained greater than 20 lbs in the last year? ☐ YES ☐ NO

Do you follow a specific diet or have special dietary habits? ☐ YES ☐ NO if yes, please specify____

What types of vigorous exercise do you regularly engage in?_______________

Have you ever had: (circle all that apply)

Anemia
Appendicitis
Arthritis
Blood Transfusion
Breast Discharge
Breast Tenderness
Cancer (specify below)
Chlamydia
Chronic Bronchitis
Chronic Headaches
Colitis
Color Blindness
Endometriosis
Dizziness
Epilepsy
Gonorrhea
Heart Disease
Hepatitis
Hirsutism (Excessive Hair Growth)
Herpes
High Blood Pressure
Immunization for German Measles
Kidney Infection
Liver Problems
Loss of Balance
Measles, German
Measles, Regular
Nongonococcal Urethritis
Ovarian Cysts
Parasitic Infections
Pelvic Infection
Pneumonia
Rheumatic Fever
Scarlet Fever
Seizures
Syphilis
Thyroid Problems
Tuberculosis
Ulcers
Urinary Tract Injections
Vaginitis
Visual Disturbances

If you have been treated for cancer? ☐ YES ☐ NO if yes, please specify_______________

Have you had X-rays of the pelvic area for therapy or diagnosis? ☐ YES ☐ NO if yes, please specify_______

Do you take prescription medications? ☐ YES ☐ NO if yes, please specify_______________

Do you take any over-the-counter medications regularly? ☐ YES ☐ NO if yes, please specify__________

Do you now or have you ever used: (circle all that apply)

Alcohol: ☐ YES ☐ NO # per week _____ *Cigarettes*: ☐ YES ☐ NO #per day_______

Coffee or other caffeine: ☐ YES ☐ NO # per day _____

Illicit or Recreational Drugs_______________

(If you would feel more comfortable please discuss this directly with your physician rather that writing it down.)

At what age did you have your first period?_______________ When was your last period?__________

Are your periods regular? ☐ YES ☐ NO What is the usual number of days between your periods?_______

What is the usual duration of your periods?__________ Do you use tampons or pads?__________

Do you have cramps before, during or after your period?____________________________

Do you take any medications specifically for cramps? ☐ YES ☐ NO If so, what medication?____________

Do you bleed or spot between periods? ☐ YES ☐ NO

How many pregnancies have you had? (Including Abortions)______________________

Pregnancy	Year	Abortion	Miscarriage	Ectopic	Therapy for Conception	How long to conceive	Live baby	Father of this child
1st								
2nd								
3rd								
4th								

Were there complications during or after your pregnancies? ☐ YES ☐ NO if yes, please specify___________

Did your mother have difficulty with conception or pregnancy?☐ YES ☐ NO if yes, please specify__________

How long have you been trying to get pregnant?____________________________

Did your mother take Diethylstilbestrol (DES) when she was pregnant with you? ☐ YES ☐ NO

What form of contraception do you use now or have you used in the past? (Circle all that apply)

Diaphragm Withdrawal Condoms Rhythm IUD Foams/Jellies Pills____________________

Please list any complications you may have had with any forms of birth control:__________________________

How many times per week do you and your partner have sexual intercourse?____________________________

How many times do you have intercourse around ovulation?____________________________

Is intercourse painful or difficult for you? ☐ YES ☐ NO

Do you use lubricants for intercourse? ☐ YES ☐ NO If so, which ones ______________________

Do you douche before or after intercourse? ☐ YES ☐ NO

Is there a family history of infertility? ☐ YES ☐ NO

Is there a family history of hormonal problems? ☐ YES ☐ NO

Have you ever been treated for infertility before? ☐ YES ☐ NO

If so, who was your physician?____________________________

Have you taken?: (Circle all that apply)

Serophene or Clomid	Repronex	Menopur
Bravelle	Follistim	Gonal F
Novarel	Pregnyl	Profasi
Metformin	Glucophage	Parlodel
Estrogen	Progesterone	Prednisone
Antibiotics	Other:______________________	

Which of the following tests have you undergone?

Basal Body Temperature Charts When?____________Results:______________________

Post Coital Exam When?____________Results:______________________

Endometrial Biopsy When?____________Results:______________________

Hysterosalpingogram When?____________Results:______________________

Ultrasound When?____________Results:______________________

Antibodies When?____________Results:______________________

Hormonal Assays When?____________Results:______________________

Mycoplasma/Chlamydia Cultures When?____________Results:______________________

Laparoscopy/Hysteroscopy When?____________Results:______________________

Other testing, please specify:______________________________________

Have you ever had surgery? ☐ YES ☐ NO

Have you ever had surgery for a tubal reversal? ☐ YES ☐ NO

Have you ever had surgery for lysis of adhesions? ☐ YES ☐ NO

Have you ever had a LEEP or cryocautery? ☐ YES ☐ NO

Please list any other surgeries that you have had:______________________________

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Have you ever had artificial insemination? ☐ YES ☐ NO

If yes, with partners or donor sperm?______________________________________

Have you ever had IVF or GIFT? ☐ YES ☐ NO

Has your partner ever fathered a child with another woman? ☐ YES ☐ NO