University of Washington Medical Center
University Reproductive Care

FEMALE SINGLE OR SS COUPLE NEW PATIENT FERTILITY HISTORY

Please complete this form and bring it with you to your scheduled appointment.

CONTACT INFORMATION:

First name: _____ Middle initial: ____ Last name:_____

Preferred name: _____ Self-declared gender: _____

Preferred pronoun (he/him, she/her etc.) _____

Date of Birth: ____/____/____ Age: _____ Occupation:_____

Home Street Address:_____

City: _____ State: _____ Zip/Postal Code: _____

Indicate which number to call or leave messages

□ Home Phone: (___) _____ □ Cell Phone: (___)_____ □ Work Phone:(___)_____

Are you married? □ Yes □ No □ Divorced □ Other _____

Spouse/Partner: □ Not Applicable

First name: _____ Middle Initial: ____ Last Name:_____

Date of Birth: ____/____/____ Age: _____ Occupation:_____

Home Street Address:_____

City: _____ State: _____ Zip/Postal Code: _____

Indicate which number to call or leave messages

□ Home Phone: (___) _____ □ Cell Phone: (___)_____ □ Work Phone:(___)_____

Who referred you?

□ Physician Name: _____ Clinic: _____

PLACE PATIENT LABEL HERE

Phone: (___)_____Address: _____

□ Former Patient/Friend: _____

□ Website/Advertisement: _____□ Insurance Carrier_____

Who is your Ob/Gyn?

Name: _____Clinic: _____ Phone: (___) _____

Address: _____

MEDICAL HISTORY AND INFORMATION:

Reason for visit? □ Fertility evaluation □ Sperm insemination
□ Other_____
What is your primary goal for this visit?_____
_____

Do you have any personal, ethical or religious objections to any of our tests or treatments, such as insemination, in vitro fertilization, egg donation, sperm donation, masturbation to collect a semen sample, etc.?
□ **No** □ Yes _____

Menstrual History:
Age when you had your first period: _____
Age when you first noticed breast development: _____ pubic hair: _____underarm hair: _____

Current menstrual cycle pattern: □ Regular □ Irregular (if irregular check all that apply)
□ <25 days □ >35 days □ No periods □ Heavy □ Light □ Bleed between periods □ Bleed after sex

Number of days between the start of one period to the start of the next period: _____
How many periods do you have a year? _____ How many days of bleeding do you have?_____
Dates of the 1st day of your last 2 periods (month/day/year): ____/____/____ , ____/____/____
If you do not have periods, at what age did you stop having them? _____
Do you have severe menstrual cramps/pain? □ **No** □ Yes: Always __Sometimes __ In the Past___

Contraceptive History: (please check all that apply and provide dates of use) □ **N/A** □ None
□ Condoms: _____ □ Diaphragm_____ □ IUD_____
□ Implanon/Nexplanon_____ □ Birth control pills_____
□ Patch _____ □ Nuva-ring _____
□ Injectable (Depo-Provera, Lunelle etc.) _____
□ Tubal sterilization (tubes tied, cut, burned, Essure, etc.) date ____/____/____ Type:_____
□ Tubes untied – date ____/____/____

Sexual History:
□ Have you used over-the-counter ovulation kits to assess for ovulation? □ Yes □ No
□ Do you have pain with sex? □ **No** □ Yes
□ Do you use lubricants (K-Y Jelly, etc.) during sex? □ Yes- what type? _____ □ **No**

Have you been treated for or diagnosed with one of the following sexually transmitted infections?
□ **No** □ Yes (Please check all that apply and provide the date of diagnosis)
□ Chlamydia _____ □ Gonorrhea _____ □ Herpes _____ □ Hepatitis B _____
□ Genital warts (HPV) _____ □ Syphilis _____ □ HIV/AIDS _____

Have you been treated for or diagnosed with one of the following problems?
□ **No** □ Yes (Please check all that apply and provide the date of diagnosis)
□ Ovarian failure_____ □ Ovarian cysts (specify type)_____□ Fibroids_____
□ Endometriosis_____□ Tubal disease_____□ Uterine polyps _____ □ Adrenal disease
□ Pelvic inflammatory disease (PID)_____ □ PCOS_____ □ Thyroid disease_____

Pap Smear History:
When was your last pap smear (month and year)? ____/____
Have you ever had an abnormal pap smear □ **No** □ Yes
If yes, when was your last abnormal pap smear?____/____
Have you had any of the following treatments for abnormal pap smear? (please check all that apply)
□ Colposcopy □ Cryosurgery (freezing) □ Laser treatment
□ Conization □ LEEP procedure

Breast Screening History:
Do you perform breast self-exams? □ No □ Yes
Have you ever had a mammogram? □ No □ Yes – date ___/___/___ Result: □ Normal
□ Abnormal – explain _____

ZIKA and West Nile exposure
Have you (or your partner) traveled to a Zika Virus Zone? □ **No** □ Yes
Have you (or your partner) traveled to a West Nile Zone? □ **No** □ Yes
Do you (or your partner) plan to travel to a Zika virus or West Nile zone? □ **No** □ Yes

Have you (or your partner) experienced any of the following in the last 6 months?
Fever: □ **No** □ Yes Rash: □ **No** □ Yes Joint pain or body aches: □ **No** □ Yes
Conjunctivitis: □ **No** □ Yes Headache: □ **No** □ Yes

Pregnancy Summary:

□ Total Number of ALL pregnancies: _____ □ Number of living children _____
□ Miscarriages (less than 20 weeks): _____ □ Ectopic/Tubal Pregnancies: _____
□ Elective Terminations (Abortions): _____
□ Full Term Deliveries:_____ □ Premature Deliveries (less than 37 weeks): _____
□ Any Pregnancies with birth defects? □ No □ Yes _____

Date Pregnancy Ended or Delivered	Months to Conception	Treatment to Conceive	Delivery Type D&C/Complications	Current Partner?
1.				□ Yes □ No
2.				□ Yes □ No
3.				□ Yes □ No
4.				□ Yes □ No
5.				□ Yes □ No
6.				□ Yes □ No

Medical History:

Are you allergic to any medications or foods? □ **No** □ Yes (list allergies and describe reactions)

Drug or food	Reaction

List all medications, including over-the-counter medicines, herbal remedies, and vitamins

Medication	Dose	Why are you taking this medication?

Do you have any medical problem(s)? ☐ **No** ☐ Yes (please list type, dates and treatments)

Medical problem	Diagnosis date	Treatments

Surgical History: Have you had any surgeries? ☐ **No** ☐ Yes

Any anesthesia problems? ☐ **No** ☐ Yes (describe)_____

Year	Reason and Type of Surgery
1.	
2.	
3.	
4.	

Social History:
Number of caffeinated beverages (coffee, tea, soda) per day? _____
Do you smoke cigarettes? ☐ **No** ☐ Quit/when_____ ☐ Yes
Number of years_____ Number of cigarettes per day _____
Do you drink alcohol? ☐ **No** ☐ Yes
Number of drinks per week: Beer ____ Wine ____ Liquor _____
Do you use recreational drugs (i.e. marijuana)? ☐ **No**
☐ Yes (describe) _____
Do you exercise? ☐ No ☐ **Yes**-- Number of hours per week _____
Type_____

Review of Physical Symptoms:

General
☐ Fever/chills
☐ Recent weight gain or loss
☐ Anorexia/bulimia
☐ Lack of energy
☐ Other:_____
☐ **None**

Head, Eyes, Ears, Nose and Throat
☐ Hearing loss/deafness
☐ Loss of sense of smell
☐ Chronic nasal congestion
☐ Blurred vision ☐ Ringing ears
☐ Other:_____
☐ **None**

Respiratory
☐ Shortness of breath
☐ Asthma
☐ Bronchitis
☐ Pneumonia ☐ Tuberculosis
☐ CPAP machine
☐ Other_____
☐ **None**

Endocrine/Hormonal
☐ Thyroid gland problems
☐ Diabetes

Breasts
☐ Surgery (Type:_____)
☐ Discharge (Type:_____)

Neurological
☐ Dizziness
☐ Weakness or loss of balance

☐ Frequently hot or cold
☐ Rapid weight gain/loss
☐ Hot flashes
☐ Increased hunger/thirst
☐ Adrenal disorder
☐ Other_____
☐ **None**

☐ Lumps
☐ Pain
☐ Cancer
☐ Other_____
☐ **None**

☐ Seizures/Epilepsy
☐ Stress headaches
☐ Migraine headaches
☐ Numbness
☐ Memory Loss
☐ Other_____
☐ **None**

Mental Health
☐ Depression
☐ Anxiety
☐ Bipolar depression disorder
☐ Personality disorder
☐ Eating disorder
☐ Suicidal
☐ Other_____
☐ **None**

Kidney/Urinary
☐ Kidney cysts
☐ Frequent bladder infections
☐ Kidney stones
☐ Blood in urine
☐ Frequent urination
☐ Other_____
☐ **None**

Cardiovascular
☐ Murmurs
☐ Chest pain
☐ Heart attack
☐ High blood pressure
☐ Mitral valve prolapse
(antibiotics are required with dental procedures ☐ No ☐Yes)
☐ Other:_____
☐ **None**

Hematologic
☐ Blood clots
☐ Sickle cell anemia
☐ Easy bruising
☐ Swollen glands/lymph nodes
☐ Stroke
☐ Blood Transfusion
date and reason:_____
☐ Other_____
☐ **None**

Skin/Extremities
☐ Hair loss
☐ Rash
☐ Acne
☐ Skin cancer
☐ Excessive facial or body hair
☐ Eczema
☐ Other_____
☐ **None**

Gastrointestinal
☐ Ulcers
☐ Nausea/Vomiting
☐ Diarrhea ☐ Constipation
☐ Blood in stool
☐ Irritable bowel disease
☐ Colitis (Ulcerative or Crohn's)
☐ Other:_____
☐ **None**

Musculoskeletal/Immune
☐ Osteoporosis
☐ Decreased energy/fatigue
☐ Rheumatoid arthritis
☐ Lupus erythematosus
☐ Myasthenia gravis
☐ Other_____
☐ **None**

Family History	**Living**	**Age and Cause of Death**
Mother	☐ Yes – age: ☐ No	
Father	☐ Yes – age: ☐ No	
Brothers (number=___)	☐ Yes – ages: ☐ No	

PLACE PATIENT LABEL HERE

Sisters (number=____)	☐ Yes – ages: ☐ No	
Maternal Grandmother	☐ Yes – age: ☐ No	
Maternal Grandfather	☐ Yes – age: ☐ No	
Paternal Grandmother	☐ Yes – age: ☐ No	
Paternal Grandfather	☐ Yes – age: ☐ No	

☐ Did your mother take DES during pregnancy to prevent miscarriage? ☐ Yes ☐ **No** ☐ Don't know

Disorders in Your Family

		Relationship to you		
Breast Cancer	☐ Yes	_____	☐ No	☐ Don't Know
Ovarian Cancer	☐ Yes	_____	☐ No	☐ Don't Know
Colon Cancer	☐ Yes	_____	☐ No	☐ Don't Know
Other Cancer_____	☐ Yes	_____	☐ No	☐ Don't Know
Diabetes	☐ Yes	_____	☐ No	☐ Don't Know
Thyroid Problems	☐ Yes	_____	☐ No	☐ Don't Know
Heart Disease	☐ Yes	_____	☐ No	☐ Don't Know
Blood Clots	☐ Yes	_____	☐ No	☐ Don't Know
Psychiatric Problems	☐ Yes	_____	☐ No	☐ Don't Know
Tuberculosis	☐ Yes	_____	☐ No	☐ Don't Know
Endometriosis	☐ Yes	_____	☐ No	☐ Don't Know
Menopause before age 40	☐ Yes	_____	☐ No	☐ Don't Know
Birth Defects	☐ Yes	_____	☐ No	☐ Don't Know
Cystic Fibrosis	☐ Yes	_____	☐ No	☐ Don't Know
Tay-Sachs Disease	☐ Yes	_____	☐ No	☐ Don't Know
Canavan Disease	☐ Yes	_____	☐ No	☐ Don't Know
Bloom Syndrome	☐ Yes	_____	☐ No	☐ Don't Know
Gaucher Disease	☐ Yes	_____	☐ No	☐ Don't Know
Niemann-Pick Disease	☐ Yes	_____	☐ No	☐ Don't Know
Fanconi Anemia	☐ Yes	_____	☐ No	☐ Don't Know
Familial Dysautonia	☐ Yes	_____	☐ No	☐ Don't Know
Muscular Dystrophy	☐ Yes	_____	☐ No	☐ Don't Know
Neurologic (brain/spine)	☐ Yes	_____	☐ No	☐ Don't Know
Neural Tube Defects	☐ Yes	_____	☐ No	☐ Don't Know
Bone/Skeletal Defects	☐ Yes	_____	☐ No	☐ Don't Know
Dwarfism	☐ Yes	_____	☐ No	☐ Don't Know
Developmental Delays	☐ Yes	_____	☐ No	☐ Don't Know
Learning Problems	☐ Yes	_____	☐ No	☐ Don't Know
Polycystic Kidneys	☐ Yes	_____	☐ No	☐ Don't Know
Heart defect from birth	☐ Yes	_____	☐ No	☐ Don't Know
Down Syndrome	☐ Yes	_____	☐ No	☐ Don't Know
Other Chromosome defects	☐ Yes	_____	☐ No	☐ Don't Know
Marfan Syndrome	☐ Yes	_____	☐ No	☐ Don't Know
Hemophilia	☐ Yes	_____	☐ No	☐ Don't Know
Sickle Cell Anemia	☐ Yes	_____	☐ No	☐ Don't Know

What is Your Race/Ethnicity?

☐ African American
☐ American Indian/Native American
☐ Ashkenazi Jewish
☐ Asian American
☐ Cajun/French Canadian
☐ Caucasian/ White
☐ Eastern European
☐ Hispanic/Caribbean
☐ Northern European
☐ Southern European
☐ Other: _____

Would you like to be screened for?

Cystic Fibrosis	☐ Yes	☐ No
Sickle Cell Anemia	☐ Yes	☐ No
Tay - Sachs disease	☐ Yes	☐ No
Thalassemia	☐ Yes	☐ No

☐ Other_____

PLACE PATIENT LABEL HERE

Thalassemia	☐ Yes _____	☐ No	☐ Don't Know
Galactosemia	☐ Yes _____	☐ No	☐ Don't Know
Deafness/Blindness	☐ Yes _____	☐ No	☐ Don't Know
Color Blindness	☐ Yes _____	☐ No	☐ Don't Know
Hemochromatosis	☐ Yes _____	☐ No	☐ Don't Know
	☐ Other-Specify _____		

Emotional Status: Please rate on a scale of 1-10 (1 is best and 10 is worst)

How do you estimate your average level of stress to be? 1 2 3 4 5 6 7 8 9 10
Over the last two weeks have you felt little pleasure in doing things?
❑Not at all ❑Several days ❑More than half the days ❑Nearly every day
Over the last two weeks have you felt down, depressed or hopeless?
❑Not at all ❑Several days ❑More than half the days ❑Nearly every day
Do you see a counselor? ☐ **No** ☐Yes- for how long? _____ How often?_____ Name of counselor: _____
Do you feel safe at home? ❑**Yes** ❑No

Vaccinations:

Chickenpox (Varicella)	☐ No	☐ **Yes** (dates _____)	☐ Don't know
MMR-Measles, Mumps and Rubella	☐ No	☐ **Yes** (dates _____)	☐ Don't know
BCG (Tuberculosis)	☐ No	☐ **Yes** (dates _____)	☐ Don't know
Hepatitis B	☐ No	☐ **Yes** (dates _____)	☐ Don't know
Polio	☐ No	☐ **Yes** (dates _____)	☐ Don't know
Hepatitis A	☐ No	☐ **Yes** (dates _____)	☐ Don't know
Tetanus	☐ No	☐ **Yes** (dates _____)	☐ Don't know
Influenza	☐ No	☐ **Yes** (dates _____)	☐ Don't know
Human papilloma virus (HPV)	☐ No	☐ **Yes** (dates _____)	☐ Don't know

Prior Fertility Testing and Treatment:

☐ Have you had prior fertility testing or treatment? ☐ **No** ☐ Yes

Prior Tests: (check all that apply):

☐ Basal body temperature chart (date_____/results_____)
☐ Thyroid blood test (date_____/results_____)
☐ Ovulation test kit (date_____/results_____)
☐ Day 3 blood test FSH level (date_____/results_____)
☐ AMH blood test (date_____/results_____)
☐ Prolactin blood test (date_____/results_____)
☐ Hysterosalpingogram (date_____/results_____)
☐ Laparoscopy surgery (date_____/results_____)
☐ Hysteroscopy surgery (date_____/results_____)

Prior Treatments: (check all that apply):

	# of cycles	Dates (mo/year)	Outcome
❑ Intrauterine insemination	_____	From___/___to___/___	❑Pregnant ❑Delivered ❑Ectopic ❑Miscarriage ❑Not Pregnant
❑ Clomiphene citrate or Letrozole with timed intercourse: Maximum # tablets per day___	_____	From___/___to___/___	❑Pregnant ❑Delivered ❑Ectopic ❑Miscarriage ❑Not Pregnant
❑ Clomiphene citrate or Letrozole with insemination: Maximum # tablets per day___	_____	From___/___to___/___	❑Pregnant ❑Delivered ❑Ectopic ❑Miscarriage ❑Not Pregnant
❑ Fertility drug injections with insemination:	_____	From___/___to___/___	❑Pregnant ❑Delivered ❑Ectopic ❑Miscarriage ❑Not Pregnant
❑ Complete in vitro fertilization cycle(s):	_____		
1. #eggs ___ #embryos transferred ___ #frozen ___		From___/___to___/___	❑Pregnant ❑Delivered ❑Ectopic ❑Miscarriage ❑Not Pregnant
2. #eggs ___ #embryos transferred ___ #frozen ___		From___/___to___/___	❑Pregnant ❑Delivered ❑Ectopic ❑Miscarriage ❑Not Pregnant
3. #eggs ___ #embryos transferred ___ #frozen ___		From___/___to___/___	❑Pregnant ❑Delivered ❑Ectopic ❑Miscarriage ❑Not Pregnant
4. #eggs ___ #embryos transferred ___ #frozen ___		From___/___to___/___	❑Pregnant ❑Delivered ❑Ectopic ❑Miscarriage ❑Not Pregnant
❑ Frozen embryo transfers:	_____		
1. #embryos transferred ___		From___/___to___/___	❑Pregnant ❑Delivered ❑Ectopic ❑Miscarriage ❑Not Pregnant
2. #embryos transferred ___		From___/___to___/___	❑Pregnant ❑Delivered ❑Ectopic ❑Miscarriage ❑Not Pregnant
3. #embryos transferred ___		From___/___to___/___	❑Pregnant ❑Delivered ❑Ectopic ❑Miscarriage ❑Not Pregnant
4. #embryos transferred ___		From___/___to___/___	❑Pregnant ❑Delivered ❑Ectopic ❑Miscarriage ❑Not Pregnant
❑ Cancelled in vitro fertilization attempts:	_____	From___/___to___/___	❑Pregnant ❑Delivered ❑Ectopic ❑Miscarriage ❑Not Pregnant
❑ Any other prior treatment (describe): _____ _____			

Additional information:_____
_____
_____

PATIENT SIGNATURE	PRINT NAME	DATE	TIME

I confirm that I have reviewed the information above.

PROVIDER SIGNATURE	PRINT NAME AND TITLE	DATE	TIME

PLACE PATIENT LABEL HERE