alaska women's health pc

NAME: ______________________ **DOB:** ____________ **DATE:** ____________

Reason for visit: ☐ Infertility Evaluation ☐ Recurrent miscarriage evaluation

Menstrual and Pap Smear History

First day of last period: ____________________

Menstrual cycle pattern: ☐ Regular periods ☐ Irregular periods ☐ No periods ☐ Spotting before periods ☐ Spotting in between periods ☐ Heavy periods ☐ Light periods

Number of days between the first day of one period and the first day of the next period: ______ days

How many days of bleeding do you have? ______ days

Age when you had your first period: ______ years old

How many periods do you have per year? ______

Do you need medication to bring on a period? ☐ Yes-type? ____________ ☐ No

Do you ever skip periods or have two periods in one month? ☐ Yes ☐ No

If you do not have periods, at what age did you stop having them? ______ years old

Do you have severe cramping or pelvic pain with your periods? ☐ Yes ☐ No

*If yes, Always: ____ Sometimes: ____ Recently: ____ In the Past: ____

Have you ever been diagnosed with polycystic ovarian syndrome (PCOS)? ☐ Yes ☐ No

*If yes, how was the diagnosis made? (i.e. symptoms, ultrasound) ____________

Pregnancy Summary

- Total number of all pregnancies: ______
- Number of full term deliveries (37-40 weeks): ____ (of these, how many were live births?)
- Number of premature deliveries (less than 37 wks): ____ (of these, how many were live births?)
- Number of miscarriages (less than 20 wks): ____
- Number of ectopic/tubal pregnancies: ____
- Number of elective terminations (abortions): ____
- Any pregnancies with birth defects? ☐ Yes ☐ No

Date Pregnancy Ended or Delivered	# weeks	Any treatments to Conceive?	Delivery Type/D&C	Fathered by current partner

Contraceptive History

Which types of contraception have you used in the past? ____________________

Did your mother take DES when she was pregnant with you? ☐ Yes ☐ No ☐ I don't know

Sexual History

How many times do you have intercourse per week? ____ times per week ☐ None ☐ Not applicable

Have you used ovulation predictor kits? ☐ Yes ☐ No

Have you used fertility monitors to time intercourse? ☐ Yes ☐ No

Do you have pain during intercourse? ☐ Yes ☐ No

Do you use lubricants (i.e. KY Jelly) during intercourse? ☐ Yes - what types: ____________ ☐ No

Any prior exposure to sexually transmitted diseases or pelvic infections?

☐ No ☐ Yes - ☐ Chlamydia- date: ____ ☐ Gonorrhea- date: ____ ☐ Herpes- date: ____ ☐ Syphilis- date: ____
☐ Genital warts/HPV- date: ____ ☐ HIV/AIDS- date: ____ ☐ Hepatitis- date: ____

Pap Smear History

When was your last pap smear (month/year)? _______/_________

When was your last abnormal pap smear? __________ ☐ N/A

Have you undergone any procedures as a result of an abnormal pap smear? ☐ Yes ☐ No

*If yes, check all that apply: ☐ Colposcopy ☐ Cryosurgery (freezing) ☐ Laser treatment ☐ Conization ☐ LEEP Procedure

Medical History

Are you allergic to any medications? ☐ No ☐ Yes (Please list medication & reaction): ____________________

Are you allergic to any foods? ☐ No ☐ Yes (Please list food & reaction): ____________________

List any medications you are currently taking, including over-the-counter medicines, with dosage if known:

____

____

Do you have any history of gynecological problems? ☐ No ☐ Yes (please list dates)

____

____

____

____

Did you have either of these childhood illnesses? ☐ Chickenpox (Varicella) ☐ German Measles (Rubella) ☐ Don't know

Have you had any gynecologic surgeries in the past? ☐ No ☐ Yes (if yes, please list)

____

____

____

____

Have you had any procedures to look at your uterus, fallopian tubes and ovaries? ☐ No ☐ Yes (if yes, please list)

(For example HSG, a tubal dye study to see if your tubes are open?)

____

____

Habits (check all that apply)

☐ Alcohol- Amounts: ____________________ History of alcohol abuse? ☐ Yes ☐ No

☐ Tobacco- Amounts: ____________________ History of tobacco usage? ☐ Yes ☐ No

☐ Recreational Drugs- Amounts: ____________________ History of drug abuse? ☐ Yes ☐ No

☐ Caffeine- Amounts: ____________________ ☐ Exercise- Amounts: ____________________

☐ 5 or more sexual partners Sexual partners: ☐ Male ☐ Female ☐ Both

Prior Infertility Treatment

Type of Treatment	# of cycles	Pregnancy achieved?
☐ Intrauterine insemination		
☐ Clomid with timed intercourse		
☐ Clomid with insemination		
☐ Letrozole with timed intercourse		
☐ Letrozole with insemination		
☐ In vitro fertilization		

Male Partner Medical History and Information

Have you been evaluated by a urologist? ☐ Yes ☐ No

Have you had a semen analysis? ☐ Yes ☐ No

Do you have difficulty with erections? ☐ Yes ☐ No

Any prior exposure to STDs/STIs? ☐ Yes ☐ No

History of undescended testicles? ☐ Yes ☐ No

Current scrotal/testicular pain? ☐ Yes ☐ No

History of testicular injury? ☐ Yes ☐ No

Family history of difficulty conceiving? ☐ Yes ☐ No