The Nevada Center for Reproductive Medicine

FEMALE PATIENT HISTORY

Name______________________________ Weight_______ Height_______ Blood Type ________

When was the first day of your last period? ______________________________

Are your periods regular? ______________________________

If yes, what is the usual number of days between periods? ______________________________

If no, how many times per year do you menstruate? ______________________________

What is the usual duration of your period? ______________________________

What medications do you regularly take? (Prescription and/or over the counter drugs?

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Do you, or have you ever, used:

Alcohol? How many drinks per week? ______________________________

Cigarettes? How many packs per day? ______________________________

Illicit or recreational drugs? ______________________________

How long have you been trying to get pregnant? ______________________________

	Year?	Abortion?	Miscarriage?	Ectopic?	Born Alive?	Fertility Drugs Required?	Current Partner Father?
1st Pregnancy							
2nd Pregnancy							
3rd Pregnancy							
4th Pregnancy							
5th Pregnancy							

Do you, or have you ever, had (circle all that apply):

Allergies? (Circle) Yes or No

If Yes, please list: ______________________________

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Anemia
Appendicitis
Arthritis
Blood Transfusions
Breast Milky Discharge
Breast Soreness
Breast Tenderness
Cancer (Specify) ______________________________

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Chlamydia
Chronic Bronchitis
Chronic Headaches

Colitis
Color Blind
Diabetes
Dizziness
Endometriosis
Epilesy
Fever
Gallbladder Problems
Gonorrhea
Heart Disease
Hepatitis
Herpes
Hirsutism (Excessive Hair Growth)
High Blood Pressure
Immunized: German Measles
Kidney Infection
Liver Problems
Loss of Balance
Measles: German

Measles: Regular
Neurological Problems
Nongonoccal Urethritis
Ovarian Cysts
Parasitic Infection
Pelvic Infection
Pneumonia
Poor Sense of Smell
Rheumatic Fever
Scarlet Fever
Seizures
Syphilis
Thyroid Problem
Tuberculosis
Ulcers
Vaginitis (Trichomoniasis, Yeast)
No. of Episodes ____________
Visual Disturbances
Weight Loss

Has your partner ever fathered a child with another woman? ______________________________

Have you ever been treated for infertility in the past? ______________________________

If yes, review diagnostic studies and treatments with our physician during your appointment.

Please list all types and dates of surgeries you have undergone: ______________________________

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