Date ____________

FEMALE PARTNER HEALTH HISTORY

Please complete the following information to the best of your ability:

Name ____ *Height* ________ *Weight* _________

Primary Reason for Consult (if trying to get pregnant, please include the number of months you have been trying to conceive) ____

____

Menstrual Period: *What was the date of the first day of your last menstrual period?* ______________

Does your menstrual period usually start with flow or with spotting? ______________

If spotting, how many days do you spot before menstrual flow? ______________

Do you experience breast tenderness before your period? ______________

How many days do you bleed with your typical menstrual cycle? ______________

In general, do you begin a menstrual cycle every 28 days? ______________

If not, how frequently do you have a menstrual cycle? ______________

Menstrual Pain: *Please circle the description below that best characterizes your menstrual pain:*

mild *mild to moderate* *moderate* *moderate to severe* *severe*

Do you ever take medications to reduce your menstrual pain? ______________

If yes, which medication(s) do you take? __________________________

Other Gynecologic History: *Do you experience pain with sexual intercourse?* ______________

If yes, what about what percent of the time does this occur? ______________

What is the month and year of your last Pap smear? ______________

Have you ever been treated for an abnormal Pap?
(if yes, please detail the date and type of procedure) __________________________

Have you ever been treated for a sexually transmitted disease? ______________

Have you ever used birth control pills? ______________

If yes, about how many total years have you take birth control pills? ______________

If you have previously undergone fertility evaluation/treatment, please provide your records and/or briefly detail your work-up __________________________________

____

____

Medical History: *Do you have any illnesses (particularly ongoing medical conditions for which you take take medications)? If yes, please elaborate* ____________________

____

____

Are you taking any medications (including vitamins and/or herbal medications)? If yes, please elaborate and include dose and how frequently each medication is taken

____

____

____

Have you ever had an allergic reaction to a medication? If yes, please include the medication and type of reaction ____________________

____

Surgical History: *Have you ever undergone any office, outpatient, or inpatient surgical procedures? If yes, please include the type and the year of the procedure(s)* ____________________

____

____

Social History: *Do you smoke cigarettes or use other tobacco products? If yes, please elaborate and include number of cigarettes per day or week and number of years of cigarette use*

____

Do you drink alcohol? If yes please elaborate and include number of drinks per day or week ____________________

Family History: *(e.g. diabetes, high blood pressure, heart disease, cancer)*

Maternal illnesses ____________________

Paternal illnesses ____________________

Sibling illnesses ____________________

Other relevant family history ____________________

Obstetric History:

Year	*Weeks of Pregnancy*	*Vaginal or Cesarean Birth*	*Birth Weight*	*Maternal and/or Fetal Complications*