

FEMALE PATIENT HISTORY

NAME _____ Date _____
 Weight _____ Height _____ Blood Type (if known) _____
 When was the first day of your last period? _____
 Are your periods regular? _____ If yes, how many days between periods? _____
 If no, how many times per year do you menstruate? _____
 What is the usual duration of your menses? _____
 What medications do you regularly take? (prescription and/or over-the-counter)
 _____,
 _____,

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? _____

Past history (if applicable):

	Year	Born Alive?	Miscarriage?	Abortion?	Ectopic?	Fert Drugs Required?	Current Partner?
1st pregnancy	_____	_____	_____	_____	_____	_____	_____
2nd pregnancy	_____	_____	_____	_____	_____	_____	_____
3rd pregnancy	_____	_____	_____	_____	_____	_____	_____
4th pregnancy	_____	_____	_____	_____	_____	_____	_____
5th pregnancy	_____	_____	_____	_____	_____	_____	_____

Has your partner ever fathered a child? _____
 Have you ever been treated for infertility? _____
 If yes, please review diagnostic studies and treatments with our physician during your appointment.
 Please list all types and dates of surgeries you have undergone:

Family history of blood clotting disorders? _____
 If yes, please explain _____

Do you or have you ever had (circle all that apply):
 Allergies? (circle) yes or no If yes please list; _____
 Have you ever been treated for cancer? _____

- | | | |
|-----------------------|--------------------------------|-----------------------------------|
| Anemia | Gonorrhea | Pneumonia |
| Appendicitis | Heart disease | Poor sense of smell |
| Arthritis | Hepatitis | Rheumatic fever |
| Blood transfusion | Herpes | Scarlet fever |
| Breast discharge | Hirsutism (excess hair growth) | Seizures |
| Breast soreness | High blood pressure | Syphilis |
| Cancer? Specify _____ | Immunization: German Measles | Thyroid problems |
| Chlamydia | Kidney infection | Tuberculosis |
| Chronic headaches | Liver problems | Ulcers |
| Colitis | Loss of balance | Vaginitis (trichomoniasis, yeast) |
| Color blindness | Measles: German | # of episodes _____ |
| Diabetes | Measles: Regular | Visual disturbances |
| Dizziness | Neurological problems | |
| Endometriosis | Nongonococcal urethritis | |
| Epilepsy | Ovarian Cysts | |
| Gallbladder problems | Parasitic infection | |

Countries of origin: Mother's family: _____ Father's family: _____

Ethnic background (Circle) : African American Asian Asian-Indian Caucasian Hispanic

Jewish American-Indian Mediterranean Middle Eastern
Other: _____

Ethnic Group

<u>(Check all that apply)</u>	<u>Have you ever been tested for:</u>	<u>Yes</u>	<u>No</u>	<u>Date</u>	<u>Result</u>
African, African/American	Sickle cell trait	_____	_____	_____	_____
Chinese, Southeast Asian, Mediterranean (Greek or Italian) or Hispanic	Thalassemia	_____	_____	_____	_____
Caucasian, Jewish	Cystic Fibrosis	_____	_____	_____	_____
Jewish	Bloom Syndrome,	_____	_____	_____	_____
	Canavan Familial Dysautonomia (FD),	_____	_____	_____	_____
	Fanconi Anemia (type C),	_____	_____	_____	_____
	Gaucher Disease (Type I),	_____	_____	_____	_____
	Glycogen Storage (Type 1a),	_____	_____	_____	_____
	Maple Syrup Urine Disease,	_____	_____	_____	_____
	Mucopolidosis, (Type IV ML IV),	_____	_____	_____	_____
	Niemann - Pick Type A,	_____	_____	_____	_____
	Tay Sachs	_____	_____	_____	_____

Other inherited disorders? _____

Would you like to be tested for the test recommended for your specific ethnic group? (Circle) **Yes No**

Are you related to your spouse (consanguinity)? _____

Fragile X testing is recommended if the exact etiology of the mental retardation is unknown. Would you like this testing performed (Circle)? **Yes No**