Northwestern Medicine®
Fertility and Reproductive Medicine

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HEALTH HISTORY

If you need help filling out this form, please contact us and we will have someone help you. You may be asked to come in ½ hour earlier than your scheduled appointment to answer your questions.

IDENTIFYING INFORMATION

Date: _____

Patient Legal Name: Last name: _____ First Name: _____ Middle Initial: _____

Partner Legal Name (if applicable): Last name: _____ First Name: _____ Middle Initial: _____

PATIENT:

Patient Age: _____

Date of Birth: _____

Sex Assigned at Birth: Male Female Intersex Decline to state

Gender Identity: Male Female Other: _____

Name by which you wish to be addressed: _____

Height: Feet: _____ Inches: _____

Current Weight (lbs): _____

Cell Phone: _____

Work Phone: _____

E-mail Address: _____

PARTNER (IF APPLICABLE):

Partner Age: _____

Date of Birth: _____

Sex Assigned at Birth: Male Female Intersex Decline to state

Gender Identity: Male Female Other: _____

Name by which you wish to be addressed: _____

Height: Feet: _____ Inches: _____

Current Weight (lbs): _____

Cell Phone: _____

Work Phone: _____

E-mail Address: _____

ETHNICITY (PLEASE MARK ALL THAT APPLY)

PATIENT

- ☐ American Indiana/Alaska Native
- ☐ Asian
- ☐ Black/African American
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White/Caucasian
- ☐ Other: _____
- ☐ Unknown

PARTNER (IF APPLICABLE)

- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black/African American
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White/Caucasian
- ☐ Other: _____
- ☐ Unknown

Additional identity information:

Pharmacy Name and Phone Number: _____

( ) _____

Chief Complaint (reason for visit): _____

***If* Infertility, duration (years):** _____

Brief Menstrual/Obstetrical history of the intended mother (if applicable):

Menstrual Cycles: Age of first menses: _____ Cycles are: Regular Irregular Cycle occurs every _____ days

Obstetrical History: Number of total pregnancies: _____ Number of live births: (<37 weeks): _____ (=/>37 weeks): _____

Number of living children: _____ Number of induced abortions: _____ Number of miscarriages: ___

Number of ectopic pregnancies: ____ Number of biochemical pregnancies: ____ Number of still births: ____

Number of total previously completed IVF cycles: Fresh: _____ Thaw/Frozen: _____

Form Completed By: _____

BASIC INFORMATION

Who referred you? .....

Who is your gynecologist (if applicable)? .....

What is your occupation? .....

Are you .....
- ❒ married (date)_____
- ❒ single
- ❒ long-term relationship
- ❒ other:_____

How many years have you been with your present partner? .....

What is your partner's occupation? .....

HEALTH STATUS

Do you have any allergies to any medicines? .....

What are the allergic reactions to the medications? .....

Do you take any current medications? .....

PAST MEDICAL HISTORY

Do you have antibiotic therapy before dental work or a surgical procedure to protect your heart? ..... ❒ yes ❒ no

Do you have a history of clots in your legs or lungs? ..... ❒ yes ❒ no

Have you had a stroke or heart attack? ..... ❒ yes ❒ no

Have you ever taken gender affirming hormones? ❒ yes ❒ no

Have you ever been told you had any of the following?

Anemia ..... ❒ yes ❒ no

Bleeding tendency ..... ❒ yes ❒ no

Prior blood transfusion ..... ❒ yes ❒ no

Lung disease ..... ❒ yes ❒ no

Heart disease ..... ❒ yes ❒ no

High blood pressure ..... ❒ yes ❒ no

Cancer ..... ❒ yes ❒ no

If yes, type and treatment .....

Chronic headaches ..... ❒ yes ❒ no

Seizures ..... ❒ yes ❒ no

Depression ..... ❒ yes ❒ no

Diabetes ..... ❒ yes ❒ no

Thyroid disease ..... ❒ yes ❒ no

Gall bladder disease ..... ❒ yes ❒ no

Stomach reflux (GERD) ..... ❒ yes ❒ no

Irritable bowel syndrome ..... ❒ yes ❒ no

Liver disease/Hepatitis ..... ❒ yes ❒ no

Infection in your kidneys/bladder ..... ❒ yes ❒ no

PREVIOUS HOSPITALIZATIONS OR SURGERIES

Please list any time you were in the hospital, the reason, and the year; list all your surgeries as well.

_____

SOCIAL HISTORY

Do you smoke? ..... ❒ yes ❒ no

If yes, how many cigarettes per day? _____

Do you drink caffeine? ..... ❒ yes ❒ no

If yes, how many cups per day? _____

Do you drink alcohol? ..... ❒ yes ❒ no

If yes, how many drinks per week? _____

Do you take recreational drugs? ..... ❒ yes ❒ no

Do you exercise? ..... ❒ yes ❒ no

If yes, how many hours per week? _____

FAMILY HISTORY

	Age	Living	# of miscarriages	Cancer	Chromosomal	Diabetes	High blood pressure
Mother		❒ yes ❒ no		❒ yes ❒ no	❒ yes ❒ no	❒ yes ❒ no	❒ yes ❒ no
Father		❒ yes ❒ no		❒ yes ❒ no	❒ yes ❒ no	❒ yes ❒ no	❒ yes ❒ no
Sister		❒ yes ❒ no		❒ yes ❒ no	❒ yes ❒ no	❒ yes ❒ no	❒ yes ❒ no
Sister		❒ yes ❒ no		❒ yes ❒ no	❒ yes ❒ no	❒ yes ❒ no	❒ yes ❒ no
Brother		❒ yes ❒ no		❒ yes ❒ no	❒ yes ❒ no	❒ yes ❒ no	❒ yes ❒ no
Brother		❒ yes ❒ no		❒ yes ❒ no	❒ yes ❒ no	❒ yes ❒ no	❒ yes ❒ no

PARTNER'S HISTORY (if applicable)

Has your partner had any pregnancies with another partner? ..... ❒ yes ❒ no

Does your partner use recreational drugs? ..... ❒ yes ❒ no

Does your partner smoke or use tobacco? ..... ❒ yes ❒ no

Does your partner drink alcohol? ..... ❒ yes ❒ no

Drinks per week: ..... _____

Drinks per month: ..... _____

Has your partner ever had a sexually transmitted disease? ..... ❒ yes ❒ no

Is your partner allergic to any medications? ..... ❒ yes ❒ no

What medicines does your partner now take? ..... _____

REVIEW OF SYSTEMS

Do you have any of the following:

Fever	❒ yes	❒ no	Cough	❒ yes	❒ no
Chills	❒ yes	❒ no	Coughing up phlegm	❒ yes	❒ no
Sweats	❒ yes	❒ no	Coughing up blood	❒ yes	❒ no
Loss of appetite	❒ yes	❒ no	Wheezing	❒ yes	❒ no
Tiredness	❒ yes	❒ no	Nausea	❒ yes	❒ no
Weight change	❒ yes	❒ no	Vomiting	❒ yes	❒ no
Blurred vision	❒ yes	❒ no	Diarrhea	❒ yes	❒ no
Double vision	❒ yes	❒ no	Constipation	❒ yes	❒ no
Burning eyes	❒ yes	❒ no	Change in bowel habits	❒ yes	❒ no
Discharge from your eyes	❒ yes	❒ no	Abdominal pain	❒ yes	❒ no
Loss of vision	❒ yes	❒ no	Blood in your stools	❒ yes	❒ no
Eye pain	❒ yes	❒ no	Black stools	❒ yes	❒ no
Pain with bright lights	❒ yes	❒ no	Yellow skin	❒ yes	❒ no
Ear pain	❒ yes	❒ no	Yellow eyes	❒ yes	❒ no
Ear discharge	❒ yes	❒ no	Vaginal discharge	❒ yes	❒ no
Ringing in your ears	❒ yes	❒ no	Loss of urine	❒ yes	❒ no
Decreased hearing	❒ yes	❒ no	Painful urine	❒ yes	❒ no
Blockage of your nose	❒ yes	❒ no	Blood in your urine	❒ yes	❒ no
Nosebleeds	❒ yes	❒ no	Frequent/excessive urination	❒ yes	❒ no
Sore throat	❒ yes	❒ no	No menstrual periods	❒ yes	❒ no
Hoarseness	❒ yes	❒ no	Abnormal vaginal bleeding	❒ yes	❒ no
Difficulty swallowing	❒ yes	❒ no	Pelvic pain	❒ yes	❒ no
Chest pain	❒ yes	❒ no	Back pain	❒ yes	❒ no
Fast heartbeat	❒ yes	❒ no	Joint pain	❒ yes	❒ no
Fainting	❒ yes	❒ no	Joint swelling	❒ yes	❒ no
Difficulty breathing	❒ yes	❒ no	Muscle cramps	❒ yes	❒ no
Difficulty breathing while you're laying down	❒ yes	❒ no	Muscle weakness	❒ yes	❒ no
Swelling of your feet or hands	❒ yes	❒ no	Stiffness or pain in your joints	❒ yes	❒ no
Itching	❒ yes	❒ no	Paranoia	❒ yes	❒ no
Rash	❒ yes	❒ no	Cold intolerance	❒ yes	❒ no
Dryness	❒ yes	❒ no	Heat intolerance	❒ yes	❒ no
Suspicious lesions on skin	❒ yes	❒ no	Excessive drinking	❒ yes	❒ no
Unable to move arms or legs	❒ yes	❒ no	Excessive eating	❒ yes	❒ no
Seizures	❒ yes	❒ no	Abnormal bruising	❒ yes	❒ no
Shaking	❒ yes	❒ no	Enlarged lymph nodes	❒ yes	❒ no
Dizziness	❒ yes	❒ no	Hives	❒ yes	❒ no
Depression	❒ yes	❒ no	Hayfever	❒ yes	❒ no
Anxiety/nervous condition	❒ yes	❒ no	Persistent infections	❒ yes	❒ no
Memory loss	❒ yes	❒ no	HIV exposure	❒ yes	❒ no

Mental illness…….. ❒ yes ❒ no | Hallucinations……. ❒ yes ❒ no

Suicidal thoughts……. ❒ yes ❒ no

BACKGROUND INFORMATION

1. Have you ever **had** or **been vaccinated** for Chicken Pox? ..... ❒ yes ❒ no
2. Have you ever **had** or **been vaccinated** for Hepatitis? ..... ❒ yes ❒ no
3. Have you ever **had** or **been vaccinated** for Rubella (German measles)?..... ❒ yes ❒ no
4. Do you or your partner or any family member have a birth defect? ..... ❒ yes ❒ no

   If yes, who has the defect and what is it? _____
5. Have any of your or your partner's previous pregnancies, if any, resulted in a birth defect? . ❒ yes ❒ no

   If yes, what was the defect? _____
6. Do you or your partner or any family member have Cystic Fibrosis? ..... ❒ yes ❒ no

   If yes, who has cystic fibrosis? _____
7. Do you or your partner or any family member have Down Syndrome? ..... ❒ yes ❒ no

   If yes, who has Down Syndrome? _____
8. Do you or your partner or any family member have hemophilia? ..... ❒ yes ❒ no

   If yes, who has hemophilia? _____
9. Do you or your partner or any family member have Muscular Dystrophy? ..... ❒ yes ❒ no

   If yes, who has Muscular Dystrophy? _____
10. Do you or your partner or any family member have a neural tube defect? ..... ❒ yes ❒ no

    If yes, who has the defect and what is it? _____
11. Do you or your partner or any family member have any other chromosomal abnormalities? ..... ❒ yes ❒ no

    If yes, who has the abnormality and what is it? _____
12. Do you or your partner or any family member have mental retardation? ..... ❒ yes ❒ no

    If yes, who has mental retardation? _____
13. Are you or your partner of Ashkenazi Jewish ancestry? ..... ❒ myself ❒ partner ❒ both

    If yes, have you/partner been screened for Tay-Sachs disease? ..... ❒ yes ❒ no

    Cystic Fibrosis? ..... ❒ yes ❒ no

    If yes, indicate who and the results: ..... _____
14. Are you or your partner black? ..... ❒ myself ❒ partner ❒ both

    If yes, have you/partner been screened for sickle cell? ..... ❒ yes ❒ no

    If yes, indicate who and the results: ..... _____
15. Are you or your partner of French-Canadian ancestry? ..... ❒ myself ❒ partner ❒ both

    If yes, have you/partner been screened for Tay-Sachs disease? ..... ❒ yes ❒ no

    Cystic Fibrosis? ..... ❒ yes ❒ no

    If yes, indicate who and the results: _____
16. Are you or your partner of Italian, Greek, Portuguese or Mediterranean background? ❒ myself ❒ partner ❒ both

    If yes, have you/partner been tested for ß-thalaseemia? ..... ❒ yes ❒ no

    If yes, indicate who and the results: ..... _____
17. Are you or your partner of Philippine, Southeast Asian, or Indian ancestry? ..... ❒ myself ❒ partner ❒ both

    If yes, have you/partner been screened for α-thalaseemia? ..... ❒ yes ❒ no

    If yes, indicate who and the results: _____

PLEASE COMPLETE THIS SECTION IF YOUR ASSIGNED SEX AT BIRTH WAS FEMALE
(Please skip to the next section if your assigned sex at birth was male**):**

MENSTRUAL HISTORY

What was your last menstrual period? _____

How many days are there typically between the first day of one period and the first day of the next period? _____

Would you describe your periods as: ..... ❒ heavy ❒ moderate ❒ light

Are your periods: ..... ❒ regular ❒ irregular

Are your periods painful? ..... ❒ yes ❒ no

Would you describe that pain as:..... ❒ moderate ❒ severe ❒ mild

GYNECOLOGIC HISTORY

Do you have hair on your face that is concerning? ..... ❒ yes ❒ no

Do you have acne? ..... ❒ yes ❒ no

Do you use lubricants for vaginal sex? ..... ❒ yes ❒ no

Do you have pain with intercourse? ..... ❒ yes ❒ no

Have you ever had an abnormal pap smear? ..... ❒ yes ❒ no

Have you had a pelvic infection? ..... ❒ yes ❒ no

Have you had any sexually transmitted diseases? ..... ❒ yes ❒ no

Have you ever used any contraception? ..... ❒ yes ❒ no

If yes, please check: ❒ oral contraceptives ❒ IUD ❒ condoms ❒ other: _____

How often do you have sex?

OBSTETRICAL HISTORY

How many times have you been pregnant? _____

For each pregnancy, please fill in the following chart:

Month/year pregnancy ended	#1	#2	**#3**	**#4**
Pregnancy outcome (circle)	Vaginal delivery C-section Miscarriage (# of weeks: __) Termination Ectopic/Tubal	Vaginal delivery C-section Miscarriage (# of weeks: __) Termination Ectopic/Tubal	Vaginal delivery C-section Miscarriage (# of weeks: __) Termination Ectopic/Tubal	Vaginal delivery C-section Miscarriage (# of weeks: __) Termination Ectopic/Tubal
With current partner?	❒ yes ❒ no	❒ yes ❒ no	❒ yes ❒ no	❒ yes ❒ no
Time it took to get pregnant?				
Used Fertility Treatment?				
Sex of Baby	❒ male ❒ female	❒ male ❒ female	❒ male ❒ female	❒ male ❒ female
Weight of Baby				
Pregnancy complications	❒ yes ❒ no	❒ yes ❒ no	❒ yes ❒ no	❒ yes ❒ no

Have you used any of the following, please check:

❒ Basal body temp monitoring ❒ Ovulation predictor kit ❒ Clomiphene ❒ Femara/Letrozole ❒ Gonadotropins (fertility shots)

❒ In Vitro Fertilization ❒ Artificial insemination: ❒ partner sperm ❒ donor sperm

Have you ever had an x-ray (HSG) of your uterus and tubes? ..... ❒ yes ❒ no

If yes, where was it done? _____

What were the results? _____

Have you ever had a sonohysterogram (ultrasound with saline) of your uterus and tubes?

If yes, where was it done? _____

What were the results? _____

Has your partner had a semen analysis? ❒ yes ❒ no ❒ N/A

If yes, what were the results? _____

GYNECOLOGIC SURGERY

If you have had any of the following, please list the dates:		**Date**
Tubes and ovaries removed	❒ yes ❒ no	
D&C; cone	❒ yes ❒ no	
D&C, Leep	❒ yes ❒ no	
Treatment of endometriosis, medical or surgical	❒ yes ❒ no	
Hysteroscopy (view inside of uterus)	❒ yes ❒ no	
Laparoscopy (view inside abdominal cavity and pelvis)	❒ yes ❒ no	
Lysis of adhesions (scar tissue removal)	❒ yes ❒ no	
Fibroid removal	❒ yes ❒ no	
Hysterectomy (uterus removal)	❒ yes ❒ no	
Cutting of a uterine septum	❒ yes ❒ no	
Tubal ligation	❒ yes ❒ no	
Tubal ligation reversal	❒ yes ❒ no	

PLEASE COMPLETE THIS SECTION IF YOUR ASSIGNED SEX AT BIRTH WAS MALE

UROLOGICAL/FERTILITY HISTORY

At what age did you begin shaving? ☐ Under 12 ☐ 12-14 ☐ 15-17 ☐ 18-20 ☐ over 20

How would you describe your beard growth? ☐ Light ☐ Medium ☐ Heavy

Compared to other men in your family? ☐ Light ☐ Medium ☐ Heavy

Type of Underwear Worn: ☐ Boxer Shorts ☐ Jockeys ☐ Other:_____

Are you circumcised? ❒ yes ❒ no If NO, does the foreskin retract easily? ❒ yes ❒ no

Have you ever been treated for gonorrhea, syphilis, prostatitis or infection of the testicles and/or seminal vesicles? ❒ yes ❒ no

Any history of hernia repair (including shortly after birth)? ..... ❒ yes ❒ no

If YES, when? _____

History of Mumps? ..... ❒ yes ❒ no

If YES, when? _____

History of undescended testes? ..... ❒ yes ❒ no

History of injury to the testes? ..... ❒ yes ❒ no

History or diagnosis of varicocele (varicose vein in scrotum)? ..... ❒ yes ❒ no

☐ If YES, has this been treated? If so, when? _____

History of genitourinary infection? ..... ❒ yes ❒ no

Has there been a recent change in libido or sexual drive? ..... ❒ yes ❒ no

Do you have difficulty maintaining an erection? ..... ❒ yes ❒ no

If applicable, do have difficulty ejaculating in the vagina? ..... ❒ yes ❒ no

Has a doctor ever told you that you were infertile? ..... ❒ yes ❒ no

Has a semen analysis ever been performed? ..... ❒ yes ❒ no

☐ If YES – When?_____ Where? _____ Results? _____

Have fathered a child outside this relationship? ..... ❒ yes ❒ no

Have you ever doubted your fertility outside this relationship? ..... ❒ yes ❒ no

Any history of treatment to promote fertility in the past? ..... ❒ yes ❒ no

☐ If YES, please explain: _____

Has artificial insemination ever been suggested to achieve pregnancy? ..... ❒ yes ❒ no

☐ If YES, ☐ with YOUR Sperm? ☐ with DONOR Sperm?

Have you ever been employed in an occupation with sustained high temperatures? ..... ❒ yes ❒ no

Have you ever been a professional driver or do you drive long distances as part of your job? ..... ❒ yes ❒ no

History of recent hospitalization or prolonged bed rest? ..... ❒ yes ❒ no

History of hot baths, sauna or steam baths? ..... ❒ yes ❒ no

Are you an IV drug user? ..... ❒ yes ❒ no

Have you ever had sex with an IV drug user? ..... ❒ yes ❒ no

Have you ever had sex with a homosexual or bisexual person? ..... ❒ yes ❒ no

Are you at risk for AIDS? ..... ❒ yes ❒ no

Total number of sexual partners: _____