



- a. Laparoscopy
  - i. When and where was it done?
  - ii. What did it show?
- 4. Previous fertility treatments: Yes or No
  - a. Clomid cycles: Yes or No
    - i. With intrauterine inseminations: Yes or No
    - ii. Natural intercourse: Yes or No
    - iii. Number of months used:
    - iv. Dosage used:
    - v. Monitoring of response: Ultrasound / bloodwork / ovulation predictor kits
  - b. Injectable medications (Gonal F, Puregon, FSH, Repronex, Metrodin)
    - i. Number of cycles?
    - ii. With intrauterine inseminations? Yes or No
  - c. Prior use of donor sperm Yes or No
    - i. Number of cycles
  - d. In vitro fertilization
    - i. Number of cycles
    - ii. Where did these cycles take place?
    - iii. Did it also involve intra-cytoplasmic sperm injection: Yes or No
    - iv. Any complications? (Ovarian hyperstimulation syndrome?)
- 5. Other treatments:

### **SEXUAL HISTORY:**

1. How many times per week do you and your partner have intercourse?
2. Is intercourse painful: Yes or No
  - a. Does this pain ever make you stop during intercourse?
3. Are there any problems with intercourse for the male? Yes or No
  - a. Pain for the male?
  - b. Premature ejaculation?
  - c. Problems gaining an erection?
4. Do you use lubricants/foams with intercourse? Yes or No

### **MENSTRUAL HISTORY:**

1. Last menstrual period (date of first day of last period):
2. Age when periods began:
3. Average number of days from the start of one menstrual period to the start of the next: \_\_\_ days
  - a. Have they always been like this?
  - b. What is the longest time between periods in the last year?
  - c. What is the shortest time between periods in the last year?
  - d. Do you require medication to bring on a period?
4. What is the flow of your periods like? Light/moderate/heavy
  - a. How many days does your period last?
5. Are your periods painful? Yes or No

- a. What medications do you take for the pain?
- b. Do they keep you from going to work or school?
- c. How many days of your period does the pain last?

**GYNECOLOGIC HISTORY:**

1. Do you experience discharge/ fluid from your breasts? Yes or No
  - a. When did this begin?
  - b. When does it occur?
  - c. What does it look like?
2. Do you have any unwanted hair growth on your body? Yes or No
  - a. Where?
  - b. How do you treat it? Shaving/plucking/medication
    - i. How often?
3. Do you have problems with acne? Yes or No
  - a. Where?
4. Previous use of birth control? Yes or No
  - a. Type: birth control pill \_\_\_\_\_ IUD \_\_\_\_\_ Other types:
  - b. Duration of use:
  - c. When did you stop using it?:
5. Do you have a history of endometriosis? Yes or No
6. Pap smears?
  - a. When was your last one? \_\_\_\_\_ Result:
  - b. Have you ever had an abnormal one? Yes or No When:
    - i. Treatment:
    - ii. Normal paps since then: Yes or No
7. History of PID (pelvic inflammatory disease): Yes or No
8. History of sexually transmitted diseases (herpes/gonorrhea/chlamydia)? Yes or No
  - a. Were you treated?
  - b. Was your partner treated?

**SURGICAL HISTORY:**

Year	Type of surgery	Who did the surgery?	Findings

Have you ever had any problems with anesthesia? Yes or No

Describe these problems:

**MEDICAL HISTORY:**

1. Do you have any history of medical problems?

<b>Illness or disease</b>	<b>Medication</b>	<b>Treatment</b>	<b>Admission to hospital – Yes or No</b>
Diabetes			
Thyroid disease			
Asthma			
Heart murmur			
HIV, Hepatitis B or C			

2. Do you have any mental illnesses? Yes or No

a. Do you suffer from depression? Yes or No

3. What prescription medications do you take regularly?

4. Do you take folic acid or Materna?

5. What medications do you take occasionally?

6. Do you take any herbal or natural products? Yes or No

a. What ones?

7. Do you have any **allergies**?

a. To medications? Yes or No

i. What happens to you when you take this medication?

b. Any other allergies?

c. Allergy to latex: Yes or No

8. Do you smoke? Yes or No

a. Have you **ever** smoked? Yes or No

When did you stop?

b. How much do you smoke?

9. How many alcohol drinks a week do you take?

10. Do you take any street drugs? Yes or No

a. How often?

**SOCIAL HISTORY:**

1. Number of years in current partnership?

a. Married/ common-law/ other

2. What is your occupation?:

a. Are you exposed to harsh chemicals in your job? Yes or No

b. What are they?

c. What type of exposure (skin, breathing, etc):

**FAMILY HISTORY:**

1. Is there a family history of any of the following:

	<b>Yes</b>	<b>No</b>	<b>Who</b>	<b>Provide details</b>
<b>Breast cancer</b>				
<b>Ovarian cancer</b>				
<b>Bowel cancer</b>				
<b>Other cancers</b>				
<b>Premature menopause &lt; 40 years</b>				
<b>Endometriosis</b>				
<b>Neural tube defects</b>				
<b>Mentally challenged</b>				
<b>Recurrent pregnancy loss</b>				
<b>Genetic problems (chromosomes)</b>				
<b>Any others – what are they?</b>				

What is your family origin/ethnic background?

What is your height:

weight: