



**Bedford  
Commons**  
OB-GYN, P.A.

## Fertility Care Program

### Medical History and Information

## *Female*

**Please Complete the Following:**

Date: \_\_\_\_\_  
 Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Partner's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Primary Care Provider: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Usual Weight: \_\_\_\_\_ Height: \_\_\_\_\_  
 Current Medications: \_\_\_\_\_  
 Allergies to medications, eggs, latex: \_\_\_\_\_

**Menstrual History**

Date of the 1<sup>st</sup> day of your last 2 periods: \_\_\_/\_\_\_/\_\_\_; \_\_\_/\_\_\_/\_\_\_  
 My periods usually come every \_\_\_ days.  
 My period usually lasts \_\_\_ days.  
 I have/have had irregular periods: \_\_\_ yes \_\_\_ no  
 My flow is \_\_\_ scant \_\_\_ moderate \_\_\_ heavy  
 I have painful periods: \_\_\_ yes \_\_\_ no  
 I have bleeding between my periods: \_\_\_ yes \_\_\_ no  
 I began menstruation at age \_\_\_.

**Birth Control**

Have you ever used any of the following? (circle answer)

- |                     |                                  |
|---------------------|----------------------------------|
| Birth Control Pills | Foam                             |
| IUD                 | Sponge                           |
| Diaphragm           | Condoms                          |
| Norplant            | Patch                            |
| Depo Provera        | Ring                             |
| Lunelle             | Tubal Sterilization/Tubes Untied |

Method	Dates	Length Used	Problems

Clinical Notes (for office use only)

**Female Medical History and Information**

**Sexual History**

How long have you been having unprotected intercourse? \_\_\_\_\_  
 How long have you been actively attempting pregnancy? \_\_\_\_\_  
 How many times do you have intercourse per week? \_\_\_\_\_ times \_\_\_\_\_ none \_\_\_\_\_ N/A  
 Have you ever used over-the-counter kits to time intercourse? \_\_\_ yes \_\_\_ no  
 If yes, does it show ovulation? \_\_\_ yes \_\_\_ no  
 Do you use lubricants (K-Y jelly, etc.) during intercourse? What types? \_\_\_\_\_  
 Have you ever had any of the following?  
 Chlamydia – date \_\_\_\_\_ Gonorrhea – date \_\_\_\_\_ Herpes – date \_\_\_\_\_  
 Genital warts/HPV – date \_\_\_\_\_ Syphilis – date \_\_\_\_\_ HIV/AIDS – date \_\_\_\_\_  
 Hepatitis – date \_\_\_\_\_ Other – date \_\_\_\_\_  
 When was your last pap smear? \_\_\_\_\_  
 Have you ever had an abnormal pap smear? \_\_\_ yes \_\_\_ no  
 If yes, date \_\_\_\_\_ and treatments \_\_\_\_\_

**Obstetric History**

Have you ever been pregnant? \_\_\_ yes \_\_\_ no If yes, complete below:  
 Total number of pregnancies: \_\_\_\_\_ number of miscarriages: \_\_\_\_\_ number of abortions \_\_\_\_\_  
 number of ectopic/tubal: \_\_\_\_\_ number of still born: \_\_\_\_\_  
 Any pregnancies with birth defects? \_\_\_ yes \_\_\_ no

Describe pregnancy/pregnancies below:

Number	Date	Weeks	Time to Conceive	Treatments used to Conceive	Type of Delivery	Complications	Current Partner yes/no
1.							
2.							
3.							
4.							

Clinical Notes (for office use only)

*Female Medical History and Information*

**Medical/Surgical History**

List any medications you are currently taking including prescription medications, over-the-counter medications, herbal and/or vitamin supplements. \_\_\_\_\_

\_\_\_\_\_

Do you have any medical problems?

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

Have you had any surgeries? \_\_\_ yes \_\_\_ no

If yes, list date of surgery, reason for surgery, and type of surgery.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Family History**

Do you have relatives (grandparents, parents, siblings, children) with medical problems? If yes, list the disease and the relative with the problem.

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

( ) check here if your family medical history is unknown.

**Social History**

Occupation: \_\_\_\_\_

How many caffeinated beverages (coffee, tea, soda) do you drink/day? \_\_\_\_\_

Have you ever or do you smoke cigarettes? \_\_\_ yes \_\_\_ no

How many/day? \_\_\_\_\_ When did you quit? \_\_\_\_\_

Do you drink alcohol? \_\_\_ yes \_\_\_ no

\_\_\_\_\_ drinks/week Type: \_\_\_\_\_

Do you use recreational drugs? \_\_\_ yes \_\_\_ no

Type: \_\_\_\_\_

List the form and frequency of any regular exercise: \_\_\_\_\_

Have you ever been told you have or suspected you have an eating disorder? \_\_\_ yes \_\_\_ no

If yes, describe. \_\_\_\_\_

Are you aware of any radiation exposure other than x-rays? \_\_\_ yes \_\_\_ no If yes, describe.

\_\_\_\_\_

