

**CELEBRATION OF LIFE SPONSORSHIP PROGRAM  
FEMALE PATIENT HISTORY -- CONFIDENTIAL - FOR OFFICE USE ONLY**

**Administrative Information:**

Social Security #: \_\_\_\_\_ Date: \_\_\_\_\_  
 Full Name: \_\_\_\_\_ Your Age: \_\_\_\_\_  
 Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Blood Type: \_\_\_\_\_  
 \_\_\_\_\_ Race: \_\_\_\_\_  
 Country: \_\_\_\_\_ Marital Status: M  S  D  W  Other: \_\_\_\_\_  
 Telephone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_  
 Partner's Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Social Security #: \_\_\_\_\_

**Reproductive and Gynecologic History**

**Reproductive:**

Total # of pregnancies you have achieved \_\_\_\_\_  
 Full term pregnancies \_\_\_\_\_ Pre-term pregnancies \_\_\_\_\_ Miscarriages \_\_\_\_\_ Therapeutic Abortions \_\_\_\_\_  
 # living children \_\_\_\_\_ # adopted children \_\_\_\_\_

Please complete the following information regarding your pregnancies beginning with most recent:

Preg #	Date	Ectopic (Y/N)	Abortion / Miscarriage (Y/N)	Liveborn (Y/N)	Stillborn (Y/N)	Term (Y/N)	IVF Pregnancy (Y/N)
1)	_____	_____	_____	_____	_____	_____	_____
2)	_____	_____	_____	_____	_____	_____	_____
3)	_____	_____	_____	_____	_____	_____	_____

Age at first pregnancy: \_\_\_\_\_ # pregnancies with current partner: \_\_\_\_\_  
 # deliveries by C-Section: \_\_\_\_\_ # infant deaths (past live birth): \_\_\_\_\_

Please mark "Y" or "N" in the following blanks regarding past pregnancies:

Exposure to Rubella	_____	Radiation Exposure	_____
Toxemia	_____	Prolapsed Cord	_____
Pregnancy Diabetes	_____	Uterine Dysfunction	_____
Incompetent Cervix	_____	Vaginal Bleeding	_____
Placenta Over Cervix	_____	Infection	_____
Increased Amniotic Fluid	_____	Placenta Separation	_____
Premature Labor	_____	Water Broke Prematurely	_____

Congenital Abnormalities  
 Specify: \_\_\_\_\_

Has anyone in your family had an infant with a congenital abnormality? \_\_\_\_\_

Specify: \_\_\_\_\_

Chromosomal Abnormalities? \_\_\_\_\_

Specify: \_\_\_\_\_

Do any chromosomal abnormalities run in your family? \_\_\_\_\_

Specify: \_\_\_\_\_

**Gynecologic:**

Have you ever had an abnormal Pap Smear? \_\_\_\_\_

If yes, give treatment: \_\_\_\_\_

**Contraception:**

	Y/N	1 <sup>st</sup> year use	Last use	Duration (years)
Birth Control Pills	_____	_____	_____	_____
IUD	_____	_____	_____	_____
Spermicide	_____	_____	_____	_____
Tubal Ligation	_____	_____	_____	_____

Please mark a "Y" in the space provided if you have been diagnosed with any of the following:

- DES Exposure \_\_\_\_\_ (Did your mother take DES while pregnant with you?)
- Primary Infertility \_\_\_\_\_ (Always infertile?)
- Secondary Infertility \_\_\_\_\_ (Infertile past previously achieving pregnancy?)
- Unexplained Infertility \_\_\_\_\_
- Ovarian Cyst \_\_\_\_\_
- Abnormal Shaped Uterus \_\_\_\_\_
- Luteal Phase Defect \_\_\_\_\_ (Abnormal progesterone level in late cycle?)
- Abnormal Uterine Bleeding \_\_\_\_\_
- Recurrent Miscarriage \_\_\_\_\_

Have you had an artificial insemination? \_\_\_\_\_ If so, how many? \_\_\_\_\_

If you have taken any of the following medications, please list the number of months in which you took them:

Clomid/Serophene	_____	HCG/Pregnyl/Profasi	_____
Danazol/Danocrine	_____	Progesterone	_____
Pergonal/Repronex/Humgon	_____	Lupron	_____
Metrodin/Fertinex/Follistim/Gonal-F	_____	Parlodel	_____

Any other medications in past or currently? Yes  No

If yes, please list medication and number of months taken:

Age at first menstrual period? \_\_\_\_\_

# days from beginning of period to beginning of next period? \_\_\_\_\_

Are your periods regular? \_\_\_\_\_

Duration of menstrual flow? \_\_\_\_\_

Do you experience menstrual cramping? \_\_\_\_\_

Do you bleed or spot between periods? \_\_\_\_\_

Do you use lubricants for intercourse? \_\_\_\_\_ If so, what? \_\_\_\_\_

Do you douche before or after intercourse? \_\_\_\_\_

Do you experience pain with intercourse? \_\_\_\_\_

How long have you tried to conceive? \_\_\_\_\_

Have you ever had a mammogram? \_\_\_\_\_ Results? \_\_\_\_\_

## Medical and Surgical History

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Type: \_\_\_\_\_

Are you allergic to any medications? \_\_\_\_\_

Current medications or supplements: \_\_\_\_\_

Current herbal or homeopathic therapies: \_\_\_\_\_

### Hospitalizations:

	Date	Reason	Surgery	Type Surgery
1)	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
2)	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
3)	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
4)	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____

Have you lost or gained 20 or more pounds in the past year? \_\_\_\_\_

If yes, explain: \_\_\_\_\_

Have you ever had anorexia or bulimia? \_\_\_\_\_

### Serious/Chronic Illness:

Please mark "Y" or "N" in the following blanks:

Heart Attack	_____	Endometriosis	_____	Rheumatic Fever	_____	Asthma	_____
Blood Clots	_____	Breast Soreness	_____	High Blood Pressure	_____	Neurologic Problems	_____
Stroke	_____	Breast Discharge	_____	Gallbladder Disease	_____	Pneumonia	_____
Valve Disease	_____	Hirsutism	_____	Liver Disease	_____	Anemia	_____
Depression	_____	Thyroid Problems	_____	Ulcers	_____	German Measles	_____
Anxiety	_____	Kidney Disease	_____	Diabetes	_____	Regular Measles	_____
Psychosis	_____	Bladder Infection	_____	Arthritis	_____	Blood Transfusion	_____
Hepatitis	_____	Scarlet Fever	_____	Seizures	_____	Tuberculosis	_____
Bronchitis	_____	Changes in cognition, speech, gait	_____	Exposure to tissues suspected of harboring transmissible spongiform encephalopathies:	_____	(yourself)	_____
						(family member)	_____
Cancer	_____						
Type:	_____	Chemotherapy?	_____	Radiation?	_____	Surgery?	_____

Please mark "Y" or "N" in the following blanks:

Gonorrhea	_____	Treatment:	_____
Syphilis	_____	Treatment:	_____
Chlamydia	_____	Treatment:	_____
Mycoplasma	_____	Treatment:	_____
Herpes	_____	Treatment:	_____
AIDS	_____	Treatment:	_____
Other	_____	Treatment:	_____
Explain	_____		

If you have any other serious illnesses we should know about, please list: \_\_\_\_\_

## Social History/Habits

Occupation \_\_\_\_\_

Are you exposed to any hazards in your job (i.e., chemicals, toxic fumes, radiation?)

Yes  No

Exercise Habits: Type \_\_\_\_\_

# hours per week \_\_\_\_\_

Have you ever been physically or sexually abused? Yes  No

<u>HABITS</u>	Usage*	Amt/Week	Years	Years Since Stopping
Tobacco	_____	_____	_____	_____
Reg. Coffee (cups)	_____	_____	_____	_____
Decaf. Coffee (cups)	_____	_____	_____	_____
Tea (cups)	_____	_____	_____	_____
<u>SOFT DRINKS</u>				
Regular (glass) Caffeinated	_____	_____	_____	_____
Decaffeinated	_____	_____	_____	_____
Diet (glass) Caffeinated	_____	_____	_____	_____
Decaffeinated	_____	_____	_____	_____
Art Sweeteners (# pkts)	_____	_____	_____	_____
Beer (glass)	_____	_____	_____	_____
Wine (glass)	_____	_____	_____	_____
Liquor (drinks)	_____	_____	_____	_____
<u>RECREATIONAL DRUGS</u>				
Marijuana	_____	_____	_____	_____
Cocaine	_____	_____	_____	_____
Others	_____	_____	_____	_____

\* Usage = C-Current; P-Past

### Family History:

<u>Reproductive:</u>	Relation*	Description	Psychiatric:	Relation*	Description
Congenital Defects	_____	_____	Depression	_____	_____
Chromosomal Abnormal.	_____	_____	Anxiety	_____	_____
Uterus Abnormalities	_____	_____	Psychosis	_____	_____
Infertility	_____	_____	Other	_____	_____
<u>Other</u>	_____	_____		_____	_____
	_____	_____	Other Illnesses:	_____	_____
Cardiovascular:	_____	_____	Cancer (type)	_____	_____
Heart Attack	_____	_____	Diabetes	_____	_____
Blood Clots	_____	_____	Liver Disease	_____	_____
Stroke	_____	_____	Kidney Disease	_____	_____
Valve Disease	_____	_____	AIDS	_____	_____
High Blood Pressure	_____	_____	Other	_____	_____

\*\* Relation = M-Mother; F-Father; B-Brother; S-Sister; C-Child; O-Other; PGM-Paternal Grandmother; PGF-Paternal Grandfather; MGM-Maternal Grandmother; MGF-Maternal Grandfather