SAN DIEGO Fertility Center

www.sdfertility.com
www.eggdonors.com

Female Medical History

Last Name	First Name	Date of Birth		
		Year	Day	Month

Height		Weight		Age	

Marital Status	Single ☐	1st Marriage ☐	2nd Marriage ☐	Other ☐

Fertility History

How long have you been trying to become pregnant?	
Have you had any fertility issues with previous partners? If so, please describe.	
Unprotected Sex for # years?	
Well timed intercourse for # years?	
Frequency of sexual intercourse per week?	
Important details (if any).	
Have you ever been pregnant before? If yes, please list details below.	

Previous Pregnancies

Total number of pregnancies with current partner	
Total number of pregnancies with previous partners	
Miscarriages	
Ectopic pregnancies	
Terminations	
Live born Children	
# C-section	
# Vaginal Delivery	
Adopted Children	

Menstrual History	
Age of first menstruation	
Are your menstrual cycles regular?	
How often do you get your menses? (time interval between menses from start to start)	
When was the first day of your last menstrual cycle?	
Duration of bleeding (days)	
How heavy are your menses? (light, regular, heavy)	
How painful are your menses on average? (mild, moderate, severe)	
Do you have bleeding between your menses?	
Have you ever been on the birth control pill? If yes, did you ever have any problems taking it?	
Any Other pertinent information.	

GYN History	
Have you ever had the following gynecological issues? If yes, please describe your condition and list any treatment you received.	
Fibroids	Appendicitis
Uterine Polyps	Gonorrhea
Endometriosis	Chlamydia
Endometrioma	Herpes (HSV)

Ovarian cysts	Other sexually transmitted infections
Abnormal Pap smear If yes, have the follow ups been normal?	HPV
When was your last Pap Smear?	When was your last mammogram?
Additional Conditions not listed	

GYN Surgery History
Have you ever had surgery on your uterus? Please describe. Ex: removal of polyps, fibroids.
Have you ever had surgery on your ovaries? Please describe? Ex: ovarian cyst,
Have you ever had surgery on your cervix? Please describe? Ex: LEEP or Cervical Conization
Have you ever had surgery on your fallopian tubes? Please describe. Ex: tubal ligation, tubal reversal, ectopic pregnancy, tubal removal.

Infertility Evaluation

Please list any results of previous infertility evaluation you have completed. Please list dates if possible.

Ovarian reserve testing	FSH/Estradiol level:
	AMH:
	Antral Follicle Count:
Hysterosalpingogram (HSG)	
Saline infusion Sonohysterogram	
Genetic Testing for carrier status	
Recurrent pregnancy loss testing	

Endocrine Testing	TSH:
	Thyroid antibody (TPO):
	Prolactin:
	Vitamin D:
	Hemoglobin A1C:
	Testosterone level:

Fertility Treatment History

Fertility Drugs Alone

Medication	# of cycles	Date of last cycle	Dose	Outcome
Clomid				
Injectable Fertility Drugs (ie. Gonal-F, Follistim, Menopur)				

Intrauterine Insemination (IUI)

Medication	# of cycles	Date of last cycle	Dose	Outcome
Natural Cycle + IUI				
Clomid + IUI				
Injectable fertility drugs + IUI				

In Vitro Fertilization (IVF)

	Date	Dose	# eggs	# Embryos	PGS? # normal	Freeze all cycle? # frozen	Fresh Transfer? # transferred	Outcome
IVF #1								
IVF #2								
IVF #3								

Frozen Embryo Transfers

	Date	Medicated?	# thawed	# survived	# transferred	Outcome
FET #1						
FET #2						
FET #3						

Please share any additional information regarding your fertility treatment history which you feel may be pertinent:

Past Medical History	
Please list your medical problems.	
List any surgeries you have had. (Non-GYN)	
Are you taking any medications? Please list.	
Are you allergic to any medications? Please list. Please describe your reaction.	
Do you have a latex allergy?	
Social History	
Have you ever smoked? For how long?	
Do you smoke currently? How much do you smoke currently?	
How many alcoholic drinks do you consume per week?	
How many Caffeinated drinks do you consume per week?	
Do you use marijuana or other drugs? If yes, please list type and frequency.	
Occupation	

Family & Genetics History

Ethnic Background: Please mark all that apply.

☐	Southeast Asia, Taiwan, China, or the Philippines
☐	Italy, Greece, or the Middle East
☐	Eastern European (Ashkenazi) Jewish or French Canadian
☐	African American, African, or Black

If you are adopted and do not know any family history regarding either of your biological parents, you do not need to complete the family history section below.

☐	I am adopted

Family History:

Has anyone in your family been affected by the following conditions?

Please mark all that apply and list any additional details.

☐	Down Syndrome	☐	Other Nerve, Muscle or Seizure Disorder (e.g. epilepsy)
☐	Other Chromosome Abnormalities	☐	Phenylketonuria (PKU)
☐	Neural Tube Defect (e.g. spina bifida, anencephaly)	☐	Kidney Disease
☐	Hemophilia or Other Bleeding Disorders	☐	Heart Defect (from birth)
☐	Cystic Fibrosis	☐	Cleft Lip and/or Cleft Palate
☐	Sickle Cell Anemia	☐	Limb Defects (extra or missing digits, malformed arms, legs, hands or feet)
☐	Thalassemia (Mediterranean anemia)	☐	Deafness / Early Onset Hearing Loss
☐	Tay Sach's Disease	☐	Blindness / Early Onset Vision Loss
☐	Muscular Dystrophy	☐	Diabetes
☐	Neurofibromatosis	☐	Cancer before age 50
☐	Huntington's Disease	☐	Heart Attack before age 40
☐	History of still birth or 3 or more first trimester miscarriages	☐	History of neonatal death
☐	Blood clotting disorders?	☐	Stroke, pulmonary embolus, deep vein thrombosis
☐	Are you and your partner related in any way? (ex: cousins?)	☐	Mental Retardation or developmental Delay
☐	Genetic defect or chromosome abnormality not listed: please describe:	☐	Any other family history you are concerned about: