RCC
The Reproductive Care Centre

PATIENT HISTORY FORM:

Revised: March 2019

Welcome to Reproductive Care Centre! This history form should be completed and brought with you to your initial consultation with your physician. Please complete the form to the best of your ability. There may be some sections in the form that you do not need to fill out because they are not relevant to you. Please print off a separate form for each patient and partner (if applicable) involved in this process.

Today's Date (DD/MM/YYYY): _____

First and Last Name: _____ **Preferred Name:**_____

Pronoun Used: □ She □ He □ They □ Other ____ **Birth Date (DD/MM/YYYY):** _____

Gender: □ Female □ Male □ Intersex □ F t M □ M t F □ Non-binary □ **Other:** _____

Age: ____ **Occupation:** _____ **Ethnic Origin:** _____ **Relationship Status:** _____

Sexual Orientation: □ Heterosexual □ Bisexual □ Gay □ Lesbian □ Queer □ Two-Spirit □ Other: _____

What is your height? _____ **What is your weight?** _____

What is the reason you are seeking fertility care? _____

_____

Have you been trying to become pregnant?: Yes - **For how long?** _____ or No

1) Pregnancy History:

□ N/A

	Year	Current partner?	Time taken to become pregnant	Miscarriage/ therapeutic abortion	Ectopic – treatment	Weeks of pregnancy	Live births
1		□ Yes □ No					
2		□ Yes □ No					
3		□ Yes □ No					
4		□ Yes □ No					

Any difficulty becoming pregnant with any of these pregnancies? _____

2) Previous Infertility Investigations and Treatments:

□ N/A

1. **Have you had an x-ray dye test of your uterus (sonoHSG- fallopian tube testing):** Yes or No □ N/A
    a. **If yes, where was it done?** _____
    b. **If yes, when was it done?** _____
    c. **If yes, what were the results?** _____
        i. **Tubes open?** Yes or No

ii. **Normal uterus?** Yes or No

2. **Previous surgeries related to infertility investigation?** Yes or No *(if yes, please answer #3. a.)*

   a. **Laparoscopy**

      i. **When and where was it done?**_____

      ii. **What did it show?**_____

3. **Previous fertility treatments:** Yes or No *(if yes, please answer questions #4. a-d., #5)*

   a. **Clomid/Letrozole 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, Menopur)**

      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** (i.e. Ovarian hyperstimulation syndrome)**?** _____

4. **Other treatments:** _____

3) Menstrual History:

□ N/A

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?**_____

4) Gynecologic History:

□ N/A

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?** Yes or No
   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?** Yes or No
   b. **Was your partner treated (if applicable)?** Yes or No
9. **Have you ever had any problems with anesthesia?** Yes or No
   a. **Describe these problems:** _____

5) Sexual History:

1. **How many times per week/month do you and your partner take part in sexual activity**?_____ □ N/A
   a. **How long have you had unprotected sexual activity with this partner?** _____
2. **Is sexual activity painful:** Yes or No □ N/A
   a. **Does this pain ever make you stop?**_____
3. **Premature ejaculation or difficultly ejaculating?** Yes or No □ N/A
4. **Problems gaining/maintaining an erection?** Yes or No □ N/A
5. **Do you use lubricants (i.e. oils, saliva)/foams with intercourse?** Yes or No □ N/A

6) Surgical History:

Have you had surgery in the past? (Please answer in the table below):

Year	Type of surgery	Who did the surgery?	Findings

7) Medical History:

1. **Do you have any history of medical problems? (Please answer in the table below):**

Illness or disease	Medication	Treatment	Admission to hospital
Diabetes			□ Yes □ No
Thyroid disease			□ Yes □ No
Asthma			□ Yes □ No
Heart Murmer			□ Yes □ No
HIV, Hepatitis B or C			□ Yes □ No

Any other medical issues (not listed in the table above): _____

2. **Do you have any mental illnesses?** Yes or No
    a. **Do you suffer from depression?** Yes or No
    b. **Do you suffer from anxiety?** Yes or No
3. **What prescription medications do you take regularly?** _____
4. **Do you take folic acid or Materna?** Yes or No □ N/A
5. **What medications do you take occasionally?** _____
6. **Do you take any herbal or natural products?** Yes or No
    a. **Which ones?** _____
7. **Please list any allergies:** Yes or No _____
    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. **If no, have you ever smoked?** Yes or No
        i. **When did you stop?** _____
    b. **If yes, how much do you smoke?** _____
9. **How many alcohol drinks a week do you take?** _____
10. **Do you take any street drugs/marijuana?** Yes or No
    a. **If yes, how often?** _____

8) Social History:

1. **Number of years in current partnership?**_____ □ N/A
    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)?:** _____

9) Family History:

1. Is there a family history of any of the following? (Please refer to the table below):

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

10) Urologic History:

□ N/A

1. **Semen Analysis**
    a. **When was it done?**_____ **c. Where was it done?** _____
    b. **What was the result?**_____
2. **Any children from a previous relationship?** Yes or No **Pregnancy outcome? (eg. Healthy child?)**_____
3. **Any history of infections or injuries of the penis or prostate?** Yes or No
4. **Any history of gonorrhea, chlamydia or genital warts?** Yes or No
5. **Undescended testicles as a baby?** Yes or No
    a. **Was this corrected with surgery?** Yes or No
    b. **At what age did this surgery occur?** _____
6. **Have you had surgery for any of the following?:**
    a. **Hernia repair:** Yes or No
    b. **Varicocele:** Yes or No
    c. **Previous vasectomy?** Yes or No
        i. **What year did this occur?** _____
    d. **Previous reversal of vasectomy?** Yes or No
        i. **What year did this occur?** _____
7. **Are you exposed to excessive heat to the testicles (hot-tub, work-related)?** _____

Thank you for taking the time to fill out this form! ☺