Female History

Welcome to Advanced Reproductive Center of Hawaiʻi. Please take a moment to provide the information requested below so our team can better serve you.

Advanced Reproductive Center *of* Hawaiʻi

▶ PATIENT NAME ____________ AGE ____________ DATE OF BIRTH ____________

Family history

Any history of the following in your immediate family (Mother, Father, Siblings):

Alcoholism ____________ Birth Defects ____________

Breast Disease ____________ Cancer ____________

Diabetes (on insulin) ____________ Heart Disease ____________

High Blood Pressure ____________ Infertility/Miscarriage ____________

General health history

Please indicate if you have ever experienced any of the following:

Headaches	Asthma	Drug Abuse	Thyroid Disease	High Blood Pressure
Migraines	Diabetes	Heart Murmur	Cancer	Pain with intercourse
Anxiety	Heart Disease	Liver Problems	Kidney Disease	Abnormal Hair Growth
Depression	Back Pain	Breast Discharge		Breast pain/lumps

Mammogram (date__________) Other *(Please specify)* ____________

Any known drug allergies ____________

Current medications that you are taking ____________

Height ____________ Weight ____________

Has your weight changed more than 10 lbs In the past year? NO YES

Have you ever had a blood transfusion? If so, when? ____________ NO YES

Surgical history

Please list all surgical procedures that you have had:

	DATE	TYPE OF SURGERY	PHYSICIAN	FINDINGS (IF ANY)
1				
2				
3				

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ARCHFO - Female History 2022-04-22 20220425

Female History *(continued)*

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Menstrual history

How old were you when your period began? ________ Are they regular? NO YES

What is the usual interval between the start of one period and the start of the next? ________

How many days does your period last? ________ Is the flow heavy, moderate or light? ________

Do you have bleeding between your periods? NO YES

Do you have cramps? NO YES If yes, every cycle? NO YES

Do you take any medications for pain relief? If yes, list ________ NO YES

Do you get moody, depressed or bloated? NO YES

When was the first day of your last period? ________

Reproductive history

Who is your current Ob-Gyn physician? ________

Who referred you for IVF treatment? ________

How long have you been trying to get pregnant? ________ When was your last PAP Smear? ________

Have you ever had an abnormal PAP Smear? If yes, when? ________ NO YES

Have you ever had a mammogram? If yes, when? ________ NO YES

Results? ________

Have you ever had any sexually transmitted diseases? If yes, when? ________ NO YES

Chlamydia Gonorrhea Herpes Other ________

Have you ever been diagnosed with tubal disease? If yes, when? ________ NO YES

Have you ever been diagnosed with endometriosis? If yes, when? ________ NO YES

Have you ever been diagnosed with an ovarian cyst? If yes, when? ________ NO YES

Have you ever been diagnosed with polycystic ovaries? If yes, when? ________ NO YES

Have you ever been diagnosed with fibroids in your uterus? If yes, when? ________ NO YES

Have you ever used an IUD? If yes, when? ________ NO YES

Have you ever taken birth control pills? If yes, when? ________ NO YES

Have you ever had pelvic inflammatory disease? If yes, when? ________ NO YES

Do you have both of your ovaries? If no, which? ________ NO YES

Did your mother take DES when she was pregnant with you? I Don't Know NO YES

Have you ever had previous artificial inseminations? If yes, when? ________ NO YES

Have you ever had a previous IVF attempt? If yes, when? ________ NO YES

Female History *(continued)*

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Pregnancy history

List ALL pregnancies, specifying under outcome whether live-birth, stillborn, ectopic, miscarriage or abortion.

1 ______ PREGNANCY YEAR ______ OUTCOME ______ PREGNANCY LENGTH ______ FATHER (PRESENT, PARTNER/PREVIOUS)

2 ______ PREGNANCY YEAR ______ OUTCOME ______ PREGNANCY LENGTH ______ FATHER (PRESENT, PARTNER/PREVIOUS)

3 ______ PREGNANCY YEAR ______ OUTCOME ______ PREGNANCY LENGTH ______ FATHER (PRESENT, PARTNER/PREVIOUS)

Are there any birth defects in your family? If yes, when? ______ NO YES

Social history

Do You smoke? If yes, how much per day? ______ NO YES

Do you drink alcohol? If yes, how often? ______ NO YES

Do you use illicit drugs? If yes, what and how often? ______ NO YES