Pope Paul VI Institute

NaProTECHNOLOGY

Female General Information Form

Pope Paul VI Institute • 6901 Mercy Road • Omaha, NE 68106 • Ph# 402-390-6600 • Fax # 402-390-9851

Date: _____

Name: _____ Age: _____ DOB: _____
Last First

Name of spouse: _____ Age: _____ DOB: _____
Last First

Referring physician: _____ Primary care physician: _____

Trying to conceive? No ☐ Yes ☐ If so how long? _____ (years and months)

Gynecological History

Please circle the appropriate answer:

Abnormal pap (date of last pap)	yes	no	Mom took DES	yes	no
Acne	yes	no	Mycoplasma	yes	no
Breast discharge	yes	no	Ovarian cysts	yes	no
Chlamydia	yes	no	Painful intercourse	yes	no
Douche	yes	no	Pelvic adhesions	yes	no
Endometriosis	yes	no	Pelvic infection	yes	no
Excessive fear	yes	no	Physical abuse	yes	no
Fibroids	yes	no	Poor sense of smell	yes	no
Gonorrhea	yes	no	Prior IUD use	yes	no
Herpes	yes	no	Sexual abuse	yes	no
Hot flashes	yes	no	Vaginal lubricants	yes	no
Irritable bowel syndrome	yes	no	Vision problems	yes	no
Lack of bladder control	yes	no	Weight gain >10 lbs	yes	no
Mammogram	yes	no	Weight loss >10 lbs	yes	no

Social History

Please circle the appropriate answer:

Alcohol weekly	yes	no	Marijuana	yes	no
Caffeine	yes	no	Regular exercise	yes	no
Cocaine	yes	no	Smoke	yes	no
IV drugs	yes	no	Weight change	yes	no

Family History

Has anybody in your family had any of the following:

Birth defects	yes	no	Mental retardation	yes	no
Bleeding disorders	yes	no	Muscular dystrophy	yes	no
Blindness	yes	no	Ovarian cancer	yes	no
Breast cancer	yes	no	Polycystic kidneys	yes	no
Chromosome problem	yes	no	Psychiatric disease	yes	no
Cystic fibrosis	yes	no	Recurrent miscarriage	yes	no
Deafness	yes	no	Sickle-cell anemia	yes	no
Diabetes	yes	no	Spina bifida	yes	no
Down syndrome	yes	no	Stillbirth	yes	no
Early menopause	yes	no	Tay-Sachs disease	yes	no
Heart attack (<50 years)	yes	no	Thyroid disease	yes	no
Hemophilia	yes	no	Tuberous sclerosis	yes	no
High blood pressure	yes	no	Other genetic disease	yes	no

Ancestral Background

There are certain ancestral backgrounds that have an increase frequency of some genetic disease. Please indicate if either your mother or father are of any of the following backgrounds:

- ☐ African
- ☐ Asian
- ☐ Caribbean
- ☐ French Canadian
- ☐ Indian
- ☐ Jewish
- ☐ Latin American
- ☐ Mediterranean
- ☐ Native American
- ☐ None of the above

Medical History *(Review of Systems)*

Have you ever had any of the following:

Abdominal pains	yes	no	Heart disease	yes	no
Anemia	yes	no	Heat/cold intolerance	yes	no
Antibiotics	yes	no	Hepatitis, liver problems	yes	no
Anxiety	yes	no	High blood pressure	yes	no
Appendicitis	yes	no	Kidney problems	yes	no
Arthritis	yes	no	Mitral valve prolapse	yes	no
Asthma	yes	no	Neck/back pain	yes	no
Autoimmune disease	yes	no	Neurological problem	yes	no
Blood clots	yes	no	Nose/gum bleeds	yes	no
Blood in stool	yes	no	Palpitations	yes	no
Blood transfusion	yes	no	Problems with vision	yes	no
Cancer	yes	no	Psychiatric treatment	yes	no
Chicken pox	yes	no	Seizures	yes	no
Diabetes	yes	no	Severe headaches	yes	no
Dizziness	yes	no	Shortness of breath	yes	no
Easy bruising	yes	no	Stomach problems	yes	no
Epilepsy	yes	no	Stress	yes	no
Excess (chronic) constipation	yes	no	Swollen joints	yes	no
Excessive thirst	yes	no	Thrombophlebitis	yes	no
Fainting	yes	no	Thyroid problems	yes	no
German measles	yes	no	Tuberculosis	yes	no
Headache	yes	no	Urinary infections	yes	no

Pregnancy History

Times pregnant_____ Term births_____ Premature births_____

Miscarriages_____ Induced abortion_____ Adopted children _____

Contraceptive Use

Type	Dates of use	Reason discontinued
1.		
2.		
3.		
4.		
5.		

Operations and Hospitalizations

Date	Diagnosis	Operation	Location or hospital	Physician
1.				
2.				
3.				
4.				

Medications

Please list all prescriptions and over-the-counter drugs used during the past year:

Medication	Dosage and frequency	Dates of use	Reason for taking
1.			
2.			
3.			
4.			
5.			
6.			

Allergies

To what (drug or substance)?	When	What type of reaction?
1.		
2.		
3.		
4.		
5.		

History of Tests, Procedures and Treatments

A. Tests

			Tests	Dates & Results
Diagnosis of Ovulation				
a. BBT used	yes	no		
b. Endometrial biopsy	yes	no		
c. LH testing (urine)	yes	no		
d. Ultrasound series (for ovulation assessment)	yes	no		
Hormone Studies				
e. Complete hormone profile	yes	no		
f. Hormone testing, other (describe)	yes	no		
g. Serum progesterone	yes	no		
Male Fertility Testing				
h. Post-coital test (Huhner test)	yes	no		
i. Seminal fluid analysis	yes	no		
j. Sperm antibodies	yes	no		
Miscellaneous				
k. Thyroid testing	yes	no		
l. Beta-endorphins	yes	no		
m. Other	yes	no		

B. Procedures

			Procedures	Dates & Results
a. Hysterosalpingogram	yes	no		
b. Selective hysterosalpingogram	yes	no		
c. Hysteroscopy	yes	no		
d. Laparoscopy	yes	no		
e. Transcervical catheterization of fallopian tubes	yes	no		
f. Other	yes	no		

C. Treatments

			Treatments	Dates
Medical Treatments				
a. Birth control pills (for endometriosis)	yes	no		
b. GNRH analogs (Lupron, Syneral, etc.)	yes	no		
c. Serum progesterone	yes	no		
d. Clomid or serophene	yes	no		
e. HMG (Pergonal-like drugs)	yes	no		
f. Mucus enhancers	yes	no		
g. Progesterone (If so, what kind?)	yes	no		
h. HCG	yes	no		
i. Glucophage	yes	no		
j. Thyroid Rx	yes	no		
Surgical Treatments				
k. Cauterization of endometrial implants	yes	no		
l. Laser laparoscopy	yes	no		
m. Laser laparotomy (open abdomen)	yes	no		
n. Myomectomy	yes	no		
o. Ovarian drilling	yes	no		
p. Ovarian wedge resection	yes	no		
q. Tubal Surgery	yes	no		
r. D&C	yes	no		

ART Treatments

s. IVF	yes	no	
t. ICSI	yes	no	
u. GIFT	yes	no	
v. ZIFT	yes	no	
w. Artificial insemination	yes	no	
Intrauterine (IUI)	yes	no	
Husband (AIH)	yes	no	
Donor (AID)	yes	no	

Male

x. Variocele repair	yes	no	
y. Male on medication	yes	no	
z. Other male infertility treatment	yes	no	

CrMS

aa. Fertility-Focused Intercourse	yes	no	
bb. Other_____	yes	no	