



REFERRED BY: _____

1. IDENTIFYING INFORMATION

Name _____ DOB ____/____/____ Age _____
 Significant Other Name _____ DOB ____/____/____ Age _____
 Date this form completed ____/____/____ Primary Care MD _____
 Primary GYN _____ Number of years together _____
 How long have you been attempting conception? _____ Marital Status _____
 Reasons you are coming to see us: _____

2. RACE (You)

- Caucasian
- Asian
- Other (_____)

ETHNICITY

- Ashkenazi Jew
- Greek/Italian
- Hispanic
- African American
- Southeastern Asian

Significant Other

- Caucasian
- Asian
- Other (_____)

- Ashkenazi Jew
- Greek/Italian
- Hispanic
- African American
- Southeastern Asian

3. PREGNANCY HISTORY

Times pregnant ____ Term births ____ Premature births ____ Miscarriages ____ Elective abortion ____ Adopted children ____

Date	Miscarriage	Elective Abortion	Ectopic	Months to conceive?	Infertility Treatment	Weight and Sex?	C-section?	Complications?	Is current Partner the father?
1.									
2.									
3.									
4.									

4. CONTRACEPTIVE USE

Type	From when to when	Reason discontinued
1.		
2.		
3.		

5. OPERATIONS AND HOSPITALIZATIONS

Date	Diagnosis	Operation	Where	Physician
1.				
2.				
3.				

6. MEDICATIONS

List all prescriptions and over-the-counter drugs used during the past year

Date	Dose and Frequency	From when to when	Reason
1.			
2.			
3.			

7. ALLERGIES

Drug or substance	When	Reaction
1.		
2.		

8. MENSTRUAL/HORMONAL

Height _____ Weight _____ Blood Type (if known) _____

Age at first period Date of last two menstrual periods ____/____/____ and ____/____/____

Are your periods regular? yes no Do you bleed between periods? yes no

How many days from onset to onset? What is the usual duration of your periods?days

Premenstrual symptoms occur: almost always rarely never

Vigorous exercise: type hrs/week type hrs/week.....

If you have a hormonal disorder, please specify type and treatment:

Last pap smear ____/____/____ Last mammogram ____/____/____

Pelvic pain/cramps: none during menses before menses after menses at midcycle
 during intercourse with bowel movements with urination cause you to miss work cause you to miss usual activities

Pelvic pain/cramps are: mild moderate severe
 worsening improving no change in midline on right side on left side

Frequency of intercourse _____

Do you have or have you had? (Check all that apply).

- Hot flushes
- Breast discharge
- Visual disturbance
- Poor sense of smell
- Chronic headache
- Head trauma
- Increased facial or body hair
- Increased acne
- Weight increase > 10 pounds
- Weight loss > 10 pounds
- Special dietary habits
- Vomiting
- Seizures
- Diabetes
- Thyroid disorder
- Autoimmune disease
- Extraordinary stress
- Psychiatric treatment

Please explain a "Yes" answer: _____

9. GYNECOLOGIC / INFECTION

Do you have or have you had?

- Pelvic infection
- Chlamydia
- Endometriosis
- Pelvic adhesions
- Cervicitis
- Genital herpes
- Appendicitis
- Colitis or enteritis
- Uterine fibroids or myomas
- Abnormal uterus shape
- Recurrent vaginitis
- Abnormal Pap smears
- Gonorrhea
- Syphilis
- Mycoplasma
- Ureaplasma
- Genital warts / condyloma
- Cryo (freezing) or surgery of the cervix
- Ovarian cysts
- Toxoplasmosis
- Cytomegalovirus (CMV)
- Tuberculosis
- Trichomonas

10. OTHER HISTORY

Your occupation: Spouse's occupation:

Cigarettes - packs smoked per day:.....

Alcohol - type and number per week:.....

Marijuana - amount:

Other drugs - type and amount:

Caffeine drinks per day:

Video display terminal hours / day:.....

Electric blanket use: yes no Toxic exposure: yes no

Ever used intravenous drugs? yes no Hot tub or sauna use: yes no

Radiation exposure: yes no

11. MEDICAL ILLNESSES

Do you have or have you had?

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney disorder | <input type="checkbox"/> Psychiatric disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Rubella | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Anesthetic complication | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Hepatitis / liver disorder | <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Gall bladder problems | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Bleeding disorder |
| <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Serious injury / accident | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Colitis / enteritis | <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Recent immunization |
| <input type="checkbox"/> Heart murmur | | | |

Please explain a "Yes" answer to any of the above:.....

12. FAMILY HISTORY

	Living?	Age or age at death	Health Problems
Mother	:	:	:
Father	:	:	:
Sister(s)	:	:	:
	:	:	:
	:	:	:
Brother(s):	:	:	:
	:	:	:
	:	:	:
Daughter(s)	:	:	:
	:	:	:
Son(s)	:	:	:
	:	:	:

- Which of your blood relatives have?
- Cancer
 - Venous Thrombosis (blood clotting).....
 - Diabetes
 - Hypertension
 - High Cholesterol
 - Heart disease
 - Stroke
 - Premature menopause
 - Endometriosis
 - Uterine fibroids (myomas)

13. GENETIC HISTORY

Do you, your partner, or anyone in either family have? Any inherited disorders?

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Neural tube defects/spina bifida/anencephaly | <input type="checkbox"/> Cystic fibrosis | <input type="checkbox"/> Tay-Sachs disease | <input type="checkbox"/> Chromosomal disorder |
| <input type="checkbox"/> Thalassemia | <input type="checkbox"/> Muscular dystrophy | <input type="checkbox"/> Sickle cell disease or trait | <input type="checkbox"/> Genetic / inherited disorder |
| <input type="checkbox"/> Down syndrome | <input type="checkbox"/> Huntington chorea | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Baby with birth defects |
| | <input type="checkbox"/> Mental retardation / fragileX | <input type="checkbox"/> Hormonal disorder | <input type="checkbox"/> Infertility |

Please explain a "Yes" answer to any of the above:.....

14. SYSTEMIC REVIEW

Headaches: Number per week _____ Medication used _____

- | | | |
|---|--|------------------------------------|
| <input type="checkbox"/> mild | <input type="checkbox"/> moderate | <input type="checkbox"/> severe |
| <input type="checkbox"/> improving | <input type="checkbox"/> worsening | <input type="checkbox"/> no change |
| <input type="checkbox"/> with visual symptoms | <input type="checkbox"/> with vomiting | |
| <input type="checkbox"/> stress related | <input type="checkbox"/> migraines | |

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Wear glasses | <input type="checkbox"/> Bladder/kidney infections | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Acne |
| <input type="checkbox"/> Wear contact lenses | <input type="checkbox"/> Urgent / frequent / painful urination | <input type="checkbox"/> Nausea and vomiting | <input type="checkbox"/> Skin disorder |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Blood / abnormal color of urine | <input type="checkbox"/> Vomiting blood | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Hayfever | <input type="checkbox"/> Unable to control urination | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Abnormal urinary tract | <input type="checkbox"/> Food intolerance | <input type="checkbox"/> Skin cancer |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Kidney x-ray | <input type="checkbox"/> Gallstones | |
| <input type="checkbox"/> Denture / bridges | <input type="checkbox"/> Bladder cystoscopy | <input type="checkbox"/> Jaundice / hepatitis | <input type="checkbox"/> Counseling |
| | | <input type="checkbox"/> Chronic constipation | <input type="checkbox"/> Recent stress increase |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Recent anxiety increase |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Blood in bowel movement | |
| <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Prolonged bleeding | <input type="checkbox"/> Irritable bowel | <input type="checkbox"/> Sensation loss / numbness |
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Bleeding from gums | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Muscle control / weakness |
| <input type="checkbox"/> Leg swelling | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Hernia | <input type="checkbox"/> Heat or cold intolerance |
| <input type="checkbox"/> Calf pain | <input type="checkbox"/> Take aspirin/ibuprofen frequently | <input type="checkbox"/> Abnormal liver test | <input type="checkbox"/> Damp skin |
| <input type="checkbox"/> Blood clots (venous thromboembolism) | | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Unusual hair loss |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Breast mass | <input type="checkbox"/> Back pain | <input type="checkbox"/> Extraordinary fatigue |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Fibrocystic changes | | |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Breast implants | | |
| <input type="checkbox"/> Cough up blood | <input type="checkbox"/> Mammogram | | |
| <input type="checkbox"/> Chest x-ray | <input type="checkbox"/> Do monthly breast self-exam | | |
| <input type="checkbox"/> TB skin test | | | |

OTHER: _____

15. MALE HISTORY:

- | | |
|--|--|
| <input type="checkbox"/> Medications: | <input type="checkbox"/> Reproductive surgery: |
| <input type="checkbox"/> Illnesses: | <input type="checkbox"/> STDs: |
| <input type="checkbox"/> Mumps: | <input type="checkbox"/> Testicular trauma: |
| <input type="checkbox"/> Smoker: | <input type="checkbox"/> Impotence: |
| <input type="checkbox"/> Alcohol: | <input type="checkbox"/> Allergies: _____ |
| <input type="checkbox"/> Ejaculatory Disorder: | _____ |

Have you seen a urologist for infertility? Yes No
 If yes: Physician name and location

Have you ever fathered a child/pregnancy with another woman? Yes No
 If yes, when? years ago

Have you ever been diagnosed with an infertility diagnosis except for currently? Yes No
 If yes, when? years ago

Comments: _____

16. HISTORY OF FERTILITY THERAPY (Fill out, if applicable).

Have you been treated for infertility previously? yes no
 If yes, who was your physician?

What cause of infertility was diagnosed?

What drugs have you taken for infertility? Please check all that apply:

- | | | |
|---|---|--|
| <input type="checkbox"/> Clomid (Serophene) | <input type="checkbox"/> hCG Profasi | <input type="checkbox"/> Antibiotics |
| <input type="checkbox"/> Gonal F | <input type="checkbox"/> Progesterone | <input type="checkbox"/> Baby aspirin |
| <input type="checkbox"/> Follistim | <input type="checkbox"/> Lupron | <input type="checkbox"/> Heparin |
| <input type="checkbox"/> Repronex | <input type="checkbox"/> Microdose Lupron | <input type="checkbox"/> Steroids |
| <input type="checkbox"/> Pergonal | <input type="checkbox"/> Antagon | <input type="checkbox"/> Oral Contraceptives |
| <input type="checkbox"/> Fertinex | <input type="checkbox"/> Parlodel | <input type="checkbox"/> Other |

Which of the following tests have you or your partner had performed? Please check all that apply and results, if known:

- | | | |
|--|---------------------|---------------|
| <input type="checkbox"/> BBT | When ____/____/____ | Results |
| <input type="checkbox"/> Postcoital Test | When ____/____/____ | Results |
| <input type="checkbox"/> Hormonal Assays (FSH, LH, Prolactin, Estradiol, DHEA-S, Testosterone, Progesterone) | When ____/____/____ | Results |
| <input type="checkbox"/> Endometrial biopsy | When ____/____/____ | Results |
| <input type="checkbox"/> Hysterosalpingogram | When ____/____/____ | Results |
| <input type="checkbox"/> Sonohystogram | When ____/____/____ | Results |
| <input type="checkbox"/> Ultrasound | When ____/____/____ | Results |
| <input type="checkbox"/> Laparoscopy, Hysteroscopy | When ____/____/____ | Results |
| <input type="checkbox"/> Mycoplasma culture | When ____/____/____ | Results |
| <input type="checkbox"/> Chlamydia culture | When ____/____/____ | Results |
| <input type="checkbox"/> GC Culture | When ____/____/____ | Results |
| <input type="checkbox"/> Thyroid tests | When ____/____/____ | Results |
| <input type="checkbox"/> Rubella (German measles) | When ____/____/____ | Results |
| <input type="checkbox"/> Varicella (Chicken pox) | When ____/____/____ | Results |
| <input type="checkbox"/> Cytomegalovirus (CMV) | When ____/____/____ | Results |
| <input type="checkbox"/> Antibody screen | When ____/____/____ | Results |
| <input type="checkbox"/> Blood type | When ____/____/____ | Results |
| <input type="checkbox"/> Chromosomes | When ____/____/____ | Results |
| <input type="checkbox"/> Genetic screening | When ____/____/____ | Results |
| <input type="checkbox"/> Hepatitis B | When ____/____/____ | Results |
| <input type="checkbox"/> Hepatitis C | When ____/____/____ | Results |
| <input type="checkbox"/> HIV | When ____/____/____ | Results |
| <input type="checkbox"/> HTLV | When ____/____/____ | Results |
| <input type="checkbox"/> RPR (Serology) | When ____/____/____ | Results |
| <input type="checkbox"/> Semen analysis | When ____/____/____ | Results |
| <input type="checkbox"/> Antisperm antibodies | When ____/____/____ | Results |
| <input type="checkbox"/> Varicocele repair | When ____/____/____ | Results |
| <input type="checkbox"/> Testicular biopsy | When ____/____/____ | Results |
| <input type="checkbox"/> OTHER: | | |

Have you ever undergone Artificial Insemination (IUI) or In Vitro Fertilization (IVF)? yes no
 If yes, partner donor sperm

Clomid yes no Fertility Shots yes no name of medications _____
 #IUI's _____ Dates _____
 #IVF cycles _____ Dates _____