

PART II: FEMALE MEDICAL HISTORY AND INFORMATION

Reason for Visit: Infertility Evaluation Sperm Insemination Other _____

What are your expectations for this visit? _____

What questions do want answered at this visit? _____

Do you have any personal, ethical, or religious objections to any of our tests or treatments such as insemination, in vitro fertilization, egg donation, sperm donation, masturbation to collect a semen sample, etc.? No Yes _____

How many months have you been having intercourse without using any form of birth control? _____

Pregnancy Summary

- Total Number of ALL Pregnancies: _____ • Number of Miscarriages (less than 20 weeks): _____
- Number of Ectopic/Tubal Pregnancies: _____ • Number of Elective Terminations (Abortions): _____
- Number of Full Term Deliveries: _____ Of these, how many were live births? ____ How many were stillborn? ____
- Number of Premature (less than 37 weeks) Deliveries: _____ Of these, how many were live births? ____ How many were stillborn? ____
- Any Pregnancies with Birth Defects? No Yes - explain _____

Date Pregnancy Ended or Delivered	Months to Conception	Treatments to Conceive	Delivery Type/D&C/Complications	Current Partner?
1. _____	_____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
2. _____	_____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
3. _____	_____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
4. _____	_____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
5. _____	_____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
6. _____	_____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N

Menstrual History

- Menstrual cycle pattern (check all that apply): Regular periods Irregular periods Spotting before periods No periods
 Heavy periods Light periods Bleeding between periods
- Number of days between the start of one period to the start of the next period: _____ days
- How many days of bleeding do you have? _____ days
- Dates of the 1st day of your last 2 menstrual periods: ____/____/____; ____/____/____
- Age when you had your first period: _____ years old
- Age when you first noticed: Breast development: ____ years old Pubic hair: ____ years old Underarm hair: ____ years old
- How many periods do you have per year? _____
- Do you need medication to bring on a period? Yes - what type? _____ No
- If you do not have periods, at what age did you stop having them? _____ years old
- Do you have severe cramping or pelvic pain with your periods? Yes: __Always __Sometimes __Recently __In the past No

Contraceptive History

- None Condoms - dates of use _____ Diaphragm - dates of use _____ IUD - dates of use _____
- Birth control pills - dates of use _____ - complications? _____ Never used birth control pills
- Injectable contraception (Depo-Provera®, Lunelle™, etc.) - dates of use _____ - complications? _____
- Skin patch - dates of use _____ - complications? _____ Foam or Jelly
- Tubal sterilization procedure (tubes tied) - date (month/year) ____/____ Tubes untied - date (month/year) ____/____
- Did your mother take DES when she was pregnant with you? Yes No Don't know

Sexual History

- How many times do you have intercourse per week? _____ times per week None Not applicable
- Have you used over-the-counter ovulation kits to time intercourse? Yes No
- Do you have pain with intercourse? Yes No
- Do you use lubricants (K-Y Jelly®, etc.) during intercourse? Yes - what types? _____ No

Have you had any of the following sexually transmitted diseases or pelvic infections? Yes (check all that apply) No

- Chlamydia - date _____ Gonorrhea - date _____ Herpes - date _____ Genital warts/HPV - date _____
- Syphilis - date _____ HIV/AIDS - date _____ Hepatitis - date _____ Other - date _____

Pap Smear History

- When was your last pap smear (month and year)? ____/____/____ Normal Abnormal
- When was your last abnormal pap smear? ____ Not applicable

Have you undergone any procedures as a result of an abnormal pap smear?

- Yes (check all that apply) No
- Colposcopy Cryosurgery (Freezing) Laser treatment Conization LEEP procedure

Breast Screening History

- Have you ever had a mammogram? No Yes - date ____ Result: normal abnormal - explain _____
- Do you perform breast self exams? Yes No

Medical History

- Are you allergic to any medications? No Yes (Please list and describe reactions) _____
- Are you allergic to any foods (peanuts, eggs, etc.)? No Yes (Please list and describe reactions) _____
- List any medications you are currently taking, including over-the-counter medicines. _____
- Do you take any herbal medicines/vitamins or health food store supplements? No Yes (Please list) _____
- Do you have any medical problem(s)? No Yes (Please list type, dates, and treatments.)
 - (1) _____
 - (2) _____
 - (3) _____
 - (4) _____
 - (5) _____
- Did you have either of these childhood illnesses? Chickenpox (Varicella) German Measles (Rubella) Don't know
Other childhood diseases: _____

Vaccinations

- Chickenpox (Varicella): No Yes (dates _____) Don't know
- MMR - Measles, Mumps, and Rubella (German Measles): No Yes (dates _____) Don't know
- BCG (Tuberculosis): No Yes (dates _____) Don't know
- Hepatitis B: No Yes (dates _____) Don't know
- Polio: No Yes (dates _____) Don't know
- Hepatitis A: No Yes (dates _____) Don't know
- Tetanus: No Yes (dates _____) Don't know
- Influenza: No Yes (dates _____) Don't know

Social History

- How many caffeinated beverages (coffee, tea, soda) do you drink per day? ____ None
- Do you smoke cigarettes? No Yes How many/day? ____ How many years? ____ Quit - when? _____
- Do you drink alcohol? No Yes
 - Beer - # per week ____ Wine- # per week ____ Liquor - # per week ____
- Do you use marijuana, cocaine, or any other similar drug? No Yes (describe _____)
- Do you exercise? No Yes (describe _____)
- Are you aware of any radiation exposures other than X-rays? No Yes (describe _____)

Physician Notes (for office use only) _____

Surgical History

• Have you had any surgeries? No Yes (List all surgeries in chronologic order.)

Year	Reason and Type of Surgery
_____	(1) _____
_____	(2) _____
_____	(3) _____
_____	(4) _____
_____	(5) _____
_____	(6) _____
_____	(7) _____

• Did you have any anesthesia problems? No Yes (describe _____)

Physical Symptoms

General:

- Recent weight gain or loss
- Anorexia/Bulimia
- Lack of energy
- Fever/Chills
- Other _____
- None

Head, Eyes, Ears, Nose, and Throat:

- Dizziness Loss of sense of smell
- Headaches Chronic nasal congestion
- Blurred vision Ringing ears
- Hearing loss/deafness
- Other _____
- None

Respiratory:

- Shortness of breath
- Asthma Bronchitis
- Pneumonia Tuberculosis
- Bloody cough
- Other _____
- None

Endocrine/Hormonal:

- Diabetes Hair loss
- Thyroid gland problems
- Rapid weight gain or loss
- Excessive hunger/thirst
- Temperature intolerance—hot flashes or feeling cold
- Other _____
- None

Breasts:

- Discharge (clear?___ bloody?___ milky?___)
- Lumps Pain Cancer
- Abnormal mammogram
- Reduction
- Augmentation/Breast implants (saline?___ silicone?___)
- Other _____
- None

Neurological Problems:

- Weakness/Loss of balance
- Seizures/Epilepsy
- Headaches
- Migraine headaches
- Numbness
- Memory loss
- Other _____
- None

Gastrointestinal:

- Nausea/Vomiting Ulcers
- Hepatitis Diarrhea
- Blood in your stools Constipation
- Irritable Bowel Syndrome
- Change in bowel habits
- Colitis (ulcerative or Crohn's)
- Other _____
- None

Genito-Urinary:

- Bladder infections
- Kidney infections
- Vaginal infections
- Frequent urination Leaking urine
- Blood in the urine
- Herpes
- Other _____
- None

Skin/Extremities:

- Unexplained rash/inflammation
- Acne
- Skin cancer
- Burn injury
- Moles changing in appearance
- Excess hair growth
- Other _____
- None

Musculoskeletal:

- Unusual muscle weakness
- Decreased energy/stamina
- Rheumatoid arthritis
- Lupus Erythematosus
- Myasthenia gravis
- Other _____
- None

Hematologic:

- Blood clotting disorder/Blood clot
- Sickle cell Anemia Thrombophlebitis
- Easy bruising
- Swollen glands/lymph nodes
- Blood transfusions (dates/reasons _____)
- Other _____
- None

Cardiovascular:

- Palpitations/Skipped beats
- Chest pain Heart attack
- Stroke Murmurs
- High blood pressure
- Rheumatic fever
- Mitral valve prolapse (Need antibiotics before dental procedures? Yes___ No___)
- Other _____
- None

Mental Health Problems:

- Depression Anxiety disorder
- Schizophrenia
- Other _____
- None

Physician Notes (for office use only) _____

Family History

	<u>Living</u>	<u>Cause of Death/Age at Death</u>
• Mother	<input type="checkbox"/> Yes - age _____ <input type="checkbox"/> No	_____
• Father	<input type="checkbox"/> Yes - age _____ <input type="checkbox"/> No	_____
• Brother(s)	<input type="checkbox"/> Yes - age _____ <input type="checkbox"/> No	_____
	<input type="checkbox"/> Yes - age _____ <input type="checkbox"/> No	_____
• Sister(s)	<input type="checkbox"/> Yes - age _____ <input type="checkbox"/> No	_____
	<input type="checkbox"/> Yes - age _____ <input type="checkbox"/> No	_____
• Maternal Grandmother	<input type="checkbox"/> Yes - age _____ <input type="checkbox"/> No	_____
• Maternal Grandfather	<input type="checkbox"/> Yes - age _____ <input type="checkbox"/> No	_____
• Paternal Grandmother	<input type="checkbox"/> Yes - age _____ <input type="checkbox"/> No	_____
• Paternal Grandfather	<input type="checkbox"/> Yes - age _____ <input type="checkbox"/> No	_____

Disorders in Your Family

	<u>Relationship to You</u>	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Breast cancer	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Ovarian cancer	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Colon cancer	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Other cancer _____	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Diabetes	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Thyroid problems	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Heart disease	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Blood clots	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Obesity	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Psychiatric problems	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Tuberculosis	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Endometriosis	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Infertility	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Menopause before age 40	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Birth defects	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Cystic Fibrosis	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Tay-Sachs disease	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Canavan disease	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Bloom syndrome	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Gaucher disease	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Niemann-Pick disease	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Fanconi Anemia	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Familial Dysautonomia	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Muscular Dystrophy	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Neurologic (brain/spine)	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Neural Tube Defects	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Bone/Skeletal Defects	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Dwarfism	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Developmental delay	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Learning problems	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Polycystic kidney disease	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Heart defect from birth	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Down syndrome	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Other chromosome defects	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Marfan syndrome	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Hemophilia	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Sickle Cell Anemia	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Thalassemia	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Galactosemia	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Deafness/Blindness	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Color Blindness	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Hemochromatosis	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
<input type="checkbox"/> None of the above	<input type="checkbox"/> Other (Specify _____)		

What is your Ancestry?

- African-American
- American Indian/Native American
- Ashkenazi Jewish
- Asian-American
- Cajun/French Canadian
- Caucasian
- Eastern European
- Hispanic/Caribbean
- Northern European
- Southern European
- Other (specify _____)

Would you like to be screened for:

- Cystic Fibrosis: ___ Yes ___ No
- Sickle Cell Anemia: ___ Yes ___ No
- Tay-Sachs Disease: ___ Yes ___ No
- Thalassemia: ___ Yes ___ No

PRIOR INFERTILITY TESTING AND TREATMENT

• Have you had prior infertility testing or treatment elsewhere? Yes No

Prior Tests (check all that apply): Basal body temperature chart (date ____/____/____/results____)
 Thyroid test (date ____/____/____/results____) Ovulation test kit (date ____/____/____/results____)
 Day 3 blood test for FSH level (date ____/____/____/results____) Hysterosalpingogram (HSG) (date ____/____/____/results____)
 Laparoscopy surgery (date ____/____/____/results____) Hysteroscopy surgery (date ____/____/____/results____)
 Progesterone blood test (date ____/____/____/results____) Prolactin blood test (date ____/____/____/results____)

Prior Treatment (check all that apply):

	# of cycles	Dates (mo/year) (mo/year) From ___/___ to ___/___	Outcome
<input type="checkbox"/> Intrauterine insemination:	_____	From ___/___ to ___/___	___Pregnant: ___Delivered ___Ectopic ___Miscarriage; ___Not Pregnant
<input type="checkbox"/> Clomiphene citrate with timed intercourse: maximum # tablets per day? _____	_____	From ___/___ to ___/___	___Pregnant: ___Delivered ___Ectopic ___Miscarriage; ___Not Pregnant
<input type="checkbox"/> Clomiphene citrate with insemination: maximum # tablets per day? _____	_____	From ___/___ to ___/___	___Pregnant: ___Delivered ___Ectopic ___Miscarriage; ___Not Pregnant
<input type="checkbox"/> Daily fertility drug injections with insemination: maximum # vials per day? _____	_____	From ___/___ to ___/___	___Pregnant: ___Delivered ___Ectopic ___Miscarriage; ___Not Pregnant
<input type="checkbox"/> Completed in vitro fertilization cycle(s): 1. # eggs___ #embryos transferred___ #frozen___ 2. # eggs___ #embryos transferred___ #frozen___ 3. # eggs___ #embryos transferred___ #frozen___ 4. # eggs___ #embryos transferred___ #frozen___	_____	_____/_____ _____/_____ _____/_____ _____/_____	___Pregnant: ___Delivered ___Ectopic ___Miscarriage; ___Not Pregnant ___Pregnant: ___Delivered ___Ectopic ___Miscarriage; ___Not Pregnant ___Pregnant: ___Delivered ___Ectopic ___Miscarriage; ___Not Pregnant ___Pregnant: ___Delivered ___Ectopic ___Miscarriage; ___Not Pregnant
<input type="checkbox"/> Frozen embryo transfers: 1. # embryos transferred_____ 2. # embryos transferred_____ 3. # embryos transferred_____ 4. # embryos transferred_____	_____	_____/_____ _____/_____ _____/_____ _____/_____	___Pregnant: ___Delivered ___Ectopic ___Miscarriage; ___Not Pregnant ___Pregnant: ___Delivered ___Ectopic ___Miscarriage; ___Not Pregnant ___Pregnant: ___Delivered ___Ectopic ___Miscarriage; ___Not Pregnant ___Pregnant: ___Delivered ___Ectopic ___Miscarriage; ___Not Pregnant
Canceled in vitro fertilization attempt(s):	_____		
<input type="checkbox"/> Any other prior treatment (describe): _____			

• Additional Information/Complications: _____

EMOTIONAL STATUS

• On a scale of 1-10 (10 being the worst), estimate the level of stress you feel due to infertility and other pressures. _____
 • Do you see a counselor? No Yes - For how long? _____ How often? _____
 • List any antidepressant/antianxiety medications you are currently taking. _____
 • Describe any emotional, marital, or sexual problems caused by your infertility. _____

PATIENT'S SIGNATURE _____	DATE _____
I confirm that I have reviewed the information above.	
PHYSICIAN'S SIGNATURE _____	DATE _____

PART III: MALE MEDICAL HISTORY AND INFORMATION

Complete with your male partner if applicable.

- Have you been evaluated by a urologist? Yes No
- Have you previously conceived with another woman? Yes: How many times?_____ No: Birth control used? Yes___ No___
- Have you had a semen analysis? Yes No
- Do you have difficulty with erections? Yes No
- Do you have retrograde ejaculation of sperm into the bladder? Yes No
- Have you had any of the following sexually transmitted diseases or pelvic infections?
 - Yes (check all that apply) No
 - Chlamydia - date_____ Gonorrhea - date_____ Herpes - date_____ Genital warts/HPV - date_____
 - Syphilis - date_____ HIV/AIDS - date_____ Hepatitis - date_____ Other_____
- Have you had a history of undescended testicles? Yes - One side___ Both___ No
- Do you have scrotal or testicular pain? Yes No
- Did you have the mumps after puberty? Yes No
- Have you had prior injury to your testicles requiring hospitalization? Yes No

- Have you been diagnosed with any of the following diseases?
 - Diabetes Mellitus - Yes___ No___ Cancer - Yes___ No___
 - Multiple Sclerosis - Yes___ No___ Other neurologic problems - Yes___ No___
 - Prostatic infections - Yes___ No___ Urinary infections - Yes___ No___
 - High Blood Pressure - Yes___ No___ If yes, any medications?_____

- Have you had any fever in the last 3 months? Yes No
- Have you had a vasectomy? Yes (date_____) No
If yes, have you had a vasectomy reversal? Yes (date_____) No
- Have you had surgery for varicocele repair? Yes No
- Have you had hernia surgery? Yes No
- Did you undergo any bladder or penis surgery as a child? Yes No
- Are you exposed to prolonged heat in the workplace? Yes No
- Are you exposed to any radiation or harmful chemicals in the workplace? Yes No
- Have you had chemotherapy for cancer? Yes No
- Are you allergic to any medications? No Yes (Please list and describe reactions) _____

List your current medications: _____

List any current medical problem(s): _____

- How many caffeinated beverages do you drink per day?_____ None
- Do you smoke cigarettes? No Yes How many/day?_____ How many years?_____ Quit - when?_____
- Do you drink alcohol? No Yes
 - Beer - # per week_____ Wine- # per week_____ Liquor - # per week_____
- Do you use marijuana, cocaine, or any other similar drug? No Yes (describe_____)
- Do you use herbal medicines/vitamins or health food store supplements? No Yes (describe_____)
- Are you aware of any radiation/toxic materials exposure? Yes No

- Do you use hot tubs regularly? Yes No
- Did your mother take DES during pregnancy to prevent miscarriage? Yes No Don't know
- Have any of your immediate family members had difficulty conceiving a child? Yes No
If yes, please describe_____

Physician Notes (for office use only) _____

Disorders in Your Family

	<u>Relationship to You</u>	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Cystic Fibrosis	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Tay-Sachs disease	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
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• Color Blindness	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Hemochromatosis	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
<input type="checkbox"/> None of the above	<input type="checkbox"/> Other (Specify _____)		

What is your Ancestry?

- African-American
- American Indian/Native American
- Ashkenazi Jewish
- Asian-American
- Cajun/French Canadian
- Caucasian
- Eastern European
- Hispanic/Caribbean
- Northern European
- Southern European
- Other (specify _____)

Would you like to be screened for:

- Cystic Fibrosis: __ Yes __ No
- Sickle Cell Anemia: __ Yes __ No
- Tay-Sachs Disease: __ Yes __ No
- Thalassemia: __ Yes __ No

SPOUSE/MALE PARTNER'S SIGNATURE _____ **DATE** _____

I confirm that I have reviewed the information above.

PHYSICIAN'S SIGNATURE _____ **DATE** _____

Physician Notes (for office use only) _____

