FEMALE FERTILITY HISTORY

Date_____ Appointment Date_____

Name_____ Partner's Name_____

Address_____

Telephone Day (_____)_____ Eve.(_____)_____

Date of Birth_____ Race_____

Duration of Relationship_____ Duration of Infertility_____

Referring Doctor_____

Nature of present employment (brief description)_____

_____

List past occupations (most current first)_____

_____

Are you exposed to chemicals or other substances in your work environment?_____

MEDICAL HISTORY

Height_____ Weight_____ Blood Type (if known)_____

Has your weight went up or down more than 20 pounds in the past year?___

Do you follow a particular diet?_____

List the types and frequency of regular vigorous exercise (swim, cycle, run) and the age you began.

Exercise_____Hrs/Wk_____Age_____

Exercise_____Hrs/Wk_____Age_____

DO YOU HAVE OR EVER HAD (CIRCLE ALL THAT APPLY)

Anemia Appendectomy Blood Clots Diabetes Breast Discharge

Cancer Chlamydia Congenital Disease Endometriosis Gonorrhea

Stomach Issues Heart Disease Hepatitis Herpes Seizures

Hirsuitism(Dark Hair Growth) High Blood Pressure Kidney Infection

Ovarian Cysts Neurological Problems Migraines Psychiatric Issues

Pelvic Infection Syphilis Thyroid Problems Recurrent Vaginal Infections

Allergies_____

Current Medications_____

DO YOU OR HAVE YOU EVER USED (CHECK ALL THAT APPLY)

_____Alcohol – How many per week?
Wine_____ Beer_____ Cocktails_____

_____Cigarettes – Number of packs per day_____
How long have you smoked?_____

_____Illicit or Recreational Drugs If you don't feel comfortable writing this down, please discuss directly with your physician. Specify_____
_____

_____Caffeine Usage – Items per day_____

MENSTRUAL AND PREGNANCY HISTORY

Age at first period?_____ First day of last period?_____

Are your periods regular? YES NO
If yes, how many days are between periods_____

If no, how many times per year do you menstruate?_____

How many days does you period last?_____

Do you have cramps before, during or after your period?_____
Mild Moderate Severe
Medication used?_____

Do you bleed or spot between periods? YES NO
If yes, explain_____

Is there anything else you want to tell us about your cycles?_____
_____

Last Pap Test Date_____ Normal Abnormal

Previous Mammogram YES NO Normal Abnormal

How many pregnancies (including abortions) have you had?_____

Year	Abortion	Miscarriage	Ectopic	Infertility Therapy to Conceive	How long to Conceive	Live Birth	Is current partner the father

Were there any complications during or after your pregnancies? YES NO
Explain_____

Did your mother have any difficulty with conception or pregnancy?
YES NO Explain_____

CONTRACEPTIVE AND SEXUAL HISTORY

Circle all forms of birth control that you have ever used and write the length of use. Pills_____ Ring_____ Patch_____ IUD_____
DepoProvera_____ Implanon_____ Tubal_____

How many times per week do you and your partner have intercourse?_____

How many times do you have intercourse around ovulation?_____

Is intercourse painful or difficult? YES NO

Do you use lubricants or intercourse? YES NO Specify_____

Circle all the disease history in you family.

Diabetes	Down's Syndrome	Hypertension
Heart Disease	Spina Bifida	Muscular Dystrophy
Kidney Disease	Cancer	Mental Retardation
Early Deaths	Infertility	Cystic Fibrosis
Cleft Lip/Palate	Sickle Cell Anemia	Recurrent Miscarriages

Other congenital anomalies or birth defects

HISTORY OF FERTILITY TREATMENT

Have you been treated for infertility before? YES NO
If yes, who was your physician_____

What cause of infertility was diagnosed_____

What medications have you taken for infertility? Circle all that apply.
Clomiphene Citrate (Serophene, Clomid) HCG Estrogen
Progesterone Repronex Lupron GnRH Antibiotics

Have you ever had Intrauterine Insemination or In Vitro Fertilization?
YES NO If yes, using partner or donor sperm_____

Which of the following tests have you had performed?

Postcoital Test Date_____ Results_____

Thyroid Tests Date_____ Results_____

Hormonal Tests (FSH, LH, DHEA Prolactin, Estrogen Progesterone, Date_____ Results_____

Testosterone)

Hysterosalpingogram Date_____ Results_____

Ultrasound Date_____ Results_____

Hysteroscopy Date_____ Results_____

Laparoscopy Date_____ Results_____

Have you ever had surgery for tubal reversal? YES NO
If yes, specify_____

Have you ever had any other surgery (D&C, thyroid, appendectomy, ovarian, lysis of adhesions)? If yes, specify_____
_____

Have you ever had cervical cone biopsy, cryo or LEEP? YES NO
If yes, specify_____

Is your partner seeing a doctor for evaluation of infertility? YES NO
If yes, who is the doctor_____

Does the doctor feel your partner has a fertility problem? YES NO
If yes, diagnosis_____

Has he ever fathered a child with another woman? YES NO
If yes, specify_____

MALE FERTILITY HISTORY

Date:_____ Appointment Date:_____

Name_____ Partner's Name_____

Address _____

Telephone: Day _____ Eve. _____

Date of Birth_____ Race_____

Duration of Relationship_____ Duration of Infertility _____

WORK BACKGROUND

Brief description of present employment _____

_____

List past occupations (most current first) _____

_____

Have you ever been exposed to heat, chemicals, toxic fumes, or nuclear radiation during employment or military service? Circle all that apply. Other_____

MEDICAL HISTORY

Height _____ Weight _____ Blood Type _____

Have you gained or lost greater that 20 pounds in the past year? YES NO

Do you follow a special food diet? YES NO If yes, specify_____

List the forms and frequency of regular exercise (swimming, cycling, running) and the age began

Exercise_____ Hrs/Wk_____ Age_____

Exercise_____ Hrs/Wk_____ Age _____

Do you frequently take saunas or steam baths? YES NO

Do you do long distance driving? YES NO

Have you ever had surgery in the pelvic area? YES NO

If yes, specify what and when_____

Have you ever received radiation or X-rays in the pelvic area? YES NO
If yes, specify _____

DO YOU HAVE OR HAVE YOU EVER HAD: (CIRCLE ALL THAT APPLY)

Appendicitis Arthritis Blood Transfusion Cancer Chlamydia Chronic Bronchitis

Diabetes Epilepsy Gonorrhea Heart Disease Hepatitis Herpes High Blood Pressure

Kidney Infection Migraines Measles: German/Regular Mumps with testes involved

Neurological Problems Inguinal Hernia Stomach/Bowel Problems Tuberculosis

Ulcers Pneumonia Prostatitis Psychiatric Disorder Rheumatic Fever Scarlet Fever

Seizures Syphilis Congenital Disease Testicular: Infection, Injury or Tumor Thyroid

Allergies _____

Current Medications _____

Have you had a high fever (over 102) beyond age 18? YES NO

DO YOU USE OR HAVE YOU EVER USED (CHECK ALL THAT APPLY)

_____ Alcohol – How many glasses per week to you usually drink?
Wine _____ Beer _____ Cocktails _____

_____Cigarettes – Number of packs per day _____

_____Illicit or Recreational Drugs If you don't feel comfortable writing this down, please discuss directly with your physician. Specify_____

_____Caffeine Usage Items per day_____

SEXUAL HISTORY

Are you circumcised? YES NO

As a child, were both testes descended into the scrotum? YES NO

How many times have you been married? _____

Have you ever tried to produce a child with another partner? YES NO

Have you ever produced a child with another partner? YES NO If yes, when?_____
If yes, how long did it take to produce a child?_____

Do you have trouble getting an erection? YES NO
Maintaining an erection? YES NO

Do you have trouble with ejaculation? YES NO

Do you have discharge from the penis? YES NO

FAMILY HISTORY

Is there a family history of infertility? YES NO If yes, specify_____

_____

FAMILY MEDICAL HISTORY (CIRCLE ALL THAT APPLY)

Diabetes Heart Disease Hypertension Kidney Disease Cancer Cystic Fibrosis

Sickle Cell Disease Early Deaths Down's Syndrome Spins Bifida Muscular Dystrophy

Cleft Lip/Palate Infertility Mental Retardation Recurrent Miscarriages

Other birth defects or congenital anomalies

FERTILITY TREATMENT HISTORY

Have you been treated for infertility before? YES NO
If yes, specify_____

What cause of infertility was diagnosed?_____

Have you ever had varicocele repair? YES NO If yes, when._____

Have you ever had vasectomy reversal or repair? YES NO If yes, when,_____

WHICH OF THE FOLLOWING TESTS HAVE YOU HAD PERFORMED?

_____Semen Analysis Date_____Results_____
_____Blood Tests (FSH, LH, Testosterone) Date_____Results_____
_____Thyroid Tests Date_____Results_____
_____Testicular Ultrasound or X-ray Date_____Results_____
_____Testicular Biopsy Date_____Results_____
_____Antibody Test Date_____Results_____
_____Chromosome Test Date_____Results_____

Is your partner currently seeing a doctor for evaluation of infertility? YES NO
If yes, whom _____

Does the doctor feel that your partner has an infertility problem? YES NO
If yes, what is the diagnosis and is she being treated?_____
_____

Has you partner ever had children with another man? YES NO
If yes, when_____