

Advanced Reproductive Medicine and Surgery, P.C.

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INFERTILITY HISTORY FORM

PART I.: CONTACT INFORMATION

First Name _____ Middle Initial _____ Last Name _____ Age _____

Date of Birth (MM/DD/YY) _____ Occupation _____

Home Street Address _____

City _____ State _____ Zip/Postal Code _____ Country _____

Indicate which number to call or leave messages:

Home Phone _____ Work Phone _____ Cell Phone _____

Are you married? YES NO DIVORCED OTHER _____

Spouse/Male Partner's

First Name _____ M.I. _____ Last Name _____ Age _____

Not Applicable

Date of Birth (MM/DD/YY) _____ Occupation _____

Home Street Address _____

City _____ State _____ Zip/Postal Code _____ Country _____

Indicate which number to call or leave messages:

Home Phone _____ Work Phone _____ Cell Phone _____

Who referred you?

Physician Name _____ Phone _____

Address _____

Former Patient/Friend _____

Website _____

Insurance (Name of Insurance) _____

Who is your OB/GYN?

Name _____ Phone _____

Address _____

Who is your Primary Care Physician?

Name _____ Phone _____

Address _____

PHYSICIAN'S NOTES (FOR OFFICE USE ONLY)

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 you 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 sperm sample, etc.? YES NO
 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? _____ Stillborn? _____
- Number of Premature(less than 37 weeks) Deliveries: _____ Of these, how many were live births? _____ Stillborn? _____
- Any pregnancies with Birth Defects? YES NO Explain _____

<i>Date Pregnancy Ended or Delivered</i>	<i>Months to Conception</i>	<i>Treatments Conceive</i>	<i>Delivery Type/D&C Complications</i>	<i>Current Partner?</i>
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 No Periods
 Heavy Periods Light Periods Bleeding Between Periods Spotting Before 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
- 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
 NO __In the past

Contraceptive History

- None Condoms – date of use _____ Diaphragm – dates of use _____ IUD – dates of use _____
- Birth control pills – dates of use _____ -complications? _____
- Never used birth control pills Skin patch – dates of use _____ -complications? _____
- Injectable contraception (Depo-Provera®, Lunelle™, etc.) – date of use _____ Foam or Jelly
- Tubal sterilization procedure (tubes tied) –date (month/year) _____ Tubes untied –date _____

• 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 disease or pelvic infections? YES NO (check all that apply)
 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 (MM/YY) _____ 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? Yes-date _____ No

Result: Normal Abnormal-explain _____

Do you perform breast self-exams? YES NO

Medical History

• Are you allergic to any medications? YES NO (Please list and describe reactions) _____

• Are you allergic to any foods (peanuts, eggs, etc.)? YES NO (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 supplements? YES NO (Please list) _____

• Do you have any medical problem(s)? YES NO (Please list type, dates, and treatments)

- (1) _____
- (2) _____
- (3) _____
- (4) _____
- (5) _____

• Did you have either of these childhood illnesses? Chickenpox (Varicella) German measles (Rubella) Not Sure
Other childhood diseases: _____

Vaccinations

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

Social History

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

PHYSICIAN'S NOTES (FOR OFFICE USE ONLY)

• Have you had any surgeries? YES NO (List all surgeries in chronologic order.)
 YEAR REASON AND TYPE OF SURGERY

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

• Did you have any anesthesia problems? YES NO 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 cold feeling
- 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 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
- Other _____
- None

Mental Health Problems:

- Depression Anxiety disorder
- Schizophrenia
- Other _____
- None

<p>PHYSICIAN'S NOTES (FOR OFFICE USE ONLY)</p> <p>_____</p> <p>_____</p> <p>_____</p>
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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>		
• 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 Dysautonia	<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 Y N
 Sickle Cell Anemia Y N
 Tay - Sachs disease Y N
 Thalassemia Y N

• 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):

<input type="checkbox"/> <u>Intrauterine insemination:</u>	# of cycles _____	Dates(mm/yy)(mm/yy) From _____ To _____	Outcome _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 ___	_____	From _____ To _____ From _____ To _____ From _____ To _____ From _____ To _____	_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 _____	_____	From _____ To _____ From _____ To _____ From _____ To _____ From _____ To _____	_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? YES NO For how long? _____ How often? _____
 • List any antidepressant/anti-anxiety medications you are currently taking. _____
 • Describe any emotional, marital, or sexual problems caused by your infertility. _____

PHYSICIAN'S NOTES (FOR OFFICE USE ONLY) _____

PART III: MALE MEDICAL HISTORY AND INFORMATION

Complete with your male partner if applicable.

- Have you been evaluated by an 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 _____ date _____
- Have you had a history of undescended testicles? YES one side ____ both sides _____ 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? YES NO (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? YES NO How many per day? ____ How many years? ____ Quit - when? _____
- Do you drink alcohol? YES NO Beer -# per week? ____ Wine -# per week? ____ Liquor -# per week? ____
- Do you use marijuana, cocaine, or any other similar drug? YES NO (describe) _____
- Do you use herbal medicines/vitamins or health food store supplements? YES NO (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'S NOTES (FOR OFFICE USE ONLY)

