Infertility History Form

IMPORTANT: Please complete this form and bring it with you to your scheduled visit.
This form was developed to assist physicians and patients in obtaining a complete infertility history. It consists of three parts:
Part I: Contact information • **Part II:** Your medical history • **Part III:** Your partner's medical history (if applicable)

PART I: CONTACT INFORMATION

Your Information

First Name: _____ Middle Initial: ____ Last Name: _____ Date of Birth (MM/DD/YYYY):___/___/_____

Partner Information

First Name: _____ Middle Initial: ____ Last Name: _____ Date of Birth (MM/DD/YYYY):___/___/_____

Who referred you? ☐ Physician: Name _____
☐ Former Patient/Friend _____
☐ Web Site _____
☐ Insurance (Name of Insurance) _____

Who is your OB/GYN? Name: _____ Address: _____ Phone: _____

PART II: FEMALE MEDICAL HISTORY AND INFORMATION

Reason for Visit: ☐ Infertility Evaluation ☐ Sperm Insemination ☐ 2nd Opinion _____ ☐ 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, explain _____

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 Elective Terminations (Abortions): _____
- Number of Premature (less than 37 weeks) Deliveries: _____
  Of these, how many were live births? _____ How many were stillborn? _____
- Number of Ectopic/Tubal Pregnancies: _____
- Number of Full Term 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.	_____	_____	_____	_____	☐ Y ☐ N
2.	_____	_____	_____	_____	☐ Y ☐ N
3.	_____	_____	_____	_____	☐ Y ☐ N
4.	_____	_____	_____	_____	☐ Y ☐ N
5.	_____	_____	_____	_____	☐ Y ☐ N
6.	_____	_____	_____	_____	☐ Y ☐ 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
- 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? _____
- Number of days from the start of one period to the start of the next period: _____ days
- How many days of bleeding do you have? _____ days
- Do you need medication to bring on a period? ☐ No ☐ Yes,what type? _____
- 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? ☐ No ☐ Yes
  If yes: ☐ Always ☐ Sometimes ☐ Recently ☐ In the past

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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? ☐ No ☐ Yes type:_____ + results on day _____
- Do you have pain with intercourse? ☐ No ☐ Yes
- Do you use lubricants (K-Y Jelly®, etc.) during intercourse? ☐ No ☐ Yes, what types?_____

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 _____ ☐ Hepatitis - date _____
☐ Genital warts/HPV - date _____ ☐ Syphilis - date _____ ☐ HIV/AIDS - 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 _____ Do you perform breast self exams? ☐ Yes ☐ No

Result: ☐ normal ☐ abnormal, explain _____

_____

MEDICAL HISTORY

Do you have now or have had

☐ Diabetes	☐ Asthma/ lung disease	☐ Thyroid disease
☐ Epilepsy	☐ Smoking	☐ Deep Vein Thrombosis/Pulmonary Embolus (blood clots)
☐ Kidney disease	☐ Substance abuse	☐ Heart disease
☐ Cancer	☐ Acid reflux	☐ Bleeding disorder
☐ Neuromuscular disorder	☐ Congenital heart disease	☐ Personal/family history of Malignant Hyperthermia
☐ Irregular heart beat	☐ Sleep apnea/CPAP usage	☐ High blood pressure

SLEEP APNEA HISTORY

Do you snore loudly (louder than talking or loud enough to be heard through closed doors)? ☐ No ☐ Yes

Do you often feel tired, fatigued or sleepy in the daytime? ☐ No ☐ Yes

Has anyone observed you stop breathing during your sleep? ☐ No ☐ Yes

MEDICATION 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) _____

_____

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

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SOCIAL HISTORY

- How many caffeinated beverages (coffee, tea, energy drinks, 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, (frequency)_____
- Do you exercise? ☐ No ☐ Yes, (describe)_____
- Are you aware of any radiation exposures other than X-rays? ☐ No ☐ Yes, (describe) _____
- Do you have any concerns with abuse, past or present _____
- What do you do for stress management?_____
- Do you do acupuncture? ☐ No ☐ Yes, (frequency) _____

FAMILY HISTORY

		Relationship to you		
Breast cancer	☐ Yes	_____	☐ No	☐ Don't Know
Ovarian cancer	☐ Yes	_____	☐ No	☐ Don't Know
Colon cancer	☐ Yes	_____	☐ No	☐ Don't Know
Other cancer	☐ Yes	_____	☐ No	☐ Don't Know
Diabetes	☐ Yes	_____	☐ No	☐ Don't Know
Thyroid problems	☐ Yes	_____	☐ No	☐ Don't Know
Heart disease	☐ Yes	_____	☐ No	☐ Don't Know
Hypertension/stroke	☐ Yes	_____	☐ No	☐ Don't Know
Blood clots	☐ Yes	_____	☐ No	☐ Don't Know
Obesity	☐ Yes	_____	☐ No	☐ Don't Know
Psychiatric problems	☐ Yes	_____	☐ No	☐ Don't Know
Tuberculosis	☐ Yes	_____	☐ No	☐ Don't Know
Endometriosis	☐ Yes	_____	☐ No	☐ Don't Know
Infertility	☐ Yes	_____	☐ No	☐ Don't Know
Menopause before age 40	☐ Yes	_____	☐ No	☐ Don't Know
Birth defects	☐ Yes	_____	☐ No	☐ Don't Know
Malignant Hyperthermia	☐ Yes	_____	☐ No	☐ Don't Know
Inherited diseases	☐ Yes	_____	☐ No	☐ Don't Know

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_____)
- ☐ Day 3 blood test for FSH level (date _____ /results _____)
- ☐ Progesterone blood test (date _____ /results_____)
- ☐ Prolactin blood test (date _____ /results _____)
- ☐ Hysterosalpingogram (HSG) (date _____ /results _____)
- ☐ Hysteroscopy surgery (date _____ /results _____)
- ☐ Laparoscopy surgery (date _____ /results _____)
- ☐ Other surgeries (dates & results) _____
- ☐ Other tests (dates & results) _____

Prior Treatments (check all that apply):	# of cycles	Dates (mo/year) (mo/year)
☐ Intrauterine insemination:		From____/____to____/____
☐ Clomiphene citrate or Letrozole with timed intercourse: ‣ maximum # tablets per day?_____		From____/____to____/____
☐ Clomiphene citrate or Letrozole with insemination: ‣ maximum # tablets per day?_____		From____/____to____/____
☐ Daily fertility drug injections with insemination: ‣ maximum # vials per day?_____		From____/____to____/____
☐ Completed in vitro fertilization cycled: # eggs____ #embryos transferred____ #frozen____ # eggs____ #embryos transferred____ #frozen____		_____/_____ _____/_____
☐ Frozen embryo transfers: # embryos transferred_____ # embryos transferred_____		_____/_____ _____/_____

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Canceled in vitro fertilization attempt(s):
Any other prior treatment (describe):

SURGICAL HISTORY

Have you had any surgeries or hospitalizations? ☐ No ☐ Yes (List all surgeries in chronologic order)

YEAR	REASON AND TYPE OF SURGERY	YEAR	REASON AND TYPE OF SURGERY

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

Physical Symptoms

General:
- ☐ Recent unintentional weight gain or loss of greater than 15 pounds
- ☐ Anorexia/Bulimia
- ☐ Lack of energy
- ☐ Fever/Chills
- ☐ Chronic Pain
- ☐ 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

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

Hematologic:
- ☐ Blood clotting disorder/Blood clot
- ☐ Sickle cell Anemia
- ☐ Thrombophlebitis
- ☐ Easy bruising
- ☐ Swollen glands/lymph nodes
- ☐ Blood transfusions (date's/reasons _____)
- ☐ Other _____

Mental Health Problems:
- ☐ Depression
- ☐ Anxiety disorder
- ☐ Schizophrenia
- ☐ Other _____
- ☐ None

Head, Eyes, Ears, Nose, and Throat:
- ☐ Dizziness
- ☐ Loss/poor sense of smell
- ☐ Headaches
- ☐ Chronic nasal congestion
- ☐ Blurred vision
- ☐ Ringing ears
- ☐ Hearing loss/deafness
- ☐ Sinus problems/hay fever
- ☐ Other _____
- ☐ None

Breasts:
- ☐ Discharge: ☐ clear? ☐ bloody? ☐ milky?
- ☐ Lumps
- ☐ Pain
- ☐ Cancer
- ☐ Abnormal mammogram
- ☐ Reduction
- ☐ Augmentation/Breast implants: ☐ saline? ☐ silicone?
- ☐ Other _____
- ☐ None

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

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

Respiratory:
- ☐ Shortness of breath
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Bloody cough
- ☐ 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)
- ☐ GERD/heartburn
- ☐ 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

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

PART III: PARTNER MEDICAL HISTORY AND INFORMATION

- Are you allergic to any medications? ☐ No ☐ Yes: Date:_____ (Please list and describe reactions) _____

  _____

  List your current medications: _____

  List any current medical problem(s): _____
- Have you had unintentional weight gain/loss greater than 15 pounds? ☐ No ☐ Yes
- Do you chew tobacco? ☐ No ☐ Yes: How much/day?_____ How many years?_____ Quit - when? _____
- 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 frequency and last used) _____
- Do you use herbal medicines/vitamins or health food store supplements? ☐ No ☐ Yes: (describe) _____
- Have you had any of the following sexually transmitted diseases or pelvic infections? ☐ No ☐ Yes (check all that apply):
  ☐ Chlamydia - date_____ ☐ Gonorrhea - date_____ ☐ Herpes - date_____ ☐ Genital warts/HPV - date_____
  ☐ Syphilis - date_____ ☐ HIV/AIDS - date_____ ☐ Hepatitis - date_____ ☐ Other _____
- Do you have any concerns with abuse, past or present? ☐ No ☐ Yes: If yes, please describe _____

  _____

Complete with male partner if applicable.

- Have you been diagnosed with any of the following diseases?
  Diabetes Mellitus ☐ No ☐ Yes — Cancer ☐ No ☐ Yes
  Multiple Sclerosis ☐ No ☐ Yes — Other neurologic problems ☐ No ☐ Yes
  Prostatic infections ☐ No ☐ Yes — Urinary infections ☐ No ☐ Yes
  High Blood Pressure ☐ No ☐ Yes: If yes, any medications? _____
- Have you had any fever in the last 3 months? ☐ No ☐ Yes
- Have you had a vasectomy? ☐ No ☐ Yes: Date _____ If yes, have you had a vasectomy reversal? ☐ No ☐ Yes: Date_____
- Have you had surgery for varicocele repair? ☐ No ☐ Yes: Date:_____
- Have you had hernia surgery? ☐ No ☐ Yes: Date:_____
- Did you undergo any bladder or penis surgery as a child? ☐ No ☐ Yes: Date:_____
- Are you exposed to prolonged heat in the workplace? ☐ No ☐ Yes: Date:_____
- Are you exposed to any radiation or harmful chemicals in the workplace? ☐ No ☐ Yes: Date:_____
- Have you had chemotherapy for cancer? ☐ No ☐ Yes: Date:_____
- Are you aware of any radiation/toxic materials exposure? ☐ No ☐ Yes
- Do you use hot tubs or saunas regularly? ☐ No ☐ Yes: Frequency:_____
- Did your mother take DES during pregnancy to prevent miscarriage? ☐ No ☐ Yes ☐ Don't know
- Have any of your immediate family members had difficulty conceiving a child? ☐ No ☐ Yes
- Do you suffer from chronic pain? ☐ No ☐ Yes
- Have you been evaluated by a urologist? ☐ No ☐ Yes
- Have you previously conceived with another woman? ☐ Yes: How many times?_____ ☐ No: Birth control used? ☐ No ☐ Yes
- Have you had a semen analysis? ☐ No ☐ Yes: Results: _____
- Do you have difficulty with erections? ☐ No ☐ Yes
- Do you have retrograde ejaculation of sperm into the bladder? ☐ No ☐ Yes
- Have you had a history of undescended testicles? ☐ No ☐ Yes: ☐ One side ☐ Both
- Do you have scrotal or testicular pain? ☐ No ☐ Yes
- Did you have the mumps after puberty? ☐ No ☐ Yes
- Have you had prior injury to your testicles requiring hospitalization? ☐ No ☐ Yes

I confirm that I have provided the above information to the best of my knowledge and that health care decisions will be made based on this information.

PATIENT'S SIGNATURE _____

DATE/TIME _____

Original - Medical Records

Provider Signature: _____

Date/Time: _____

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