

Date: ___/___/___

Medical History Form - Infertility

Name:		Date of Birth: / /	
Address:	City:	State:	Zip Code:
Telephone (Home): () -	Work: () -	Cell: () -	
Employer:			

Partner's Name:	Date of Birth: / /
Employer:	

Referring Physician:	Phone:	Fax:	
Address:	City:	State:	Zip Code:
Primary Care Physician:	Phone:	Fax:	
Address:	City:	State:	Zip Code:

Preferred Pharmacy:			
Address:	City:	State:	Zip Code:

Why are you seeing the doctor?

List all surgical procedures:

Type of Surgery	Date	Length of Stay	Name of Hospital/Surgeon

List all medications that you are currently taking:

Medication	Dose	Frequency (times per day)	Start Date

List all allergies (medication, food....)

Allergy	Reaction

Past Medical History (Please circle yes or no to each of the following...)

Have you been vaccinated against Hepatitis B?	Yes	No
Have you been screened for sickle cell trait?	Yes	No
Are you of Jewish or French Canadian ancestry?	Yes	No
If Yes, have you been screened for Tay-Sachs disease?	Yes	No
Is your partner of Jewish or French Canadian ancestry?	Yes	No
If Yes, has he been screened for Tay-Sachs disease?	Yes	No
Have you been screened for cystic fibrosis?	Yes	No
Has your partner been screened for cystic fibrosis?	Yes	No
Do any genetic disorders run in the family?	Yes	No
Do any genetic disorders run in your partner's family?	Yes	No
Have you ever had a problem with anesthesia?	Yes	No
Have you ever been given antibiotics before dental work?	Yes	No

Do you have a history of any of the following....

Asthma?	Yes	No
High blood pressure?	Yes	No
Heart valve disease?	Yes	No
High cholesterol?	Yes	No
Diabetes?	Yes	No
Blood transfusions?	Yes	No
Blood clotting disorders?	Yes	No

Anemia?	Yes	No
Thyroid problems?	Yes	No
Seizures?	Yes	No
Migraines?	Yes	No
Hepatitis?	Yes	No
Spastic colon/colitis?	Yes	No
Rheumatoid arthritis?	Yes	No
Lupus Erythematosus (SLE)?	Yes	No
Bladder/Kidney infection?	Yes	No
Sexually transmitted diseases? Type(s) _____	Yes	No
Pelvic inflammatory disease?	Yes	No
Have you had any complications with previous pregnancies?	Yes	No
Did your mother take diethylstilbestrol (DES) when she was pregnant with you?	Yes	No

Social History

Occupation: _____ **Ethnic Background:** _____

Education: (circle) High School Grad 2 Yr College 4 Yr College
 Post Graduate

Marital Status: Single Married (____yrs) Divorced Widowed Separated Domestic Partner
 (____yrs)

Diet: Regular Vegetarian Diabetic Lo-Carb
Other: _____

Family History:

Please check which family members have a history of each of the following disorders...

	Mother	Father	Brother	Sister	Son	Daughter	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Maternal Aunt	Maternal Uncle	Paternal Aunt	Paternal Uncle
Problems with anesthesia														
Cancer														
Thyroid problems														
Infertility														
Hormonal disorders														
High blood pressure														
Blood clotting disorders														
Diabetes														
Kidney Disease														
Heart Disease														
Birth defects														
Neurological disorders														
Other:														
Other:														

GYN History:

Age you started having periods _____ **# Days between Periods** _____ (1st day of one period to 1st day of next period)

Days of Flow _____ **Are your periods regular? (circle)** Yes
No

Do you bleed or spot between periods? Yes No **Do you bleed/spot with intercourse?**
Yes No

Menstrual cramps: None Mild Moderate Severe **What pain medicine do you use?** _____

Do you have pelvic or abdominal pain? Yes No

If Yes, where is the pain located? _____ **What does it feel like?**

Most recent form of birth control used _____

Other forms of birth control used in the past _____

How often do you have intercourse? _____

Do you use lubricants? Yes No

Is intercourse painful or difficult for you? Yes No

Date of Last Pap Smear: _____ **Results:** Normal Abnormal

Have you ever had an abnormal Pap Smear? Yes No **If Yes, Date:**

If Yes, what was the treatment? None Cone Biopsy Cryotherapy
LEEP

Date of last mammogram: _____ **Results:** Normal Abnormal

What are your plans for conceiving a child?

As soon as possible In the future Never Unsure

What is the duration of your infertility? _____

How do you monitor ovulation?

Cervical mucous Basal Body Temp Ovulation kit Don't monitor

Other: Please Explain _____

Have you used any of the following infertility treatments? If yes, please list date.

Clomid	Yes	No	Unsure	Date: _____
Femara (letrozole)	Yes	No	Unsure	Date: _____
Fertility shots	Yes	No	Unsure	Date: _____
Inseminations	Yes	No	Unsure	Date: _____
In Vitro Fertilization	Yes	No	Unsure	Date: _____
ICSI	Yes	No	Unsure	Date: _____
Frozen Embryo Transfers	Yes	No	Unsure	Date: _____
GIFT	Yes	No	Unsure	Date: _____

Have you had a hysterosalpingogram (HSG) done? Yes No

If Yes, Results? Normal Abnormal

Has a semen analysis been done? Yes No If Yes, Results? Normal Abnormal

Obstetrical History

In order, starting with your first pregnancy, please answer the following...

Date	Outcome (full term birth, preterm birth, miscarriage, ectopic, ...)	Complications	Time to Conceive	Infertility treatments used	Is your current partner the father?