

GYNECOLOGIC HISTORY:

When was the first day of your last period? _____

Do you have regular periods? Yes _____ No _____

Age at first period? _____ Number of days of bleeding? _____

Number of days between the start of one period to the start of the next one? _____

Amount of bleeding: Light _____ Medium _____ Heavy _____

Do you have pain with menstruation? Yes _____ No _____

Degree of pain: Mild _____ Moderate _____ Severe _____

Pain relieved by over the counter medications? Yes _____ No _____

Starts with the onset of bleeding? Yes _____ No _____

Begins a few days prior to the onset of bleeding? Yes _____ No _____

Persists more than 48 hours? Yes _____ No _____

Do you have pain with ovulation? Yes _____ No _____

Do you experience pain with sexual intercourse? Yes _____ No _____

Pain is mostly on the exterior? Yes _____ No _____

Pain is mostly internal (deep penetration)? Yes _____ No _____

Are you experiencing a vaginal discharge? Yes _____ No _____

Associated with itching or burning? Yes _____ No _____

Associated with an unusual odor? Yes _____ No _____

What is the name and contact information of your Obstetrician/Gynecologist?

When was your last Pap smear and the result? _____

Have you ever had an abnormal Pap smear? Yes _____ No _____

If yes, what follow up was needed? _____

Have you ever had a mammogram? Yes _____ No _____

If yes, what was the result and the date? _____

Have you ever had a sexually transmitted disease?
(i.e. Chlamydia, Gonorrhea, Syphilis, Herpes) Yes _____ No _____

When? _____ Was it treated? Yes _____ No _____

Have you ever had Pelvic Inflammatory Disease (PID)? Yes _____ No _____

When? _____ Were you hospitalized? Yes _____ No _____

Do you experience milky or any discharge from your breasts? Yes _____ No _____

Do you have uterine fibroids, ovarian cysts or endometriosis? Yes _____ No _____

Please indicate all that apply above.

Have you ever used an IUD or any other form of contraception? Yes _____ No _____

Have you ever used birth control pills? Yes _____ No _____

How many years? _____

When did you last use it? _____

PREVIOUS SURGERIES:

Have you ever had surgery? Yes _____ No _____

Procedure	Date	Indication	Outcome

MEDICAL CONDITIONS:

Do you have any of the following conditions?

Condition	Yes/No	Comments
Any Type of Cancer – Please specify		
Anxiety or Panic disorder		
Arthritis		
Asthma		
Bladder Infection		
Bleeding Tendency		
Breast Cancer		
Breast Lump or Cancer		
Bronchitis		
Clot Formation in Legs or Lung		
Diabetes		
Depression or Mood Disorders		
Gastric/Duodenal ulcer		
Glasses/Contact Lenses		
Heart Disease		
Heart Murmur		
Hepatitis		
High Blood Pressure		
Intestinal Bleeding		
Kidney Disease		
Kidney Infection		
Kidney Stones		
Lung Disease		
Migraine		
Neurological or Psychiatric Disorders		
Ovarian or Uterine Cancer		
Paralysis		
Pneumonia		
Polycystic Ovary Syndrome (PCOS)		
Problems with Anesthesia		
Rheumatic Fever		
Rheumatoid Arthritis		
Systemic Lupus Erythematosus		
Thrombophlebitis		
Thyroid Disease		
Tuberculosis		
Varicose Veins		
Other		

DRUG ALLERGIES:

Are you allergic to any medications that you know of? Yes _____ No _____

Medication	Reaction

CURRENT MEDICATIONS:

Are you currently taking any medications or supplements? Yes _____ No _____

Medication	Dose	Frequency

FAMILY HISTORY:

Is there a history of any of the following conditions in the family?

Condition	Yes/ No	Comments
Any Type of Cancer		
Birth Defects or Down's Syndrome		
Blood Disorders		
Blood Clots in Legs or Lung		
Breast Cancer		
Cystic Fibrosis or Thalassemia		
Diabetes or Insulin Resistance		
Early Menopause or Ovarian Failure		
Genetic Diseases		
Heart Disease		
High Blood Pressure		
Infertility		
Kidney Disease		
Systemic Lupus Erythematosus (SLE)		
Mental Retardation		
Twins or Triplets		
Ovarian or Uterine Cancer		
Polycystic Ovary Syndrome (PCOS)		
Recurrent Miscarriages		
Rheumatoid Arthritis		
Sickle Cell Disease		
Thyroid Disease		
Other		

PARTNER HISTORY: Gender - Please circle one: Female / Male

Occupation: _____

Do you have any medical problems? Yes _____ No _____

Have you ever had any surgeries? Yes _____ No _____

Any family history of any major illnesses? Yes _____ No _____

(You may refer to Page 4 for illnesses) _____

Have you initiated any pregnancies in the past? # _____ Yes _____ No _____

Number with current partner? _____

When was the most recent pregnancy? _____

Have you been evaluated by a Urologist? (If applicable/male partner) Yes _____ No _____

Diagnosis: _____

Have you ever had a semen analysis? (If applicable/male partner) Yes _____ No _____

Result: Date: _____

Volume (ml or cc): _____

Count (million/ml): _____

Motility (% moving sperm): _____

Morphology (% normal forms): _____ (Kruger's or WHO Criteria?)

Have you ever had sperm DNA testing? (If applicable/male partner)

Sperm DNA fragmentation index (DFI): _____ %

High Density Stainability (HDS): _____ %

Are you allergic to any medications? Yes _____ No _____

Medication: _____ Reaction: _____

Are you taking any medications? Yes _____ No _____

Medication: _____ Dose: _____ Frequency: _____

Do you use Tobacco? Yes _____ No _____ #Packs/day _____

Do you use Alcohol? Yes _____ No _____ #Drinks/wk _____

Have you ever used drugs? Yes _____ No _____

Do you use a hot tub or wear tight underwear? Yes _____ No _____ #Times/wk _____

Weight: _____ Height: _____

Have you (♂) had any of the following tests or procedures? For male partner only.

Test/ Procedure	Date	Result	Comment
Male Blood Tests			
FSH			
LH			
Testosterone			
TSH			
Prolactin			
DQ Alpha or HLA			
Semen Culture			
Surgery			
Vasectomy			
Vasectomy Reversal			
Testicular Biopsy			
Varicocele Surgery			
Hernia Repair			
Undescended Testicle			
Removal of Testicle (s)			

TESE or MESA			
Other			

PREVIOUS INFERTILITY EVALUATION: For Female Patient only.

Have you (♀) ever had any of the following tests or procedures? Please enter all that apply.

Test/ Procedure	Date	Result
Female Blood Tests		
FSH (Cycle day 3)		
Estradiol (Cycle day 3)		
Anti-Mullerian Hormone (AMH)		
Inhibin B level		
LH (Cycle day 3)		
Progesterone (7 days after ovulation)		
TSH		
Prolactin		
DHEAS		
Testosterone		
17 Hydroxy-Progesterone		
Blood type and Rh status		
Rubella/Varicella Titers		
HIV		
Hepatitis B surface antigen		
Hepatitis C antibody		
RPR/ VDRL (Syphilis)		
Blood tests (Immunologic)		
Anti-Nuclear Antibodies (ANA)		
Anti-Phospholipid Antibodies (APA)		
Anti-Paternal Leukocyte Antibodies (APLA)		
Natural Killer (NK) cell assay		
Immunophenotype		
DQ Alpha or HLA testing		
Anti-Thyroglobulin Antibodies (ATA)		
Anti-Microsomal Antibodies (AMA, TPO)		
Anti-Sperm Antibodies		
IgA level		
Thrombophilia work up (clotting disorders)		
Cervical/Vaginal Cultures		
Chlamydia/Gonorrhea		
Ureaplasma/Mycoplasma		
General Assessment		
Gynecological exam		
Mammogram		
Physical exam		
Basal Body Temperature Chart (BBT)		
Ovulation Predictor Kits (OPK or LH kit)		
Endometrial biopsy		
Pelvic exam		
Vaginal ultrasound		

Hysterosalpingogram (HSG) (Dye Test)		
Fluid ultrasound (Hydrosonography)		
Hysteroscopy (Camera to look inside uterus)		
Laparoscopy (Camera to look inside abdomen)		
Laparotomy (Open abdominal surgery)		
Other		

PREVIOUS INFERTILITY TREATMENT

Have you ever used any of the following medications or treatments?

Medication	Date	Dose	# Cycles	Comment
Clomiphene Citrate (Oral) or Femara (Oral)				
Gonal F, Follistim, Repronex, Menopur, Bravelle, Luveris (Injectible Medications)				
HCG (Profasi, Ovidrel)				
Progesterone				
Aspirin				
Heparin or Lovenox				
Prednisilone (Medrol)				
Prednisone				
Dexamethasone				
Intravenous Immunoglobulin (IVIG) or Intralipid				
Leukocyte Immunization Therapy (LIT)				
Treatment				
Timed Intercourse				
Intrauterine Insemination (IUI)				
In Vitro Fertilization (IVF) 1. 2. 3. 4.				
Ovum Donation (OD)				
Gestational Surrogacy (SUR)				
OD + SUR				
Gamete Intrafallopian Tube Transfer (GIFT)				
Zygote Intrafallopian Tube Transfer (ZIFT)				
Other				