



## Welcome

To better focus your visit with the doctor based on your needs, please complete this form prior to your initial visit. Thank you.

### Personal Information

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone numbers Cell \_\_\_\_\_ -- \_\_\_\_\_ -- \_\_\_\_\_

Home \_\_\_\_\_ -- \_\_\_\_\_ -- \_\_\_\_\_

Work \_\_\_\_\_ -- \_\_\_\_\_ -- \_\_\_\_\_

Email address: \_\_\_\_\_

Partner's Name (if applicable): \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Partner's Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Who referred you to us? \_\_\_\_\_

Your Obstetrician/ Gynecologist: \_\_\_\_\_

Your Internist/ Family Physician (if you have one): \_\_\_\_\_



What is the reason for your visit today and how long have you been trying to conceive?

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### Medical History

Do you have any medical problems?  Yes  No If yes, which one(s)? Check all that apply:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Alcoholism                      | <input type="checkbox"/> Epilepsy                       | <input type="checkbox"/> Ovarian Cysts             |
| <input type="checkbox"/> Anemia                          | <input type="checkbox"/> Gallbladder Problems           | <input type="checkbox"/> Parasitic Infection       |
| <input type="checkbox"/> Anxiety disorder                | <input type="checkbox"/> Gonorrhea                      | <input type="checkbox"/> PID                       |
| <input type="checkbox"/> Arthritis                       | <input type="checkbox"/> Heart Disease                  | <input type="checkbox"/> Pneumonia                 |
| <input type="checkbox"/> Bipolar disorder                | <input type="checkbox"/> Hepatitis B or C               | <input type="checkbox"/> Poor Sense of Smell       |
| <input type="checkbox"/> Bleeding disorder               | <input type="checkbox"/> Herpes                         | <input type="checkbox"/> Premature ovarian failure |
| <input type="checkbox"/> Blood clot in leg or lung       | <input type="checkbox"/> Hirsutism (excess hair growth) | <input type="checkbox"/> Rheumatic Fever           |
| <input type="checkbox"/> Breast Discharge (galactorrhea) | <input type="checkbox"/> High Blood Pressure            | <input type="checkbox"/> Scarlet Fever             |
| <input type="checkbox"/> Cancer? Specify type: _____     | <input type="checkbox"/> HIV                            | <input type="checkbox"/> Seizures                  |
| <input type="checkbox"/> Chlamydia                       | <input type="checkbox"/> Human Papilloma Virus (HPV)    | <input type="checkbox"/> Substance (drug) abuse    |
| <input type="checkbox"/> Chronic Headaches               | <input type="checkbox"/> Liver Problems                 | <input type="checkbox"/> Syphilis                  |
| <input type="checkbox"/> Colitis                         | <input type="checkbox"/> Loss of balance                | <input type="checkbox"/> Thyroid Problems          |
| <input type="checkbox"/> Color Blindness                 | <input type="checkbox"/> German Measles                 | <input type="checkbox"/> Tuberculosis              |
| <input type="checkbox"/> Diabetes                        | <input type="checkbox"/> Measles                        | <input type="checkbox"/> Trichomoniasis            |
| <input type="checkbox"/> Depression                      | <input type="checkbox"/> Neurological Problems          | <input type="checkbox"/> Ulcers                    |
| <input type="checkbox"/> Endometriosis                   | <input type="checkbox"/> Nongonococcal Urethritis       | <input type="checkbox"/> Visual Disturbances       |

What is your current weight? (in lbs.) \_\_\_\_\_ What is your height? (in inches) \_\_\_\_\_

Have you lost or gained more than 10 pounds of weight in the last year?  Yes  No

Do you follow a particular food diet or have any special dietary habits?  Yes  No

If yes, what is it? \_\_\_\_\_

Do you exercise regularly?  Yes  No

If yes, what type of exercise do you do and for how many hours per week? \_\_\_\_\_

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Have you ever had an eating disorder? (anorexia, bulimia)  Yes  No

If yes, what is it? \_\_\_\_\_



## Gynecologic History

At what age did you have your first period? \_\_\_\_\_

When was the beginning of your last (most recent) period? \_\_\_\_\_

Are your periods regular?  Yes  No

If yes, what is the usual number of days between periods? \_\_\_\_\_

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

What is the usual duration of your period? (number of days of bleeding) \_\_\_\_\_

Do you have painful periods?  never  sometimes  often  usually

How would you describe the level of your pain?  mild  moderate  severe

Do you have to take pain medication for your periods?  Yes  No

If yes, specify medication: \_\_\_\_\_

Do you bleed or spot between your periods?  Yes  No

When was your most recent Pap smear? \_\_\_\_\_ Was it normal?  Yes  No  I don't know

When was your most recent mammogram? \_\_\_\_\_ Was it normal?  Yes  No  I don't know

What form of contraception do you use or have you used in the past? \_\_\_\_\_

Have you ever taken birth control pills?  Yes  No

Have you ever used an intrauterine device (IUD)?  Yes  No

How many times per week do you and your partner have sexual intercourse? \_\_\_\_\_

How many times do you have intercourse around ovulation? \_\_\_\_\_

Have you ever used used a basal body temperature chart?  Yes  No

If yes, what day of the cycle did your temperature rise? \_\_\_\_\_

Have you ever used used an ovulation predictor kit (OPK)?  Yes  No

If yes, what day of the cycle did your kit turn positive? \_\_\_\_\_

Do you ever have pain during intercourse?  Yes  No

Do you use lubricants?  Yes  No

## Obstetrical History

How many times have you been pregnant? \_\_\_\_\_

How many of your pregnancies were full term births (>37 weeks)? \_\_\_\_\_

1<sup>st</sup> pregnancy: What year? \_\_\_\_\_ How long did it take to conceive? \_\_\_\_\_

Was infertility therapy required?  Yes  No If yes, what? \_\_\_\_\_

Was the baby born alive?  Yes  No If yes, is the current partner the genetic father?  Yes  No

If not, the pregnancy  Ended in miscarriage  Was an ectopic  Ended in abortion

2<sup>nd</sup> pregnancy: What year? \_\_\_\_\_ How long did it take to conceive? \_\_\_\_\_



Was infertility therapy required?  Yes  No If yes, what? \_\_\_\_\_

Was the baby born alive?  Yes  No If yes, is the current partner the genetic father?  Yes  No

If not, the pregnancy  Ended in miscarriage  Was an ectopic  Ended in abortion

3<sup>rd</sup> pregnancy: What year? \_\_\_\_\_ How long did it take to conceive? \_\_\_\_\_

Was infertility therapy required?  Yes  No If yes, what? \_\_\_\_\_

Was the baby born alive?  Yes  No If yes, is the current partner the genetic father?  Yes  No

If not, the pregnancy  Ended in miscarriage  Was an ectopic  Ended in abortion

4<sup>th</sup> pregnancy: What year? \_\_\_\_\_ How long did it take to conceive? \_\_\_\_\_

Was infertility therapy required?  Yes  No If yes, what? \_\_\_\_\_

Was the baby born alive?  Yes  No If yes, is the current partner the genetic father?  Yes  No

If not, the pregnancy  Ended in miscarriage  Was an ectopic  Ended in abortion

Additional pregnancies: What year? \_\_\_\_\_ How long did it take to conceive? \_\_\_\_\_

Was infertility therapy required?  Yes  No If yes, what? \_\_\_\_\_

Was the baby born alive?  Yes  No If yes, is the current partner the genetic father?  Yes  No

If not, the pregnancy  Ended in miscarriage  Was an ectopic  Ended in abortion

Did you have any complications during or after your pregnancies?  Yes  No

If yes, explain: \_\_\_\_\_

Are there any children in the family with birth defects or mental retardation?  Yes  No

Did your mother have any difficulty with conceiving or with recurrent pregnancy loss?  Yes  No

If yes, explain: \_\_\_\_\_

Did your mother take diethylstilbestrol (DES) when she was pregnant with you?  Yes  No

At what age did your mother go through menopause? \_\_\_\_\_

## Surgical History

Have you ever had surgery?  Yes  No If yes, which one(s)? Check all that apply:

- Appendectomy
- Cervical conization or cauterly
- Cesarean section
- D & C
- Endometriosis
- Hysteroscopy
- Laparoscopy
- LEEP procedure
- Lysis of adhesions
- Myomectomy
- Removal of ovarian cysts
- Tubal ligation (sterilization)

Other, please list: \_\_\_\_\_

Do you take any prescription or over-the-counter medications regularly?  Yes  No

If yes, please list: \_\_\_\_\_

Do you have any allergies?  Yes  No

If yes, please list: \_\_\_\_\_



## Prior Fertility Testing and Treatment

Have you been tested for infertility before?  Yes  No

If yes, with whom, where and when? \_\_\_\_\_

What cause(s) of infertility was diagnosed? (check all that apply)

- Cervical factor
- Male factor
- Tubal factor
- Decreased ovarian reserve (poor egg quality)
- Ovulatory dysfunction
- Unexplained
- Endometriosis
- PCOS
- Uterine factor

Other, please list: \_\_\_\_\_

Have you had any of the following tests?  Yes  No If yes, check all that apply:

- Day 3 FSH & Estradiol
- Hormonal Testing (Prolactin, Progesterone)
- Clomiphene Challenge Test
- Hysterosalpingogram (HSG)
- Endometrial Biopsy
- Sonohysterogram (SHG)
- Genetic testing (Cystic fibrosis, Fragile X)
- Thyroid testing
- Gonorrhea, Mycoplasma, Chlamydia cultures
- Ultrasound

Other, please specify: \_\_\_\_\_

Have you ever taken medications to enhance your fertility?  Yes  No If yes, check all that apply:

- Antibiotics for a pelvic infection
- Gonadotropins (Gonal F, Follistim, Repronex)
- Bromocriptine (Dostinex, Parlodel)
- Injections (Lupron, hCG)
- Clomiphene citrate (Clomid)
- Progesterone

Other, please list: \_\_\_\_\_

Have you ever undergone Intrauterine Insemination (IUI)?  Yes  No

Have you ever taken Clomid or gonadotropins (Gonal F, Follistim) to induce ovulation?  Yes  No

If yes, When	Where	Medication & dose	Number of mature follicles	Outcome
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Have you undergone In Vitro Fertilization (IVF)?  Yes  No

If yes, When Where Medication & dose No. of eggs retrieved No. of embryos transferred Outcome

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\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

Social History

What is your ethnicity?  African American  Asian  Caucasian  Hispanic

Indian  Native American  Other: \_\_\_\_\_

What do you do professionally? \_\_\_\_\_

You are:  Married  Single  Divorced  Widowed

Do you currently use or have you recently used (check all that apply):

Caffeine. How many cups of coffee/ caffeinated tea/ cola do you usually drink daily? \_\_\_\_\_

Alcohol. How many glasses of alcohol do you usually drink per week? \_\_\_\_\_

Tobacco. How many cigarettes do you usually smoke per day? \_\_\_\_\_

Recreational Drugs. (Marijuana, Cocaine, etc.) Which one(s) and how often? \_\_\_\_\_

Partner's History (if applicable)

Name: \_\_\_\_\_

Do you have any medical problems?  Yes  No

If yes, what is it? \_\_\_\_\_

Have you ever had any surgery?  Yes  No

If yes, what is it? \_\_\_\_\_

Have you ever had a complete semen analysis performed?  Yes  No

If yes, when, where and results: \_\_\_\_\_

Have you ever seen a doctor to evaluate your fertility?  Yes  No

If yes, physician's name and when: \_\_\_\_\_

# New Patient History



What is your diagnosis and how has have you been treated?

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Have you ever achieved a pregnancy in the past?  Yes  No

If yes, is it with your current partner?  Yes  No If yes, when? \_\_\_\_\_

Do you ever have difficulties achieving an erection?  Yes  No

If yes, how often? \_\_\_\_\_

Do you ever have difficulties ejaculating?  Yes  No

If yes, how often? \_\_\_\_\_

Have you ever had a serious injury to your genitals?  Yes  No

If yes, when ? \_\_\_\_\_

Have you ever had any infections of your penis, prostate or testicles?  Yes  No

If yes, when and where? \_\_\_\_\_

Do you take any prescription or over-the-counter medications regularly?  Yes  No

If yes, please list: \_\_\_\_\_

Do you have any allergies?  Yes  No

If yes, please list: \_\_\_\_\_

What do you do professionally? \_\_\_\_\_

Do you currently use or have you recently used (check all that apply):

Alcohol. How many glasses of alcohol per week do you usually drink? \_\_\_\_\_

Tobacco. How many cigarettes per day? \_\_\_\_\_

Recreational Drugs. (Marijuana, Cocaine, etc.) Which one(s) and how often? \_\_\_\_\_