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: _______-_____-_______ Date of Birth: ___/___/_____

Address: ____

____

____

Phone numbers Cell _________--___________--___________

Home _________--___________--___________

Work _________--___________--___________

Email address: ____

Partner's Name (if applicable): __________________ Date of Birth: ___/___/_____

Partner's Social Security Number: _________-_______-_________

Who referred you to us?____

Your Obstetrician/ Gynecologist: ____

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

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

____

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____

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 ☐ Ovulatory dysfunction ☐ Tubal factor

☐ Diminished ovarian reserve ☐ PCOS ☐ Unexplained

☐ Endometriosis ☐ Recurrent miscarriages ☐ Uterine factor

☐ Male factor

Other, please list: ______________________________

____

Have you had any of the following tests? Check all that apply:

☐ Day 3 FSH & Estradiol ☐ Hormonal Testing (Prolactin, Progesterone)

☐ AMH level ☐ Hysterosalpingogram (HSG) ☐ Endometrial Biopsy

☐ Sonohysterogram (SHG) ☐ Genetic testing (e.g., Cystic fibrosis)

☐ Thyroid testing ☐ Gonorrhea, 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)

☐ Bromocriptine (Dostinex, Parlodel) ☐ Injections (Lupron, hCG)

☐ Clomiphene citrate (Clomid) ☐ Progesterone

Other, please list: ______________________________

____

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

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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

____

____

____

____

____

Have you undergone In Vitro Fertilization (IVF)? ☐ Yes ☐ No

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

____

____

____

____

Medical History

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

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

Gynecologic History

At what age did you have your first period? ____

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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

Have you ever had an abnormal Pap test? ☐ Yes ☐ No

If yes, when and what was done? ____

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

Have you ever had an abnormal mammogram? ☐ Yes ☐ No

If yes, when and what was done? ____

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)? ____________

1st 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

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2nd 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

3rd 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

4th 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: ____

Surgical History

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

☐ Appendectomy ☐ Endometriosis ☐ Lysis of adhesions

☐ Cervical conization or cautery ☐ Hysteroscopy ☐ Myomectomy

☐ Cesarean section ☐ Laparoscopy ☐ Removal of ovarian cysts

☐ D & C ☐ LEEP procedure ☐ 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: ____

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

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

If yes, explain: ____

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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 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?

____

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?__________________

____

Family History

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, who: ____

Does anyone in your family have (please check all that apply & list whom):

- ☐ Infertility ____
- ☐ Recurrent abortions (2 or more miscarriages) __________________________________
- ☐ Blood clots in the leg (DVT) or lung (PE) ______________________________________
- ☐ Type II diabetes ____
- ☐ Breast cancer ____
- ☐ Ovarian cancer ____
- ☐ Colon cancer ____

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

At what age did your mother go through menopause? ____________________________________

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