

Infertility History Form

Date form completed: _____

Patients name: _____ Partner's name: _____

Age: _____ Date of Birth: _____ Age: _____ Date of Birth: _____

Occupation: _____ Occupation: _____

Prior marriage: No Yes # _____ Prior marriage: No Yes # _____

Attempted pregnancy prior marriage? No Yes Attempted pregnancy prior marriage? No Yes

Ethnic origin _____ Ethnic Origin: _____

Women's Medical History

1. Reason for visit: Infertility Donor Insemination Recurrent pregnancy Loss
 Other: _____

2. Duration of infertility: _____ months.

Pregnancy History

1. Number of pregnancies: _____
2. Number of pregnancies greater than 20 weeks: _____
3. Number of pregnancies less than 20 weeks: _____
4. Number of tubal pregnancies (ectopic): _____
5. Number of elective termination of pregnancies: _____
6. Number of living children: _____

Date of delivery	Months to conceive	Vaginal or C-Section	Fathered by Current Partner?
_____	_____	_____	No <input type="checkbox"/> Yes <input type="checkbox"/>
_____	_____	_____	No <input type="checkbox"/> Yes <input type="checkbox"/>
_____	_____	_____	No <input type="checkbox"/> Yes <input type="checkbox"/>

7. Date of Miscarriage or termination	Months to conceive	Weeks of Pregnancy	D&C	Fathered by Current Partner?
_____	_____	_____	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
_____	_____	_____	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
_____	_____	_____	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>
_____	_____	_____	No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>

Menstrual History

Date of last period ___/___/___

1. How often do you have a period? (from start to start)
_____ days
2. Are your periods:
 heavy normal light
 regular irregular days from start to start _____
3. Do you have spotting between periods? Yes No
 after period before period mid cycle
4. Do you have severe pain with periods?
 Yes No Sometimes Always

Sexual History

1. How often do you have intercourse during your fertile period?
_____ # times per week.
2. Do you have pain with intercourse?
 No Yes Sometimes Always
3. Do you use lubrication during intercourse?
 No Yes Name _____
4. Do you use an ovulation kit to time intercourse?
 No Yes How long? _____ months
5. Do you have any sexual concerns that you would like to discuss?
 No Yes With Partner In Private

Medical History

1. Do you have any medical illnesses?
 No Yes
Please list: _____

2. Do you take any routine medications, including herbal preparations? No Yes
Please list: _____

3. Are you allergic to any medications?
 No Yes
Please list: _____

4. Do you have any martial, sexual or emotional problems related to infertility?
 No Yes
5. Do you have any of the following medical conditions:
Check all that apply
____ Bleeding disorders
____ Thrombophlebitis
____ Pulmonary embolism (blood clot in lung)
____ Antiphospholid syndrome
____ Lupus
____ Other collagen disease
____ Diabetes
____ High Blood Pressure

- ___ Heart Disease
- ___ Celiac Disease (gluten intolerance)
- ___ Chronic Anemia
- ___ Chronic Fatigue
- ___ Osteoporosis
- ___ Frequent Abdominal pain
- ___ Frequent Diarrhea
- ___ Eating Disorder
- ___ Depression
- ___ None of the above

Gynecological History

- ___ Uterine Myoma (fibroid)
- ___ Endometriosis
- ___ Pelvic Adhesions
- ___ Tubal Obstruction

Surgical History

None

List all of your pelvic or abdominal surgeries

Date	Type	Diagnosis
___	_____	_____
___	_____	_____
___	_____	_____

Endocrine History

Do you have or have you had any of the following:

- ___ Thyroid disease
- ___ Hashimoto's disease
- ___ Polycystic ovary disease
- ___ Acne
- ___ Increased facial or body hair
- ___ Insulin resistance
- ___ Gestational diabetes
- ___ Hair loss
- ___ Increased prolactin
- ___ Inappropriate breast milk production
- ___ None of the above

Social History

1. Do you smoke? No Yes Amount? _____
2. Do you drink alcohol? No Yes Amount? _____
Type: _____
3. Do you use recreational drugs? No Yes Amount? _____
Type: _____
4. Are you on a special diet? No Yes Type: _____

5. Do you exercise? No Yes
Type and amount: _____

6. Have you had any of the following sexually transmitted infections?

None

Check all that apply

Gonorrhea

Chlamydia

HPV (human papilloma virus)

Herpes

Tubal infection (PID)

HIV (AIDS)

Hepatitis B

Hepatitis C

Mycoplasma or ureoplasma

For Doctor's Use Only

Prior Infertility Testing

Blood hormone testing Unknown Yes No

Results:

FSH _____

Estradiol _____

TSH _____

Prolactin _____

LH _____

Inhibin B _____

Anti Mullerian Hormone _____

Fasting Glucose _____

Fasting Insulin _____

Have you had any immunology or thrombophilia testing?

Unknown Yes No

Have you had any of the following tests?

Check all that apply:

X-ray of tubes (HSG)

Antral follicle count

Sonohysterogram (saline ultrasound)

Hysteroscopy

Laparoscopy

Prior Infertility Treatment

Have you seen other doctors for infertility? No Yes

Please list the doctors and the approximate dates you saw them:

_____	_____
_____	_____
_____	_____
_____	_____

Have you had any of the following treatments? (If no, go to the next section).

1. Clomiphene citrate: No Yes # of cycles _____
Outcome: not pregnant pregnant miscarriage
2. Intrauterine inseminations: No Yes # of cycles _____
Outcome: not pregnant pregnant miscarriage
3. Clomiphene and insemination: No Yes # of cycles _____
Outcome: not pregnant pregnant miscarriage
4. Gonadotropin and insemination: No Yes # of cycles _____
Outcome: not pregnant pregnant miscarriage
5. IVF (inVitro Fertilization) No Yes # of cycles _____
Outcome: not pregnant pregnant miscarriage
6. Frozen Embryo Transfer: No Yes # of cycles _____
Outcome: not pregnant pregnant miscarriage
7. Have you used donor eggs or donor sperm as part of your treatment?
No Yes

Genetic History

Have you, your spouse or your families had a history of any of the following disorders? (check all that apply)

- ___ Mental retardation
- ___ Learning Problems
- ___ Fragile X Syndrome
- ___ Cystic Fibrosis
- ___ Muscular dystrophy
- ___ Thalassemia A or B
- ___ Down's Syndrome
- ___ Tay Sach's Disease
- ___ Hemophilia
- ___ Von Willebrand's disease
- ___ Bleeding disorders
- ___ Thrombophilia
- ___ Blood clots in veins
- ___ Celiac Disease
- ___ Polycystic kidneys
- ___ Hypospadias
- ___ Other birth defects
- ___ Cancer of breast, ovary or colon
- ___ Menopause before age 40
- ___ Bone defects
- ___ Neural tube defects
- ___ Sickle cell anemia
- ___ None of the above

Los Olivos Male Infertility History

For Doctor's Use Only

1. Have you had a semen analysis? No Yes
How many? _____
2. Has the analysis been normal? No Yes
3. Have you fathered a pregnancy? No Yes
4. Do you have any medical illnesses? No Yes
Please list: _____

5. Do you take regular prescription medication? No Yes
Please list: _____

6. Do you take herbal medications? No Yes
Please list: _____

7. Have you had mumps after you reached puberty? No
Yes
8. Have you had any injuries to your testicles? No Yes
9. Have you had any surgery to your genital organs? No
Yes Please list: _____

10. Have you seen a urologist in the past for any reason?
No Yes
Reason: _____

11. Do you have difficulty having an erection? No Yes
12. Do you use hot tubs regularly? No Yes
How often: _____
13. Do you smoke? No Yes
Type and amount? _____

14. Do you use recreational drugs? No Yes
Type and amount: _____

15. Do you drink alcohol? No Yes
Amount? _____
16. Have you been exposed to radiation, chemicals, pesticides
or other toxins in the work place? No Yes
Type: _____

