



N o v a I n V i t r o  
F e r t i l i z a t i o n

**Comprehensive Medical History Form**

Date: \_\_\_\_\_

Who referred you to our practice?

- Former Patient
- Friend
- SART Data
- Self-referral
- Yelp
- Physician - please list name:
- Internet Search- please specify what search terms:

Reason for consultation: \_\_\_\_\_

What are your goals or expectations for your consultation? \_\_\_\_\_

**Female Demographic Information**

	Patient	Partner
Name:		
Date of Birth:		
Occupation:		

Current weight: \_\_\_\_\_ pounds      Height: \_\_\_ feet \_\_\_\_\_ inches

Ethnicity:

- White
- Hispanic or Latino
- American Indian or Alaska Native
- Black or African American
- Native Hawaiian or Other Pacific
- Asian
- Other: \_\_\_\_\_
- Decline to answer

**Fertility History:**

Duration of relationship: \_\_\_\_\_ years and \_\_\_\_\_ months

Duration of unprotected intercourse: \_\_\_\_\_ years and \_\_\_\_\_ months

How long have you been actively attempting pregnancy? \_\_\_\_\_ years and \_\_\_\_\_ months

How frequently do you and your partner have intercourse? \_\_\_\_\_ per week / \_\_\_\_\_ per month

Have you ever used a method to keep you from getting pregnant?       Yes       No

If yes, what method(s)? \_\_\_\_\_

If known, what is the cause of your infertility? \_\_\_\_\_



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**Pregnancy history (female):**

Pregnancy	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>
Mo/Yr of conception				
How long did it take to conceive?				
Infertility treatment? (Y/N)				
Did your current partner sire the pregnancy?				
Outcome (vaginal delivery, cesarean, ectopic, miscarriage, termination)				
Live birth > 37 weeks? (Y/N)				
Other pregnancy complications?				

How old were you when your periods first started? \_\_\_\_\_ years

Did you develop regular monthly periods at that time?  Yes  No

Do you have monthly menstrual periods now?  Yes  No

If yes, what is the usual number of days *between* the start of one period to the start of the next period? \_\_\_\_\_ days

Dates of the 1<sup>st</sup> day of your last 2 menstrual periods: \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_

How many menstrual periods do you have per year? \_\_\_\_\_

Do you have severe cramping or pelvic pain with your menstrual periods?  Yes  No

Do you have pain with intercourse?  Yes  No

Have you been diagnosed with endometriosis?  Yes  No

Have you ever had a pelvic infection?  Yes  No

Have you ever had any of the following sexually transmitted diseases or pelvic infections?

- Chlamydia
- Syphilis
- Gonorrhea
- Herpes
- Genital Warts/HPV



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Please complete the following table as accurately as possible, especially the "Physician/Clinic" column.

Test	Date(s)	Physician/Clinic	Results/Findings
Thyroid Test (TSH)			
Day 3 blood test for FSH/Estrogen			
AMH			
Prolactin level			
Hysterosalpingogram (X-Ray of Tubes/HSG)			
Sonohysterography (water ultrasound)			
Hysteroscopy			
Genetic Testing			
Endometrial receptivity testing			

**Health care maintenance:**

When was your last pap smear (month/year)? \_\_\_ / \_\_\_  Normal  Abnormal

When was your last abnormal pap smear? \_\_\_ / \_\_\_  Not applicable

Do you perform self breast exams?  Yes  No

Have you ever had a mammogram?  Yes  No

When was your last mammogram? \_\_\_\_\_ month \_\_\_\_\_ year  Normal  Abnormal

**Medications/Supplements:**

Are you allergic to any medications?  No  Yes: \_\_\_\_\_

Are you currently taking any medications or supplements?

If yes please list below:

Medication/Supplement	Start Date	Dose



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**Surgical history:**

Please list any surgeries you have had in chronological order:

Year	Reason and Type of Surgery

**Social History:**

How many caffeinated beverages (coffee, soda, tea) do you drink per day? \_\_\_\_\_

On average how much water are you consuming daily? \_\_\_\_\_

Do you exercise regularly?  Yes  No  
If yes, describe: \_\_\_\_\_

Do you smoke cigarettes or have you ever used tobacco products?  Yes  No

Do you drink alcohol?  Yes  No

Have you ever used illicit drugs?  Yes  No

Are you allergic to any foods?  Yes  No  
If yes, describe: \_\_\_\_\_

Have you had significant weight change in the last year?  Yes  No

**Emotional Status:**

On a scale of 1-10 (10 being the worst), estimate the level of stress you feel due to infertility and other pressures: \_\_\_\_\_

Do you see a counselor?  Yes  No

List any anti-depressant/anti-anxiety medication you are currently taking: \_\_\_\_\_

Has your infertility produced marital or sexual dysfunction?  Yes  No

**Family History:**

Have any of these illnesses occurred in your family:

- High blood pressure                       Breast cancer                                       Infertility
- Diabetes     Ovarian cancer



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**Immunization History:**

- Chickenpox (Varicella):                     No    Yes (dates:                    )    Don't Know
- MMR- Measles, Mumps, Rubella  
(German Measles):                     No    Yes (dates:                    )    Don't Know
- Tetanus (Tdap):                     No    Yes (dates:                    )    Don't Know
- Hepatitis B:                     No    Yes (dates:                    )    Don't Know
- Polio:                     No    Yes (dates:                    )    Don't Know
- Influenza:                     No    Yes (dates:                    )    Don't Know

**Prior Infertility Treatment:**

Treatment	# of Cycles	Dates: From (Mo/Yr) / To (Mo/Yr)	Outcome
<input type="checkbox"/> Clomid or Femara / Letrozole with intercourse			
<input type="checkbox"/> Clomid or Femara / Letrozole with insemination			
<input type="checkbox"/> Injectable medications with insemination			
<input type="checkbox"/> Intrauterine insemination (IUI) alone			

**In Vitro Fertilization Treatment History**

Treatment	Cycle 1	Cycle 2	Cycle 3	Cycle 4
Cycle date				
IVF center/physician				
Maximum gonadotropin dose (Follistim, Gonal-F, Menopur)				
# Eggs retrieved				
Was ICSI performed? (Y/N)				
# Eggs fertilized				
#Eggs/embryos frozen				
Was genetic testing performed on the embryos?				
Did an embryo transfer take place in a fresh or frozen cycle?				
How many embryos transferred?				
Embryo age (day 2, 3, 5)				
Outcome				



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**Male History:**

**Male:** pregnancies from previous marriage(s) or partner(s):

Pregnancy	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>
Mo/Yr of conception				
How long did it take to conceive?				
Gender				
Outcome	<input type="checkbox"/> Living <input type="checkbox"/> Miscarriage <input type="checkbox"/> Ectopic <input type="checkbox"/> Abortion	<input type="checkbox"/> Living <input type="checkbox"/> Miscarriage <input type="checkbox"/> Ectopic <input type="checkbox"/> Abortion	<input type="checkbox"/> Living <input type="checkbox"/> Miscarriage <input type="checkbox"/> Ectopic <input type="checkbox"/> Abortion	<input type="checkbox"/> Living <input type="checkbox"/> Miscarriage <input type="checkbox"/> Ectopic <input type="checkbox"/> Abortion

Have you ever been evaluated by a urologist?  Yes  No

Do you have difficulty with erections?  Yes  No

Do you have retrograde ejaculation of sperm into the bladder?  Yes  No

Have you ever had any of the following sexually transmitted diseases or pelvic infections?

- Chlamydia
- Syphilis
- Gonorrhea
- HIV/AIDS
- Herpes
- Hepatitis
- Genital Warts/HPV

Do you have a history of undescended testicles?  Yes  No

Do you have scrotal or testicular pain?  Yes  No

Have you had prior injury to your testicles requiring hospitalization?  Yes  No

Have you had a high fever in the last 3 months?  Yes  No

Have you had a vasectomy?  Yes  No

Have you had surgery for varicocele repair?  Yes  No

Have you had hernia surgery?  Yes  No

Did you undergo any bladder or penis surgery as a child?  Yes  No

Are you exposed to any radiation or harmful chemicals in the workplace?  Yes  No

Have you had chemotherapy for cancer?  Yes  No

Have you ever used testosterone, androgen or androgenic hormones?  Yes  No



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Please complete the following table as accurately as possible, especially the "Physician/Clinic" column.

Test	Date(s)	Physician/Clinic	Results
Semen Analysis			
Chromosomes (karyotype)			
Genetic Testing			

Medications/Supplements:

Are you allergic to any medications?  No  Yes: \_\_\_\_\_

Are you currently taking any medications or supplements?

If yes please list below:

Medication/Supplement	Start Date	Dose