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?____

Pregnancy history (female):

Pregnancy	1st	2nd	3rd	4th
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 1st 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 ☐ Gonorrhea ☐ Genital Warts/HPV
☐ Syphilis ☐ Herpes

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

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
☐ Diabetes
☐ Breast cancer
☐ Ovarian cancer
☐ Infertility

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
☐ Clomid or Femara / Letrozole with intercourse			
☐ Clomid or Femara / Letrozole with insemination			
☐ Injectable medications with insemination			
☐ 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				

Male History:

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

Pregnancy	1st	2nd	3rd	4th
Mo/Yr of conception				
How long did it take to conceive?				
Gender				
Outcome	☐ Living ☐ Miscarriage ☐ Ectopic ☐ Abortion	☐ Living ☐ Miscarriage ☐ Ectopic ☐ Abortion	☐ Living ☐ Miscarriage ☐ Ectopic ☐ Abortion	☐ Living ☐ Miscarriage ☐ Ectopic ☐ Abortion

Have you been circumcised? ☐ Yes ☐ No

If no, does your foreskin fully retract? ☐ Yes ☐ No

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, androgel or androgenic hormones? ☐ Yes ☐ No

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

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