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INFERTILITY HISTORY

Female

Name ____ Age ____________________

GYNECOLOGICAL HISTORY:
At what age did you first start having periods? _______ every _______ days. Lasting _______ days.
Is your flow: Heavy Moderate Light? Do you spot between periods? ________________________
Do you have cramping with menses? ____
What type of contraceptives have you used in the past? ______________________________________
Have you ever had any sexually transmitted diseases (such as Chlamydia, Gonorrhea, Genital Warts, Syphilis)? _______________________ If so, which STD? ______________________________
Have you had any pelvic surgeries (appendectomy, bowel repair, ovarian cyst removal, D&C, treatment for cervical dysplasia)? ___________________ If so, which one? ______________________________
Have you had any pelvic infections, pelvic pain or feeling of heaviness in the abdomen?
____
Do you have a history of abnormal pap smears? ____
Have you ever been pregnant in the past? ______________________ Number of pregnancies? ______
Have you had any abortions? ____________________ if so, how long ago? ____________________
Do you have a history of fibroids (type, size and location)? __________________________________

MEDICAL HISTORY:
Do you have any chronic medical conditions (including diabetes, hypertension, asthma, arthritis, thyroid disease and ulcers)? ____
Are you or have you ever been in cancer therapy? ____
Do you have chronic bladder or urinary tract infections? ____________________________________
Do you use medications to treat medical or psychiatric conditions? ____________________________
Do you have any allergies to medicines? ____

PERSONAL HISTORY:
Lifestyle and nutrition (including diet, exercise, smoking, alcohol, and recreational drug use).
____
Usual weight __________. Have you had any recent weight loss or gain? ______________________
Have you been exposed to any environmental toxins (lead, radiation, pesticides, and insecticides)?
____

FAMILY HISTORY:
Is there a history of fertility-related problems? ____
Is there a history of recurrent miscarriages or difficult pregnancies? ____________________________
Did you mother take DES? ____
Mother's age at time of menopause _______________ Sister's age at time of menopause _____________
Is there a history of genetic disorders such as sickle cell anemia, Tay-Sachs disease, muscular dystrophy, or hemophilia? ____

PREVIOUS INFERTILITY WORK-UPS AND TREATMENTS:
Have you had any hormone studies done (FSH, TSH, LH, estradiol, progesterone, testosterone, and prolactin)? ____
Have you had any pelvic or vaginal ultrasounds? _____________________ if so, where? _____________
____
Have you had a hysterosalpingogram (HSG)? ________________________ if so, where? ____________
____
Have you had any post-coital tests (PCT)? ___________________________ if so, where? ____________
____
Basal body temperature (BBT), cervical mucus observations and/or cultures? _______________________
Endometrial biopsy? ____
Please list all ovulation induction cycles (name of stimulation medicine(s) and dosage, number of days taken, estradiol levels, number of follicles) ____
____
Please list intrauterine inseminations ____
____
Previous assisted reproductive technology cycles such as IVF and/or GIFT _________________________
____

Infertility: Male

NAME ____ AGE _______________________

MEDICAL HISTORY:
Do you have any chronic medical conditions (including diabetes, hypertension, asthma, arthritis, thyroid disease and ulcers)? ____
Are you or have you ever been in cancer therapy? ____
Do you have chronic bladder or urinary tract infections? ____
Do you use medications to treat medical or psychiatric conditions? __________________________________
Do you have any allergies to medicines? ____
Have you ever had any sexually transmitted diseases (such as Chlamydia, Gonorrhea, Genital Warts, Syphilis)? ____________________________ If so, which STD? ____
Have you had a semen analysis? ___________ if so, where and when? _________________________________
Have you had mumps? ___________________________________ if so, at what age? ____________________

PERSONAL HISTORY:
Do you haveany children from previous marriages or relationships? __________________________________
Number of children? ___________________ Number of pregnancies (including any that resulted in miscarriage or abortion) ____
Lifestyle and nutrition (including diet, exercise, smoking, alcohol and recreational drug use) _____________
____
Usual weight _____________. Have you had any recent weight loss or gain? ___________________________
Have you been exposed to any environmental toxins (lead, radiation, pesticides, and insecticides)?
____
What type of contraceptives have you used in the past? ____
How often do you have relations? ____
Do you wear tight clothing (such as tight jeans or briefs)? ____