

1. IDENTIFYING INFORMATION

Date _____

Name _____ Age _____
 Partner's Name _____ Age _____
 Number of years together _____ Marital Status _____
 Primary MD _____ Primary GYN _____
 Reproductive Endocrinologist: _____
 Reasons you are coming to see us: _____

2. HISTORY/LIFESTYLE

Your occupation: _____ Partner's occupation: _____
 Height: _____ Weight: _____
 Previous marriage: yes no Children from previous marriage? yes no
 Partner's previous marriage? yes no Children from previous marriage? yes no
 Exercise type: _____ Frequency/week: _____
 Stress level (scale of 1 to 10): _____
 Alcoholic drinks/week: _____
 Tobacco use # of cigarettes: _____
 Diet: Very Healthy Moderately Healthy Poor How many meals/day? _____
 Cravings for: Sugar Salt Sour

3. PREGNANCY HISTORY

	Number	Year
How many pregnancies have you had?	_____	_____
How many children do you have?	_____	_____
How many abortions have you had?	_____	_____
How many miscarriages have you had?	_____	_____

Are you currently pregnant? yes no maybe

4. CONTRACEPTIVE USE

Type	Dates	Reason Discontinued
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

5. MEDICATIONS *List all prescriptions, over-the-counter drugs, supplements, & herbs used during the past year*

Medication	Dose/Frequency	Dates of Use	Reason Prescribed
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____



6. ALLERGIES

Drug or Substance	When	Reaction
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

7. MENSTRUAL/HORMONAL

Age of first period: _____ Date of last two menstrual periods: ____/____/____ and ____/____/____

Last pap smear: ____/____/____ Last mammogram: ____/____/____

Do you menstruate regularly? yes no
If yes, your cycle is ____ days total

Do you menstruate irregularly? yes no
If yes, your cycle varies from ____ to ____ days

How many days does your period last? _____

During your period, the flow is: Light Medium Heavy Clots present

Color of menstrual blood:	Light red on days	_____	Purple on days	_____
	Bright red on days	_____	Brown on days	_____
	Dark red on days:	_____	Black on days	_____

Do you have any of the following symptoms after menstruation?
 fatigue dizziness insomnia night sweats others: _____

Do you spot before your period? yes no

Do you spot after your period? yes no

Do you spot mid-cycle? yes no

Do you know if you ovulate? yes no

If yes, on what day? _____

How do you know? _____

Pelvic pain/cramps: none during menses before menses after menses at mid-cycle
 during intercourse with bowel movements with urination
 cause you to miss work cause you to miss usual activity

Pelvic pain/cramps are: mild moderate severe
 worsening improving no change in midline on right side on left side

Frequency of intercourse: _____

Do you need to use a lubricant? yes no

Do you have intercourse during menstruation? yes no

Do you have milk or discharge from your breasts? yes no

If you have a hormonal disorder, please specify type and treatment: _____



8. GYNECOLOGIC/INFECTIOUS HISTORY

Do you have or have you had?

- Abnormal pap smear
- Abnormal uterus shape
- Cancer of Uterus/Ovaries/Cervix
- Cervicitis
- Chlamydia
- Colitis/enteritis
- Cryo (freezing of cervix)
- Cytomegalovirus
- Endometriosis
- Genital herpes
- Genital warts
- Gonorrhea
- Mycoplasma
- Ovarian cysts
- Pelvic adhesions
- Pelvic infections
- Recurrent vaginitis
- Syphilis
- Toxoplasmosis
- Trichomonas
- Tuberculosis
- Uterine fibroids

9. FERTILITY THERAPY HISTORY

Have you been treated for infertility previously? yes no

If yes, who was your physician? _____

What cause of infertility was diagnosed? _____

What drugs have you taken for infertility?

- Clomid (Serophene)
- gonaf F
- Follistim
- Repronex
- Pergonal
- Fertilinex
- hCG Profasi
- Progesterone
- Lupron
- Microdose Lupron
- Antagon
- Parlodel
- Antibiotics
- Baby aspirin
- Heparin
- Steroids
- Oral contraceptives
- Other _____

Which of the following tests have you or your partner had performed?

- | | | |
|--|---------------------|----------------|
| <input type="checkbox"/> FSH & LH | When ____/____/____ | Results: _____ |
| <input type="checkbox"/> Progesterone | When ____/____/____ | Results: _____ |
| <input type="checkbox"/> Estradiol (E2) | When ____/____/____ | Results: _____ |
| <input type="checkbox"/> Prolactin | When ____/____/____ | Results: _____ |
| <input type="checkbox"/> DHEA-S, Testosterone | When ____/____/____ | Results: _____ |
| <input type="checkbox"/> Endometrial biopsy | When ____/____/____ | Results: _____ |
| <input type="checkbox"/> Hysterosalpinogram | When ____/____/____ | Results: _____ |
| <input type="checkbox"/> Sonohystogram | When ____/____/____ | Results: _____ |
| <input type="checkbox"/> Ultrasound | When ____/____/____ | Results: _____ |
| <input type="checkbox"/> Laparoscopy, Hysteroscopy | When ____/____/____ | Results: _____ |
| <input type="checkbox"/> BBT | When ____/____/____ | Results: _____ |
| <input type="checkbox"/> Postcoital Test | When ____/____/____ | Results: _____ |
| <input type="checkbox"/> Mycoplasma culture | When ____/____/____ | Results: _____ |
| <input type="checkbox"/> Chlymidia culture | When ____/____/____ | Results: _____ |
| <input type="checkbox"/> Thyroid tests | When ____/____/____ | Results: _____ |
| <input type="checkbox"/> Cytomegalovirus | When ____/____/____ | Results: _____ |
| <input type="checkbox"/> Antibody screen | When ____/____/____ | Results: _____ |
| <input type="checkbox"/> Blood type | When ____/____/____ | Results: _____ |
| <input type="checkbox"/> Chromosomes | When ____/____/____ | Results: _____ |
| <input type="checkbox"/> Genetic screening | When ____/____/____ | Results: _____ |
| <input type="checkbox"/> Hepatitis B | When ____/____/____ | Results: _____ |
| <input type="checkbox"/> Hepatitis C | When ____/____/____ | Results: _____ |
| <input type="checkbox"/> HIV | When ____/____/____ | Results: _____ |
| <input type="checkbox"/> Semen analysis | When ____/____/____ | Results: _____ |
| <input type="checkbox"/> Antisperm antibodies | When ____/____/____ | Results: _____ |
| <input type="checkbox"/> Varicocele repair | When ____/____/____ | Results: _____ |
| <input type="checkbox"/> Testicular Biopsy | When ____/____/____ | Results: _____ |

