History and Physical

A. Identifying Data Date this form when completed_____

Your name _____ Partner's name_____
Age_____ Birth date_____ Height_____ Weight_____
Length of marriage (or relationship)_____
How long have you been trying unsuccessfully to get pregnant? _____
_____
Have you previously been pregnant? _____
Have you previously tried to get pregnant? _____
Reason for your visit today? _____
_____

B. Pregnancy History

Times pregnant_____ Term births_____ Premature births _____
Miscarriages _____ Elective abortion _____ Adopted children_____

	Date	Miscarriage	Elective abortions	Ectopic	Months to Conceive	Infertility Treatment	Weight & Sex	C-Section	Complication	Is current partner the father
1.										
2.										
3.										
4.										
5.										

C. Contraceptive Use

Type From when to when Reason discontinued

1._____

2._____

3._____

D. Operations and Hospitalizations

Date	Diagnosis	Operation	Where performed	Physician
1.				
2.				
3.				
4.				
5.				
6.				

E. Medications: List all prescriptions and over the counter drugs used in the past year.

Date	Dosage and frequency	From when to when	Reason for taking
1.			
2.			
3.			
4.			
5.			
6.			

F. Allergies

To what (drug or substance)	When	What type of reaction?

G. Menstrual (hormonal) history

Date your last menstrual period began_____
Your age at your first period_____
Are your periods regular? _____
How many days from onset to onset? _____
How many days do your period last? _____
Do you bleed between periods? _____
Do you always have premenstrual symptoms___always___rarely___never?
Vigorous exercise: Type _____hours/week_____
Type _____hours/week_____
If you have a hormonal disorder, please specify type and treatment _____
_____

Pelvic pain/cramps: ___none___during your period___before your period ___after your period ___at mid cycle ___during intercourse ___with urination ___ with bowel movements ___cause you to miss usual activities ___cause you to miss work
Pelvic pain/cramps are ___mild ___moderate ___severe ___getting worse ___ improving ___not changing ___ on the right side ___ on the left side ___ in the middle
What medications do you take for pain/cramps? _____
Do you have or have you had:

	Yes	**No**		**Yes**	**No**
Hot flashes	___	___	Increased facial or body hair	___	___
Breast discharge	___	___	Increased acne	___	___
Vision problems	___	___	Weight gain (> 10 lb.)	___	___
Poor sense of smell	___	___	Weight loss (>10 lb.)	___	___
Chronic headache	___	___	Special dietary habits	___	___
Head injury	___	___	Vomiting	___	___
Seizures	___	___	Diabetes	___	___
Thyroid disorder	___	___	Autoimmune disease	___	___
Excessive stress	___	___	Psychiatric treatment	___	___

If you answered yes to any question, please explain _____
_____
_____
_____

H. Physical Conditions/Infections

Do you have, or have you had:

	Yes	No		Yes	No
Pelvic infection	___	___	Appendicitis	___	___
Chlamydia	___	___	Colitis or enteritis	___	___
Antichlamydial antibodies	___	___	Endometriosis	___	___
Gonorrhea	___	___	Pelvic Adhesions	___	___
Syphilis	___	___	Uterine fibroids or myoma	___	___
Mycoplasma	___	___	Abnormal uterus (shape, etc.)	___	___
Urea plasma	___	___	Ovarian cysts	___	___
Tuberculosis	___	___	Toxoplasmosis	___	___
			Cytomegalovirus	___	___

I. Combined

Do you have or have you had:

	Yes	No		Yes	No
Cervitis	___	___	Recurring vaginitis	___	___
Genital Herpes	___	___	Abnormal pap smears	___	___
Genital warts/ condyloma	___	___	Cryo (freezing) or		
Trichomonas	___	___	surgery of the cervix	___	___

How many times a week do you have sexual intercourse? _____
How many times do you have intercourse around ovulation? _____
Do you use lubricants for intercourse? _____
Do you douche before or after intercourse? _____
Have you ever had unwanted sexual experiences? _____
Do you have any sexual problems at this time? _____

J. Other medical history

Your occupation_____
Years of formal education_____
Cigarettes--packs smoked/day_____
Alcohol--type and number of drinks/week_____
Marijuana--amount_____
Other drugs--type and amount_____
Ever used intravenous drugs? _____
Caffeine drinks per day_____
Radiation exposure_____
Toxic Exposure_____
Video display terminal--hours/day_____
Electric blanket use_____
Hot tub or sauna use_____
List all serious or chronic illnesses or injuries not already described_____
_____
_____
Do you or you family members have: ___infertility hormonal disorder___other inherited disorders?
If yes, please explain_____
_____
_____

K. Partner's Medical History

Your partner's age____ Occupation_____
List all serious or chronic illnesses or injuries_____
Medications_____
_____
Cigarettes--packs smoked/day_____
Alcohol--type and number of drinks/week_____
Marijuana--amount_____
Other drugs--type and amount_____
Ever used intravenous drugs? _____
Caffeine drinks per day_____
Radiation exposure_____
Toxic exposure_____
Video display terminal--hours/day_____
Electric blanket use_____
Hot tub or sauna use_____
Any problems with erection or ejaculation_____
Has semen analysis ever been abnormal_____
Has your partner seen a doctor for infertility evaluation? _____
Doctor_____
Diagnosis_____
Treatment_____
Has your partner ever fathered a pregnancy with another woman? _____
Any inherited diseases in your partners' family? _____
Does your partner have or has he had:

	Yes	No		Yes	No
Chlamydia	___	___	Vasectomy	___	___
Antichlamydial antibodies	___	___	Vasectomy reversal	___	___
Gonorrhea	___	___	Varicocele	___	___
Syphilis	___	___	Varicocele surgery	___	___
Genital Herpes	___	___	Biopsy of testicles	___	___
Genital warts/condyloma	___	___	Hernia surgery	___	___
Mycoplasm	___	___	Abdominal surgery	___	___
Urea plasma	___	___	Cancer	___	___
Urethritis/epididymitis	___	___	High blood pressure	___	___
Prostatitis	___	___	Diabetes	___	___
Penile discharge or pain	___	___	Colitis	___	___
Un-descended testicle	___	___	Seizures	___	___
Injury to the testicle(s)	___	___	Psychiatric treatment	___	___
Mumps with injury to the testicles	___	___	Excessive stress	___	___
Physical abnormality	___	___	Strenuous exercise	___	___
DES exposure in womb	___	___	Tight underwear	___	___

L. Previous Evaluation

Have you've had:

	Not Done	Result Normal	Result Abnormal	Approx. date	Values (if known)
Basal Body temperature (BBT)	_____	_____	_____	_____	_____
Urine LH surge	_____	_____	_____	_____	_____
Endometrial biopsy	_____	_____	_____	_____	_____
Blood tests:					
FSH	_____	_____	_____	_____	_____
LH	_____	_____	_____	_____	_____
Prolactin	_____	_____	_____	_____	_____
Thyroid tests (TSH, T4)	_____	_____	_____	_____	_____
DHEAS	___	___	___	_____	_____
Testosterone	___	___	___	_____	_____
Estradiol	___	___	___	_____	_____
Progesterone	___	___	___	_____	_____
Postcoital test	___	___	___	_____	_____
Cervical Mucus penetration test	___	___	___	_____	_____
Mycoplasma culture	___	___	___	_____	_____
Chlamydia culture	___	___	___	_____	_____
Antichlamydial antibodies	___	___	___	_____	_____
Female antisperm antibodies	___	___	___	_____	_____
Hysterosalpingogram (HSG)	___	___	___	_____	_____
Ultrasound	___	___	___	_____	_____
IVP (kidney x-ray)	___	___	___	_____	_____
Laparoscopy	___	___	___	_____	_____
Hysteroscopy	___	___	___	_____	_____
Karyotype	___	___	___	_____	_____
Anticardiolipin antibodies	___	___	___	_____	_____
Lupus anticoagulant	___	___	___	_____	_____
Antinuclear antibodies (ANA)	___	___	___	_____	_____
Coagulation screen	___	___	___	_____	_____
Biochemistry/hematology panel	___	___	___	_____	_____
Blood type	___	___	___	_____	_____
Other	___	___	___	_____	_____

Has your partner ever had:

Semen analysis	___	___	___	_____	_____
Hamster egg penetration assay	___	___	___	_____	_____
Semen anti-sperm antibodies	___	___	___	_____	_____

List all causes of infertility previously diagnosed_____

_____

_____

_____

M. Previous Treatment

	How many Months?	Dose (If known)	Approx. dates taken
Antibiotics	_____	_____	_____
Clomiphene (Clomid, Serophene)	_____	_____	_____
hMG (Repronex)	_____	_____	_____
FSH (Gonal-F,Follistim)	_____	_____	_____
HCG (Profasi, Novarel)	_____	_____	_____
Progesterone	_____	_____	_____
Dexamethasone	_____	_____	_____
GnRH agonist/Anatgonist (Ganirelix, Lupron)	_____	_____	_____
Danazol	_____	_____	_____
Intrauterine insemination	_____	_____	_____
Insemination with donor sperm	_____	_____	_____
IVF (in vitro fertilization)	_____	_____	_____
Gift	_____	_____	_____
Other	_____	_____	_____

Please use the remainder of this page to explain any additional information you feel we may need.