History and Physical

Family Beginnings

A. Identifying Data Date this form when completed

Your name Partner's name

Age Birth date Height Weight

Length of marriage (or relationship)

Patient Self-Reported Ethnicity: (circle all that apply)

American Indian or Alaska Native	Hispanic or Latino	Black or African American
Asian	Native Hawaiian or Other Pacific	White

Partner Self-Reported Ethnicity:

American Indian or Alaska Native	Hispanic or Latino	Black or African American
Asian	Native Hawaiian or Other Pacific	White

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.										Yes
2.										Yes
3.										Yes
4.										Yes
5.										Yes

C. Contraceptive Use

	Type	From when to when	Reason discontinued
1.			
2.			
3.			
4.			
5.			

D. Operations and Hospitalizations

	Date	Diagnosis	Operation	Where performed	Physician
1.					
2.					
3.					
4.					
5.					
6.					
7.					

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.				
7.				

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 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	☐	☐
Gonorrhe	☐	☐	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	☐	☐
Prostatits	☐	☐	Diabetes	☐	☐
Penile discharge or pain	☐	☐	Colitis	☐	☐
Undescended 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 had:

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

Has your partner had:

Semen analysis	Not Done				
Hamster egg penetration assay	Not Done				
Semen anti-sperm antibodies	Not Done				

List all causes of infertility previously diagnosed

Previous Treatment

	How many Months?	Dose (If known)	Approx. dates taken
Antibiotics			
Clomiphene (Clomid, Serephene)			
hMG (Repronex)			
FSH (Gonal-F, Follistim)			
HCG (Profasi, Novarel)			
Progesterone			
Dexamethasone			
GnRH Agonist / Antagonist (Ganarelix, 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.