



Date: _____

IDENTIFYING INFORMATION

Name: _____ Partner's name: _____

Address: _____

Telephone (Home): _____ Work: _____ Cell: _____

Date of birth: _____ Partner's date of birth: _____

Insurance company: _____ I.D.# _____

Name of employer: _____

Employer address: _____

Job title/description: _____

E-mail address: _____

MEDICAL HISTORY

Height: _____ Blood pressure: _____

Body weight: Current _____ Last year: _____ Teenage years: _____

BMI [body weight (lbs.) x 705 / height (")] = _____

Blood type: ABO _____ Rhesus ()ve _____ Du()ve _____ Antibodies ()ve _____

Have you ever received transfusions? _____ When? _____

Have you received immunizations to Rubella? _____ When? _____

Do you consume any special foods (health or diet products)? _____

Do you undertake any exercise on a regular basis? _____

How often? _____/week, Type: _____

Do you take any vitamins/minerals/herbs? _____

Do you take **over-the-counter medication(s)** on a regular basis? YES NO IF YES, what? _____

Do you take **Prescription medication(s)**? YES NO IF YES, what? _____

Do you consume alcohol? _____/week. Do you use tobacco? _____/day.

Do you use recreational drugs? _____/week.

Are you currently receiving therapy or have you received any therapy in the recent past? _____

Were you exposed to radiation, toxic agents, or chemicals? _____

Are you under stress at work? _____ At home? _____

Allergies: Food Shellfish Medication Latex Iodine Other please explain: _____

Have you ever had any of the following conditions? (check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart condition | <input type="checkbox"/> Chronic headaches |
| <input type="checkbox"/> Abnormal bleeding/bruising | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Color blindness |
| <input type="checkbox"/> Sickle cell or thalassemia | <input type="checkbox"/> Arrhythmias | <input type="checkbox"/> Head trauma |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Visual disturbance |
| <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Poor sense of smell |
| <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Colitis | <input type="checkbox"/> Dizziness/loss of balance |
| <input type="checkbox"/> Autoimmune disease | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Epilepsy/seizures |



- | | | |
|--|--|---|
| <input type="checkbox"/> Neurological problems | <input type="checkbox"/> Chronically warm or cold | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Painful swallowing | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Change of voice/hoarseness | <input type="checkbox"/> Chronic bronchitis |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Craving for salt | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Increased thirst | <input type="checkbox"/> Loss of scalp hair | <input type="checkbox"/> Chronic constipation |
| <input type="checkbox"/> Changes in appetite | <input type="checkbox"/> Growth of hair on face/body | <input type="checkbox"/> Cirrhosis/Jaundice |
| <input type="checkbox"/> Increased sweating | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Hiatus hernia | <input type="checkbox"/> Enteritis/appendicitis | <input type="checkbox"/> Chronic diarrhea |
| <input type="checkbox"/> Peptic ulcer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Gallbladder problems |
| <input type="checkbox"/> Liver problems | <input type="checkbox"/> Repetitive cystitis | <input type="checkbox"/> Kidney infection |
| <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Painful urination |
| <input type="checkbox"/> Urgency | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Parasitic infections | <input type="checkbox"/> Cancer | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Measles: German | <input type="checkbox"/> Measles: Regular |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Discharge from nipples | <input type="checkbox"/> |

SURGICAL HISTORY

	YES	NO
Teeth extraction	<input type="checkbox"/>	<input type="checkbox"/>
Tonsillectomy/adenoidectomy	<input type="checkbox"/>	<input type="checkbox"/>
Appendectomy	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any fractures?	<input type="checkbox"/>	<input type="checkbox"/>
Other surgery (please explain) _____		

MENSTRUAL HISTORY

	YES	NO
Menstruation: Age at first period _____		
Last menstrual period _____		
Are your periods regular?	<input type="checkbox"/>	<input type="checkbox"/>
Usual number of days between periods _____		
How long do they last? _____		
If they are irregular, how many periods do you have in a year? _____		
Cramps: Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>		
Bloating: Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>		
Breast tenderness <input type="checkbox"/> Mood swings <input type="checkbox"/> Headaches <input type="checkbox"/> Other _____		

Do you have to take pain medication for cramps?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain: _____		

Do you bleed or spot between periods?	<input type="checkbox"/>	<input type="checkbox"/>
Do you spot before your period?	<input type="checkbox"/>	<input type="checkbox"/>



CONTRACEPTIVE/SEXUAL HISTORY

	YES	NO
Did you use contraception in the past?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please specify: Birth control pills <input type="checkbox"/> IUD <input type="checkbox"/> Diaphragm <input type="checkbox"/> Condom <input type="checkbox"/> Gels/Foams <input type="checkbox"/> Withdrawal <input type="checkbox"/> Rhythm <input type="checkbox"/>		
Do you douche?	<input type="checkbox"/>	<input type="checkbox"/>
How often do you have intercourse? _____ /week _____ /other		
Do you have any pain during intercourse?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain: _____		
Do you Use any lubricants?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain: _____		
Have you had any sexually transmitted diseases? (Syphilis, gonorrhea, herpes, Chlamydia, warts, HIV, pelvic inflammatory disease)	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain: _____ _____		
Do you have frequent vaginal infections? Urethral infection <input type="checkbox"/> Lesions at genital organs <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you have any procedures on the cervix?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain: _____ _____		
Do you have a history of endometriosis?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a history of ovarian cysts?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a history of breast condition/disease?	<input type="checkbox"/>	<input type="checkbox"/>

OBSTETRICAL HISTORY

	YES	NO
Have you ever been pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how many pregnancies have you had? _____		
Did any of them end in miscarriage/abortion?	<input type="checkbox"/>	<input type="checkbox"/>
When? _____		
Did you have any problems or complications during the pregnancy (ies)?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain? _____ _____		
Did you have any problems or complications during the delivery?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain? _____ _____		
Did you have any problems or complications after the delivery?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain? _____ _____		
How long have you been trying to get pregnant? _____		



FAMILY HISTORY

Is there a family history of any of the following disorders? (check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Heart condition |
| <input type="checkbox"/> Strokes | <input type="checkbox"/> Infertility | <input type="checkbox"/> Habitual abortion |
| <input type="checkbox"/> Frequent miscarriage | <input type="checkbox"/> Cancer | <input type="checkbox"/> Sickle cell or thalassemia |
| <input type="checkbox"/> Cystic fibrosis | <input type="checkbox"/> Hemophilia (bleeding disorder) | <input type="checkbox"/> Hydrocephalus (fluid in skull) |
| <input type="checkbox"/> Thyroid condition | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Birth defect |

If you have answered yes to any of the above, please explain in detail: _____

	YES	NO
Did your mother take DES?	<input type="checkbox"/>	<input type="checkbox"/>

Mothers age: _____ Fathers age: _____

Siblings: Male: _____

Female: _____

HISTORY OF FERTILITY THERAPY

Did you undergo evaluation or infertility treatment in the past? YES NO

If yes, name of physician _____

What was the diagnosis of the infertility? _____

Which of the following test did you have performed? (check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> BBT | <input type="checkbox"/> Postcoital test | <input type="checkbox"/> Blood test for hormonal evaluation |
| <input type="checkbox"/> Chromosomal analysis | <input type="checkbox"/> Endometrial biopsy | <input type="checkbox"/> Hysterosalpingogram |
| <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Cervical cultures | <input type="checkbox"/> Chlamydia culture |
| <input type="checkbox"/> Laparoscopy/hysteroscopy | <input type="checkbox"/> CBC | <input type="checkbox"/> Chem 20 |
| <input type="checkbox"/> PT/PTT | <input type="checkbox"/> Antiphospholipid | <input type="checkbox"/> Lupus antibodies |
| <input type="checkbox"/> Anticardiolipin antibody | | |

What type of medical treatment did you receive? _____

What type of surgical treatment did you receive? _____

Did you undergo insemination? YES NO

Did you undergo in vitro fertilization? YES NO

Was your partner evaluated for infertility? YES NO