North Clinic
~ Where caring is a tradition ~

INFERTILITY HISTORY FORM

PART 1: CONTACT INFORMATION

First Name	Middle Initial	Last Name
Date of Birth MM / DD / YY		Age
Male Partner's First Name	Middle Initial	Last Name
Date of Birth MM / DD / YY		Age
Name of Primary Physician		
Address		Phone

PART 2: FEMALE MEDICAL HISTORY AND INFORMATION

Reason for Visit: ☐ Infertility Evaluation ☐ Sperm Insemination ☐ Other _____

How many months have you been trying to conceive (unprotected intercourse or insemination)? _____

PREGNANCY SUMMARY

- Total number of ***ALL*** pregnancies _____
- Number of full term deliveries _____ Of these, how many were live births? _____ How many were stillborn? _____
- Number of premature deliveries (less than 37 weeks) _____ Of these, how many were live births? _____ How many were stillborn? _____
- Number of miscarriages (less than 20 weeks) _____
- Number of ectopic/tubal pregnancies _____
- Number of elective terminations (abortions) _____
- Any pregnancies with birth defects? ☐ No ☐ Yes Explain _____

	DATE PREGNANCY ENDED OR DELIVERED	MONTHS TO CONCEPTION	TREATMENTS TO CONCEIVE	DELIVERY TYPE D&C / COMPLICATIONS	CURRENT PARTNER?
1.					☐ Yes ☐ No
2.					☐ Yes ☐ No
3.					☐ Yes ☐ No
4.					☐ Yes ☐ No
5.					☐ Yes ☐ No
6.					☐ Yes ☐ No

MENSTRUAL HISTORY

- Menstrual Cycle Pattern (check all that apply): ☐ Regular Periods ☐ Irregular Periods ☐ No Periods
  ☐ Spotting Before Periods ☐ Heavy Periods ☐ Light Periods ☐ Bleeding Between Periods
- Number of days between the start of one period to the start of the next period _____ days
- How many days of bleeding do you have? _____ days
- Date of the first day of your last two menstrual periods _____ and _____
- Age when you had your first period _____ years old
- How many periods do you have per year? _____
- Do you need medication to bring on a period? ☐ Yes - what type? _____ ☐ No
- If you do not have periods, when did you stop having them? _____ years old
- Do you have severe cramping or pelvic pain with your periods?
  ☐ Yes: ○ Always ○ Sometimes ○ Recently ○ In the past ☐ No

CONTRACEPTIVE HISTORY

☐ None ☐ Condoms: Dates of Use _____ ☐ Diaphragm: Dates of Use _____ ☐ IUD: Dates of Use _____

☐ Birth Control Pills: Dates of Use _____ Complications? _____ ☐ Never Used Birth Control Pills

☐ Injectable Contraception (Depo-Provera®, Lunelle™, etc.): Dates of Use _____ Complications? _____

☐ Skin Patch: Dates of Use _____ Complications? _____ ☐ Foam or Jelly

☐ Tubal Sterilization Procedure (tubes tied): Date (month, year) _____

☐ Tubes Untied: Date (month, year) _____

☐ Did your mother takes DES when she was pregnant with you? ☐ Yes ☐ No ☐ Don't Know

SEXUAL HISTORY

- How many times do you have intercourse per week? _____ ☐ None ☐ Not Applicable
- Have you used over-the-counter ovulation kits to time intercourse? ☐ Yes ☐ No
- Do you have pain with intercourse? ☐ Yes ☐ No
- Do you use lubricants (K-Y Jelly®, etc.) during intercourse? ☐ Yes - what type? _____ ☐ No
- Any prior exposure to sexually transmitted diseases or pelvic infections? ☐ Yes ☐ No If yes, check all that apply
  ☐ Chlamydia (date) _____ ☐ Gonorrhea (date) _____ ☐ Herpes (date) _____
  ☐ Genital Warts/HPV (date) _____ ☐ Syphilis (date) _____
  ☐ HIV/AIDS (date) _____ ☐ Hepatitis (date) _____

PAP SMEAR HISTORY

- When was your last pap smear (month, year) _____ ☐ Normal ☐ Abnormal
- When was your last abnormal pap smear? (month, year) _____ ☐ Not Applicable
- Have you undergone any procedures as a result of an abnormal pap smear?
  ☐ Yes – check all that apply: ☐ Colposcopy ☐ Cryosurgery (freezing) ☐ Laser Treatment
  ☐ Conization ☐ LEEP Procedure ☐ No

MEDICAL HISTORY

- Are you allergic to any medications? ☐ Yes ☐ No If yes, please list and describe reactions:

_____

_____

- List any medications you are currently taking, including over-the-counter medicines:

_____

_____

- Do you take any herbal medicines, vitamins or health food store supplements? ☐ Yes ☐ No If yes, please list:

_____

_____

- Do you have any medical problems? ☐ Yes ☐ No If yes, please list type, dates and treatments:

1. _____
2. _____
3. _____
4. _____
5. _____

SOCIAL HISTORY

- How many caffeinated beverages (coffee, tea, soda) do you drink per day? _____ ☐ None
- Do you smoke cigarettes? ☐ Yes – How many per day? _____ For how many years? _____
  ☐ Quit? When? _____ ☐ No
- Do you drink alcohol? ☐ Yes ☐ No
  ☐ Beer (no. per week) _____ ☐ Wine (no. per week) _____ ☐ Liquor (no. per week) _____
- Do you use marijuana, cocaine or any other similar drug? ☐ Yes ☐ No If yes, describe:

_____

- Do you exercise? ☐ Yes ☐ No If yes, describe:

_____

SURGICAL HISTORY

Have you had any surgeries? ☐ Yes ☐ No If yes, list all surgeries in chronological order:

	YEAR	REASON AND TYPE OF SURGERY
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____

Did you have any anesthesia problems? ☐ Yes ☐ No If yes, describe: _____

MEDICAL HISTORY *(continued)*

DISORDERS IN YOUR FAMILY		RELATIONSHIP TO YOU		
Breast Cancer	☐ Yes		☐ No	☐ Don't Know
Ovarian Cancer	☐ Yes		☐ No	☐ Don't Know
Colon Cancer	☐ Yes		☐ No	☐ Don't Know
Other Cancer _____	☐ Yes		☐ No	☐ Don't Know
Diabetes	☐ Yes		☐ No	☐ Don't Know
Thyroid Problems	☐ Yes		☐ No	☐ Don't Know
Heart Disease	☐ Yes		☐ No	☐ Don't Know
Blood Clots	☐ Yes		☐ No	☐ Don't Know
Obesity	☐ Yes		☐ No	☐ Don't Know
Psychiatric Problems	☐ Yes		☐ No	☐ Don't Know
Tuberculosis	☐ Yes		☐ No	☐ Don't Know
Endometriosis	☐ Yes		☐ No	☐ Don't Know
Infertility	☐ Yes		☐ No	☐ Don't Know
Menopause Before Age 40	☐ Yes		☐ No	☐ Don't Know
Birth Defects	☐ Yes		☐ No	☐ Don't Know
Cystic Fibrosis	☐ Yes		☐ No	☐ Don't Know
Tay-Sachs Disease	☐ Yes		☐ No	☐ Don't Know
Canavan Disease	☐ Yes		☐ No	☐ Don't Know
Bloom Syndrome	☐ Yes		☐ No	☐ Don't Know
Gaucher Disease	☐ Yes		☐ No	☐ Don't Know
Niemann-Pick Disease	☐ Yes		☐ No	☐ Don't Know
Fanconi Anemia	☐ Yes		☐ No	☐ Don't Know
Familial Dysautonia	☐ Yes		☐ No	☐ Don't Know
Muscular Dystrophy	☐ Yes		☐ No	☐ Don't Know
Neurologic (brain/spine)	☐ Yes		☐ No	☐ Don't Know
Neural Tube Defects	☐ Yes		☐ No	☐ Don't Know
Bone/Skeletal Defects	☐ Yes		☐ No	☐ Don't Know
Dwarfism	☐ Yes		☐ No	☐ Don't Know
Developmental Delay	☐ Yes		☐ No	☐ Don't Know
Learning Problems	☐ Yes		☐ No	☐ Don't Know
Polycystic Kidney Disease	☐ Yes		☐ No	☐ Don't Know
Heart Defect from Birth	☐ Yes		☐ No	☐ Don't Know
Down's Syndrome	☐ Yes		☐ No	☐ Don't Know
Other Chromosome Defects	☐ Yes		☐ No	☐ Don't Know
Marfan Syndrome	☐ Yes		☐ No	☐ Don't Know
Hemophilia	☐ Yes		☐ No	☐ Don't Know
Sickle Cell Anemia	☐ Yes		☐ No	☐ Don't Know
Thalassemia	☐ Yes		☐ No	☐ Don't Know
Galactosemia	☐ Yes		☐ No	☐ Don't Know
Deafness/Blindness	☐ Yes		☐ No	☐ Don't Know
Color Blindness	☐ Yes		☐ No	☐ Don't Know
Hemochromatosis	☐ Yes		☐ No	☐ Don't Know

☐ None of the Above ☐ Other _____

EMOTIONAL STATUS

- On a scale of 1-10 (10 being the worst), estimate the level of stress you feel due to infertility and other pressures: _____
- Do you see a counselor? ☐ Yes ☐ No
- Describe any emotional, marital or sexual problems caused by your infertility: _____

_____

PRIOR INFERTILITY TESTING AND TREATMENT

Have you had prior infertility testing or treatment elsewhere? ☐ Yes ☐ No

PRIOR TESTS (check all that apply):

☐ Basal Body Temperature Chart Date: _____ Results: _____
☐ Thyroid Test Date: _____ Results: _____
☐ Ovulation Test Kit Date: _____ Results: _____
☐ Day 3 Blood Test for FSH Level Date: _____ Results: _____
☐ Hysterosalpingogram (HSG) Date: _____ Results: _____
☐ Laparoscopy Surgery Date: _____ Results: _____
☐ Hysteroscopy Surgery Date: _____ Results: _____
☐ Progesterone Blood Test Date: _____ Results: _____
☐ Prolactin Blood Test Date: _____ Results: _____

PRIOR TREATMENTS (check all that apply):	**No. of Cycles**	**Dates**	**Pregnant**
☐ Intrauterine Insemination	_____	From _____ To _____	☐ Yes ☐ No
☐ Clomiphene Citrate w/Timed Intercourse Maximum Tablets Per Day _____	_____	From _____ To _____	☐ Yes ☐ No
☐ Clomiphene Citrate w/Insemination Maximum Tablets Per Day _____	_____	From _____ To _____	☐ Yes ☐ No
☐ Daily Fertility Drug Injections w/Insemination Maximum Vials Per Day _____	_____	From _____ To _____	☐ Yes ☐ No
☐ Completed In Vitro Fertilization Cycle(s)	_____		
1. No. Eggs _____ No. Embryos Transferred _____	No. Frozen _____	_____	☐ Yes ☐ No
2. No. Eggs _____ No. Embryos Transferred _____	No. Frozen _____	_____	☐ Yes ☐ No
3. No. Eggs _____ No. Embryos Transferred _____	No. Frozen _____	_____	☐ Yes ☐ No
4. No. Eggs _____ No. Embryos Transferred _____	No. Frozen _____	_____	☐ Yes ☐ No
☐ Frozen Embryo Transfers	_____		
1. No. Embryos Transferred _____		_____	☐ Yes ☐ No
2. No. Embryos Transferred _____		_____	☐ Yes ☐ No
3. No. Embryos Transferred _____		_____	☐ Yes ☐ No
4. No. Embryos Transferred _____		_____	☐ Yes ☐ No
Cancelled In Vitro Fertilization Attempt(s)	_____		

I confirm that I have reviewed the information above.

_____ _____
Patient's Signature and Date Physician's Signature and Date

PART 3: MALE PARTNER MEDICAL HISTORY AND INFORMATION

Complete with your male partner, if applicable

- Have you ever been evaluated by a urologist? ☐ Yes ☐ No
- Have you previously conceived with another woman? ☐ Yes ☐ No If yes, how many times? _____
- Birth control used? ☐ Yes ☐ No
- Have you had a semen analysis? ☐ Yes ☐ No
- Do you have difficulty with erections? ☐ Yes ☐ No
- Do you have retrograde ejaculation of sperm into the bladder? ☐ Yes ☐ No
- Any prior exposure to sexually transmitted diseases or infections? ☐ Yes ☐ No If yes, check all that apply

  ☐ Chlamydia (date) _____ ☐ Gonorrhea (date) _____ ☐ Herpes (date) _____
  ☐ Genital Warts/HPV (date) _____ ☐ Syphilis (date) _____
  ☐ HIV/AIDS (date) _____ ☐ Hepatitis (date) _____
- Do you have a history of undescended testicles? ☐ Yes ☐ No If yes, ☐ One Side ☐ Both Sides
- Do you have scrotal or testicular pain? ☐ Yes ☐ No
- Did you have the mumps after puberty? ☐ Yes ☐ No
- Have you had prior injury to your testicles requiring hospitalization? ☐ Yes ☐ No
- Have you been diagnosed with any of the following diseases?

  Diabetes Mellitus ☐ Yes ☐ No
  Cancer ☐ Yes ☐ No
  Multiple Sclerosis ☐ Yes ☐ No
  Other Neurological Problems ☐ Yes ☐ No
  Prostatic Infections ☐ Yes ☐ No
  Urinary Infections ☐ Yes ☐ No
  High Blood Pressure ☐ Yes ☐ No If yes, any medications? _____
- Have you had a vasectomy? ☐ Yes ☐ No If yes, date _____

  If yes, have you had a vasectomy reversal? ☐ Yes ☐ No If yes, date _____
- Have you had surgery for varicocele repair? ☐ Yes ☐ No
- Have you had hernia surgery? ☐ Yes ☐ No
- Did you undergo any bladder or penis surgery as a child? ☐ Yes ☐ No
- Are you exposed to prolonged heat in the workplace? ☐ Yes ☐ No
- Are you exposed to any radiation or harmful chemicals in the workplace? ☐ Yes ☐ No
- Have you had chemotherapy for cancer? ☐ Yes ☐ No
- Are you allergic to any medications? ☐ Yes ☐ No If yes, please list and describe reactions:

  _____

  _____

  _____
- List your current medications _____
- List any current medical problem(s) _____

- How many caffeinated beverages do you drink per day? _____ ☐ None
- Do you smoke cigarettes? ☐ Yes – How many per day? _____ For how many years? _____
  ☐ Quit? When? _____ ☐ No
- Do you drink alcohol? ☐ Yes ☐ No
  ☐ Beer (no. per week) _____ ☐ Wine (no. per week) _____ ☐ Liquor (no. per week) _____
- Do you use marijuana, cocaine or any other similar drug? ☐ Yes ☐ No If yes, describe:

_____

- Do you use herbal medicines/vitamins or health food store supplements? ☐ Yes ☐ No If yes, describe:

_____

- Are you aware of any radiation/toxic materials exposure? ☐ Yes ☐ No
- Do you use hot tubs regularly? ☐ Yes ☐ No
- Did your mother take DES during pregnancy to prevent miscarriage? ☐ Yes ☐ No ☐ Don't Know
- Have any of your immediate family members had difficulty conceiving a child? ☐ Yes ☐ No If yes, describe:

_____

DISORDERS IN YOUR FAMILY		**RELATIONSHIP TO YOU**		
Cystic Fibrosis	☐ Yes	_____	☐ No	☐ Don't Know
Tay-Sachs Disease	☐ Yes	_____	☐ No	☐ Don't Know
Canavan Disease	☐ Yes	_____	☐ No	☐ Don't Know
Bloom Syndrome	☐ Yes	_____	☐ No	☐ Don't Know
Gaucher Disease	☐ Yes	_____	☐ No	☐ Don't Know
Niemann-Pick Disease	☐ Yes	_____	☐ No	☐ Don't Know
Fanconi Anemia	☐ Yes	_____	☐ No	☐ Don't Know
Familial Dysautonia	☐ Yes	_____	☐ No	☐ Don't Know
Muscular Dystrophy	☐ Yes	_____	☐ No	☐ Don't Know
Neurologic (brain/spine)	☐ Yes	_____	☐ No	☐ Don't Know
Neural Tube Defects	☐ Yes	_____	☐ No	☐ Don't Know
Bone/Skeletal Defects	☐ Yes	_____	☐ No	☐ Don't Know
Dwarfism	☐ Yes	_____	☐ No	☐ Don't Know
Developmental Delay	☐ Yes	_____	☐ No	☐ Don't Know
Learning Problems	☐ Yes	_____	☐ No	☐ Don't Know
Polycystic Kidney Disease	☐ Yes	_____	☐ No	☐ Don't Know
Heart Defect from Birth	☐ Yes	_____	☐ No	☐ Don't Know
Down's Syndrome	☐ Yes	_____	☐ No	☐ Don't Know
Other Chromosome Defects	☐ Yes	_____	☐ No	☐ Don't Know
Marfan Syndrome	☐ Yes	_____	☐ No	☐ Don't Know
Hemophilia	☐ Yes	_____	☐ No	☐ Don't Know
Sickle Cell Anemia	☐ Yes	_____	☐ No	☐ Don't Know
Thalassemia	☐ Yes	_____	☐ No	☐ Don't Know
Galactosemia	☐ Yes	_____	☐ No	☐ Don't Know
Deafness/Blindness	☐ Yes	_____	☐ No	☐ Don't Know
Color Blindness	☐ Yes	_____	☐ No	☐ Don't Know
Hemochromatosis	☐ Yes	_____	☐ No	☐ Don't Know

☐ None of the Above ☐ Other _____

I confirm that I have reviewed the information above.

_____ _____

Male Partner's Signature and Date Physician's Signature and Date