Pacific In Vitro Fertilization Institute Date: ___________ Patient Name: ___________________________
DOB: __________Partner Name: ___________________________

FEMALE HISTORY

Height:__________________ Weight:__________________

Have you been treated for infertility before: _____No _____Yes Name of Physician:__________________

How long have you been having intercourse without any form of birth control? ______________months/years

INFERTILITY DIAGNOSIS (check all that apply)

____ Male Infertility
____ History of Endometriosis
____ Ovulation Disorders (PCO)
____ Diminished Ovarian Reserve

TUBAL Sterilization Date: ____/____
____ Tubal Ligation (not reversed)
____ Hydrosalpinx (in place)
____ Other tubal disease (no hydrosalpinx)

Date Tubes Untied: ____/____
____ Uterine
____ Other
____ Unexplained

MENSTRUAL HISTORY

Age at first period: __________
days bleeding: __________
Date of 1st day of your last 2 menstrual periods: _____/_____/20___ ; _____/_____/20____

Number of days between start of period to start of next period: _________
How many periods do you have a year: __________

MENSTRUAL PATTERN (check all that apply)

____ Regular periods
____ Irregular periods
____ Heavy periods
____ Light periods
____ No periods Do you need medication to bring on a period? ___Yes ___No What medication:______________

____ Bleeding between periods
____ Spotting between periods
____ Breast tenderness
____ Bloating

____ Fatigue
____ Personality/Mood Changes
____ Headaches

Do you have cramping or pelvic pain with your periods? ___Never ___Sometimes ___Always ___Recently ____In the past

Are cramps present ____Before ___During ___After your period. Cramps are: ____Mild ____Moderate ____Severe

What pain medication do you take for cramps: ____

When was your last pap smear: _____/_____/_____ _____Normal _____Abnormal Physician:__________________

When was the abnormal pap smear: _____/_____/_____ _____Not applicable

Have you undergone any procedures as a result of an abnormal pap smear? ____No ____Yes (check all that apply)

____ Coloscopy
____ Laser Treatment
____ Cryosurgery (Freezing)
____ Conization
____ LEEP Procedure

Have you ever had a mammogram? ___Yes ___No Date of last exam: _____/_____/_____
_____Normal _____Abnormal

PREGNANCY HISTORY

Total # of ALL Pregnancies	# Full Term Births (>37 weeks)	# Pre-Term Births (<37 weeks)	# Stillborn	# Miscarriages (>20 weeks)	# Elective Termination (abortion)	# Ectopic or Tubal Pregnancies	Date of Last Pregnancy	# Pregnancies w/ current partner

CONTRACEPTION HISTORY

____ None
____ Condoms Dates of use: ___________________
____ Diaphragm Dates of use: ___________________
____ IUD Dates of use: ___________________
____ Injectable Dates of use: ___________________ Complications? ________________________
____ Skin Patch Dates of use: ___________________ Complications? ________________________
____ Foam or Jelly Dates of use: ___________________ Complications? ________________________
____ Oral Contraceptive Dates of use: ___________________ Complications? ________________________
Brand: ___________________

Pacific In Vitro Fertilization Institute Date: ___________ Patient Name:_____________________________
Date of Birth: ___________________________

MEDICAL HISTORY

Do you have any medical problem(s)? _____No _____Yes (list dates and treatments)

Type: ____________________________ Date: ____/____/____ Treatment: ______________________
Type: ____________________________ Date: ____/____/____ Treatment: ______________________

Do you have or have you ever had: (check all that apply):

____	Blood Transfusions (date ____/____/____)	____	Pelvic Infection	____	Ovarian cysts
____	Hepatitis (date ____/____/____)	____	HIV/AIDS	____	Seizures
____	Herpes (date____/____/____)	____	High Blood Pressure	____	Kidney Infection
____	Heart Disease ___________________	____	Thyroid Problems	____	Diabetes
____	Chickenpox (date ____/____/____)	____	Epilepsy	____	Liver Problems
____	Chlamydia (date ____/____/____)	____	Loss of Balance	____	Genital Warts/HPV
____	Syphilis (date ____/____/____)	____	Neurological Problems	____	TB
____	Measles/Rubella (date____/____/____)	____	Vaginitis (Trichomoniasis/yeast infections)		
____	Gonorrhea (date ____/____/____)	____	Other: ____		

Have you ever been treated for Cancer? ____No ____Yes - explain
therapy______________________________________

Are you allergic to any MEDICATIONS? ____No ____Yes - list all and describe reaction:

Medication: ______________________________ Reaction: ____
Medication: ______________________________ Reaction: ____

Are you allergic to any FOODS? ____No ____Yes - list all and describe reaction:

Food: ______________________________ Reaction: ____
Food: ______________________________ Reaction: ____

Within the last year, have you taken any PRESCRIPTION MEDICATIONS? ____No ____Yes - list all:

Prescription: ______________________________ For: ____
Prescription: ______________________________ For: ____

Are you taking any OVER-THE-COUNTER MEDICATION? ____No ____Yes - list all:

Medication: ______________________________ For: ____
Medication: ______________________________ For: ____

Do you take any HERBAL MEDICINES/VITAMINS or health food supplements? ____No ____Yes - list all:

Medication: ______________________________ For: ____
Medication: ______________________________ For: ____

SOCIAL HISTORY

How many caffeinated beverages (coffee, tea, soda) do you drink a day? _____________ _____None
Do you smoke cigarettes? ____No ____Yes How many/day:__________ How many years:_____________
Age started:_____________ Quitting? ______________

Do you drink alcohol? ____No ____Yes #Beer/week_____ #Wine per week_____ #Liquor/week_____

Do you use marijuana, cocaine or other simular drugs? ____No ____Yes - describe_____________________________

Do you exercise? ____No _____Yes Type:_________________ Freq hrs/week: ________________

Pacific In Vitro Fertilization Institute Date: ___________ Patient Name:___________________________
Date of Birth: _________________________

Fertility Testing and Treatment

What TESTING have you done for infertility? (Check all that apply)

_____ Thyroid Test Date: _____________ Result: ____________________________________
_____ Ovulation test kit Date: _____________ Result: ____________________________________
_____ Hormone blood test Date: _____________ Result: _____FSH _____Prolactin _____LH
_____E2l _____TSH _____Free T-4
_____ Endometrial Biopsy Date: _____________ Physician: ______________________________
_____ Hysterosalpingogram (HSG) Date:_________ Physician: ______________________________
_____ Laparoscopy Date: _____________ Physician: ______________________________
_____ Hysteroscopy Date: _____________ Physician: ______________________________

What DRUGS have you taken for infertility? (Check all that apply)

_____ Clomiphene Citrate (Serophene, Clomid)
_____ hCG (Profasi, A.P.L.)
_____ Danazol (Danocrine)
_____ hMG (Pergonal)
_____ Progesterone
_____ Antibiotics
_____ GnRH or LHRH (Factrel)
_____ Bromocriptine (Parlodel)
_____ Urofollitropin
_____ Estrogens
_____ Prednisone (or cortisone-like drugs)
_____ Other – Specify:_________________________

What TREATMENTS have you had for infertility? (Check all that apply)

_____ Artificial Insemination (IUI) # cycles_____ date last cycle_____ Physician:____________________
_____ Clomid with timed intercourse # cycles_____ date last cycle_____ Physician:____________________
_____ Clomid with insemination # cycles_____ date last cycle_____ Physician:____________________
_____ Fertility drug with insemination # cycles_____ date last cycle_____ Physician:____________________
_____ In Vitro Fertilization # cycles_____ date last cycle_____ Physician:____________________
_____ Frozen Embryo Transfer # cycles_____ date last cycle_____ Physician:____________________

Have you ever had SURGERY (D&C, ovarian, appendectomy, thyroid)? _____No _____Yes – Please specify_____________

Procedure: ______________________ Date: _______________________ Physician:____________________
Procedure: ______________________ Date: _______________________ Physician:____________________
Procedure: ______________________ Date: _______________________ Physician:____________________

FAMILY HISTORY

Do you or your partner have any history of inheritable, congenital or genetic diseases, mental retardation or concerns about fetal abnormalities? ____
____

List any members of your immediate family who have a history of infertility or breast cancer:
Relationship:_____________________ Condition:____________________ Treatment:____________________

EMOTIONAL STATUS

On a scale of 1-10 (10 being the worst), estimate the level of stress you feel due to infertility pressures: ________________
Do you see a counselor? _____No _____Yes – for how long? ___________ Treatment:____________________

Would you like information and/or a referral to a specialist who can help you with emotions related to infertility? ____No ____Yes

PHYSICIAN NOTES: ____
____
____