**Pacific In Vitro Fertilization Institute** Date: _____ Patient Name: _____
Pt. 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: _____ Number of days between start of period to start of next period: _____
# days bleeding: _____ How many periods do you have a year: _____
Date of 1st day of your last 2 menstrual periods: _____/_____/20___ ; _____/_____/20____

**MENSTRUAL PATTERN (check all that apply)**

____ Regular periods
____ Irregular periods
____ Heavy periods
____ Light periods
____ No periods

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

____ Fatigue
____ Personality/Mood Changes
____ Headaches

Do you need medication to bring on a period? ___Yes ___No What medication:_____

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: _____
_____
_____