Pacific In Vitro Fertilization Institute Date: _____ Patient Name: _____
DOB: Month _____ Day_____ Year _____
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	TUBAL Sterilization Date: ____/____		Date Tubes Untied: ____/____	
____	History of Endometriosis	____	Tubal Ligation (not reversed)	____	Uterine
____	Ovulation Disorders (PCO)	____	Hydrosalpinx (in place)	____	Other
____	Diminished Ovarian Reserve	____	Other tubal disease (no hydrosalpinx)	____	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	____	Bleeding between periods	____	Fatigue
____	Irregular periods	____	Spotting between periods	____	Personality/Mood Changes
____	Heavy periods	____	Breast tenderness	____	Headaches
____	Light periods	____	Bloating		
____	No periods	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	____	Cryosurgery (Freezing)	____	LEEP Procedure
____	Laser Treatment	____	Conization		

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

PREGNANCY HISTORY

Dates of ALL Pregnancies	Full Term Birth (>37 weeks)	Pre-Term Birth (<37 weeks)	Stillborn	Miscarriage (# of weeks)	Elective Termination (abortion)	Ectopic or Tubal Pregnancy	Vaginal or C-section	Pregnancy w/ current partner	Fertility treatment (if any)

CONTRACEPTION HISTORY

____	None		____	Injectable	Dates of use: _____
____	Condoms	Dates of use: _____	____	Skin Patch	Dates of use: _____
____	Diaphragm	Dates of use: _____	____	Foam or Jelly	Dates of use: _____
____	IUD	Dates of use: _____	____	Oral Contraceptive	Dates of use: _____
					Brand: _____

Pacific In Vitro Fertilization Institute Date: _____ Patient Name:_____
DOB: Month _____ Day_____ Year _____

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 similar drugs? ____No ____Yes - describe_____

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

Pacific In Vitro Fertilization Institute Date: _____ Patient Name:_____
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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
_____E2 _____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: _____
_____
_____