

Infertility History Form

This form was developed by the American Society for Reproductive Medicine to assist physicians and patients in obtaining a complete infertility history.

Patient's First Name	Middle Initial	Last Name
Date of birth (mm/dd/yyyy)	AGE	
Male Partner's First Name	Middle Initial	Last Name
Date of Birth (mm/dd/yyyy)	AGE	

FEMALE MEDICAL HISTORY AND INFORMATION

Reason for Visit	<input type="checkbox"/> Infertility Evaluation <input type="checkbox"/> Sperm Insemination <input type="checkbox"/> Other:(specify) _____
What are your expectations for this visit?	
What questions do want answered at this visit?	
Do you have any personal, ethical, or religious objections to any of our tests or treatments such as insemination, in vitro fertilization, egg donation, sperm donation, masturbation to collect a semen sample, etc?	<input type="checkbox"/> No <input type="checkbox"/> Yes (specify) _____
How many months have you been having intercourse without using any form of birth control?	

Pregnancy Summary

Total Number of ALL Pregnancies	Number of Miscarriages (less than 20 weeks)																																			
Number of Ectopic/Tubal Pregnancies	Number of Elective Terminations (Abortions)																																			
Number of Full Term Deliveries	Of these, how many were live births? How many were stillborn?																																			
Number of Premature (less than 37 weeks) Deliveries	Of these, how many were live births? How many were stillborn?																																			
Any Pregnancies with Birth Defects?	<input type="checkbox"/> No <input type="checkbox"/> Yes – explain: _____																																			
<table border="1"> <thead> <tr> <th>Date Pregnancy Ended or Delivered (MM/YYYY)</th> <th>Months to Conception</th> <th>Treatments to Conceive</th> <th>Delivery Type / D&C / Complications</th> <th>Current Partner?</th> </tr> </thead> <tbody> <tr> <td>1. / /</td> <td>months</td> <td></td> <td></td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>2. / /</td> <td></td> <td></td> <td></td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>3. / /</td> <td></td> <td></td> <td></td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>4. / /</td> <td></td> <td></td> <td></td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>5. / /</td> <td></td> <td></td> <td></td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>6. / /</td> <td></td> <td></td> <td></td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </tbody> </table>		Date Pregnancy Ended or Delivered (MM/YYYY)	Months to Conception	Treatments to Conceive	Delivery Type / D&C / Complications	Current Partner?	1. / /	months			<input type="checkbox"/> Yes <input type="checkbox"/> No	2. / /				<input type="checkbox"/> Yes <input type="checkbox"/> No	3. / /				<input type="checkbox"/> Yes <input type="checkbox"/> No	4. / /				<input type="checkbox"/> Yes <input type="checkbox"/> No	5. / /				<input type="checkbox"/> Yes <input type="checkbox"/> No	6. / /				<input type="checkbox"/> Yes <input type="checkbox"/> No
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4. / /				<input type="checkbox"/> Yes <input type="checkbox"/> No																																
5. / /				<input type="checkbox"/> Yes <input type="checkbox"/> No																																
6. / /				<input type="checkbox"/> Yes <input type="checkbox"/> No																																

Menstrual History

Menstrual cycle pattern (check all that apply)	<input type="checkbox"/> Regular periods <input type="checkbox"/> Irregular periods <input type="checkbox"/> Spotting before periods <input type="checkbox"/> No periods <input type="checkbox"/> Heavy periods <input type="checkbox"/> Light periods <input type="checkbox"/> 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
Dates of the 1 st day of your last 2 menstrual periods:	_____ / _____ / _____
Age when you had your first period:	_____ years old
Age when you first noticed:	Breast development: _____ years old Pubic hair: _____ years old Underarm hair: _____ years old
How many periods do you have per year?	_____
Do you need medication to bring on a period?	<input type="checkbox"/> Yes – what type? _____ <input type="checkbox"/> No
If you do not have periods, at what age did you stop having them?	_____ years old
Do you have severe cramping or pelvic pain with your periods?	<input type="checkbox"/> Yes: Always, Sometimes, Recently, In the past <input type="checkbox"/> No

Contraceptive History

<input type="checkbox"/> None <input type="checkbox"/> Condoms – dates of use _____ <input type="checkbox"/> Diaphragm – dates of use _____ <input type="checkbox"/> IUD – dates of use _____
<input type="checkbox"/> Birth control pills – dates of use _____ - complications? _____ <input type="checkbox"/> Never used birth control pills
<input type="checkbox"/> Injectable contraception (Depo-Provera®, Lunelle™, etc.) – dates of use _____ - complications? _____
<input type="checkbox"/> Skin patch – dates of use _____ - complications? _____ <input type="checkbox"/> Foam or Jelly
<input type="checkbox"/> Tubal sterilization procedure (tubes tied) – date (month/year) ____/____
<input type="checkbox"/> Tubal sterization reversed – date (month/year) ____/____

Did your mother take DES when she was pregnant with you? Yes No

Sexual History

How many times do you have intercourse per week?	_____ times per week	<input type="checkbox"/> None	<input type="checkbox"/> Not applicable
Have you used over-the-counter ovulation kits to time intercourse?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have pain with intercourse?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you use lubricants (K-Y Jelly®, etc.) during intercourse?		<input type="checkbox"/> Yes – what type? _____	<input type="checkbox"/> No
Have you had any of the following sexually transmitted diseases or pelvic infections? <input type="checkbox"/> Yes (check all that apply) <input type="checkbox"/> No			
<input type="checkbox"/> Chlamydia – date _____	<input type="checkbox"/> Gonorrhea – date _____	<input type="checkbox"/> Herpes – date _____	<input type="checkbox"/> Genital warts/HPV – date _____
<input type="checkbox"/> Syphilis – date _____	<input type="checkbox"/> HIV/AIDS – date _____	<input type="checkbox"/> Hepatitis – date _____	<input type="checkbox"/> Other – _____

Pap Smear History

When was your last Pap smear (month and year)?	_____/_____/_____	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
When was your last abnormal Pap smear?	_____/_____/_____	<input type="checkbox"/> Not applicable	
Have you undergone any procedures as a result of an abnormal Pap smear?			
<input type="checkbox"/> Yes (check all that apply)			<input type="checkbox"/> No
<input type="checkbox"/> Colposcopy <input type="checkbox"/> Cryosurgery (Freezing) <input type="checkbox"/> Laser treatment <input type="checkbox"/> Conization <input type="checkbox"/> LEEP procedure			

Breast Screening History

Have you ever had a mammogram?	<input type="checkbox"/> No	<input type="checkbox"/> Yes – date _____	Result: <input type="checkbox"/> normal	<input type="checkbox"/> abnormal – explain _____
Do you perform breast self exams?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		

Medical History

Are you allergic to any medications?	<input type="checkbox"/> No	<input type="checkbox"/> 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?	<input type="checkbox"/> No	<input type="checkbox"/> Yes (please list)
Do you have any medical problem(s)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes (please list type, dates, and treatments)
	(1)	
	(2)	
	(3)	
	(4)	
	(5)	

Did you have either of these childhood illness? Chickenpox (Varicella)
 German Measles
 Don't know
 Other childhood diseases: _____

Vaccinations

Chickenpox (Varicella)	<input type="checkbox"/> No	<input type="checkbox"/> Yes (dates _____)	<input type="checkbox"/> Don't know
MMR – Measles, Mumps, and Rubella (German Measles)	<input type="checkbox"/> No	<input type="checkbox"/> Yes (dates _____)	<input type="checkbox"/> Don't know
BCG (Tuberculosis)	<input type="checkbox"/> No	<input type="checkbox"/> Yes (dates _____)	<input type="checkbox"/> Don't know
Hepatitis B	<input type="checkbox"/> No	<input type="checkbox"/> Yes (dates _____)	<input type="checkbox"/> Don't know
Polio	<input type="checkbox"/> No	<input type="checkbox"/> Yes (dates _____)	<input type="checkbox"/> Don't know
Hepatitis A	<input type="checkbox"/> No	<input type="checkbox"/> Yes (dates _____)	<input type="checkbox"/> Don't know
Tetanus	<input type="checkbox"/> No	<input type="checkbox"/> Yes (dates _____)	<input type="checkbox"/> Don't know
Influenza	<input type="checkbox"/> No	<input type="checkbox"/> Yes (dates _____)	<input type="checkbox"/> Don't know

Social History

How many caffeinated beverages (coffee, tea, soda) do you drink per day?	_____	<input type="checkbox"/> None	
Do you smoke cigarettes?	<input type="checkbox"/> No	<input type="checkbox"/> Yes – how many/day? _____	How many years? _____
	<input type="checkbox"/> Quit – when? _____		
Do you drink alcohol?	<input type="checkbox"/> No	<input type="checkbox"/> Yes :	
	<input type="checkbox"/> Beer - # per week _____	<input type="checkbox"/> Wine - # per week _____	<input type="checkbox"/> Liquor?# per week _____
Do you use marijuana, cocaine, or any other similar drug?	<input type="checkbox"/> No	<input type="checkbox"/> Yes (describe)	
Do you exercise?	<input type="checkbox"/> No	<input type="checkbox"/> Yes (describe)	
Are you aware of any radiation exposures other than X-ray	<input type="checkbox"/> No	<input type="checkbox"/> Yes (describe)	

Surgical History

Year	Reason and Type of Surgery
(1)	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	

Did you have any anesthesia problems? No Yes (describe)

Physical Symptoms

General	Head, Eyes, Ears, Nose, and Throat	Respiratory
<input type="checkbox"/> Recent weight gain or loss <input type="checkbox"/> Anorexia/Bulimia <input type="checkbox"/> Lack of energy <input type="checkbox"/> Fever/Chills <input type="checkbox"/> Other _____ <input type="checkbox"/> None	<input type="checkbox"/> Dizziness <input type="checkbox"/> Loss of sense of smell <input type="checkbox"/> Headaches <input type="checkbox"/> Chronic nasal congestion <input type="checkbox"/> Blurred vision <input type="checkbox"/> Ringing ears <input type="checkbox"/> Hearing loss/deafness <input type="checkbox"/> Other _____ <input type="checkbox"/> None	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Bloody cough <input type="checkbox"/> Other _____ <input type="checkbox"/> None

Endocrine/Hormonal	Breasts	Neurological Problems
<input type="checkbox"/> Diabetes <input type="checkbox"/> Hair loss <input type="checkbox"/> Thyroid gland problems <input type="checkbox"/> Rapid weight gain or loss <input type="checkbox"/> Excessive hunger/thirst <input type="checkbox"/> Temperature intolerance – hot flushes or feeling cold <input type="checkbox"/> Other _____ <input type="checkbox"/> None	<input type="checkbox"/> Discharge (clear? ___ bloody? ___ milky? __) <input type="checkbox"/> Lumps <input type="checkbox"/> Pain <input type="checkbox"/> Cancer <input type="checkbox"/> Abnormal mammogram <input type="checkbox"/> Reduction <input type="checkbox"/> Augmentation/Breast implants (saline? ___ silicone? ___) <input type="checkbox"/> Other _____ <input type="checkbox"/> None	<input type="checkbox"/> Weakness/Loss of balance <input type="checkbox"/> Seizures/Epilepsy <input type="checkbox"/> Headaches <input type="checkbox"/> Migraine headaches <input type="checkbox"/> Numbness <input type="checkbox"/> Memory loss <input type="checkbox"/> Other _____ <input type="checkbox"/> None

Gastrointestinal	Genito-Urinary	Skin/Extremities
<input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Ulcers <input type="checkbox"/> Hepatitis <input type="checkbox"/> Diarrhea <input type="checkbox"/> Blood in your stools <input type="checkbox"/> Constipation <input type="checkbox"/> Irritable Bowel Syndrome <input type="checkbox"/> Change in bowel habits <input type="checkbox"/> Colitis (ulcerative or Crohn's) <input type="checkbox"/> Other _____ <input type="checkbox"/> None	<input type="checkbox"/> Bladder infections <input type="checkbox"/> Kidney infections <input type="checkbox"/> Vaginal infections <input type="checkbox"/> Frequent urination <input type="checkbox"/> Leaking urine <input type="checkbox"/> Blood in the urine <input type="checkbox"/> Herpes <input type="checkbox"/> Other _____ <input type="checkbox"/> None	<input type="checkbox"/> Unexplained rash/inflammation <input type="checkbox"/> Acne <input type="checkbox"/> Skin cancer <input type="checkbox"/> Burn injury <input type="checkbox"/> Moles changing in appearance <input type="checkbox"/> Excess hair growth <input type="checkbox"/> Other _____ <input type="checkbox"/> None

Musculoskeletal	Hematologic	Cardiovascular
<input type="checkbox"/> Unusual muscle weakness <input type="checkbox"/> Decreased energy/stamina <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Lupus Erythematosus <input type="checkbox"/> Myasthenia gravis <input type="checkbox"/> Other _____ <input type="checkbox"/> None	<input type="checkbox"/> Blood clotting disorder/Blood clot <input type="checkbox"/> Sickle cell Anemia <input type="checkbox"/> Thrombophebitis <input type="checkbox"/> Easy bruising <input type="checkbox"/> Swollen glands/lymph nodes <input type="checkbox"/> Blood transfusions (date/reasons _____) <input type="checkbox"/> Other _____ <input type="checkbox"/> None	<input type="checkbox"/> Palpitations/Skipped beats <input type="checkbox"/> Chest pain <input type="checkbox"/> Heart attack <input type="checkbox"/> Stroke <input type="checkbox"/> Murmurs <input type="checkbox"/> High blood pressure <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Mitral valve prolapse (Need antibiotics before dental procedures? Yes ___ No ___) <input type="checkbox"/> Other _____ <input type="checkbox"/> None

Mental Health Problems
<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety disorder <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other _____ <input type="checkbox"/> None

Family History

	Living	Cause of Death/Age at Death
Mother	<input type="checkbox"/> Yes – age _____ <input type="checkbox"/> No	
Father	<input type="checkbox"/> Yes – age _____ <input type="checkbox"/> No	
Brother(s)	<input type="checkbox"/> Yes – age _____ <input type="checkbox"/> No <input type="checkbox"/> Yes – age _____ <input type="checkbox"/> No	
Sister(s)	<input type="checkbox"/> Yes – age _____ <input type="checkbox"/> No <input type="checkbox"/> Yes – age _____ <input type="checkbox"/> No	
Maternal Grandmother	<input type="checkbox"/> Yes – age _____ <input type="checkbox"/> No	
Maternal Grandfather	<input type="checkbox"/> Yes – age _____ <input type="checkbox"/> No	
Paternal Grandmother	<input type="checkbox"/> Yes – age _____ <input type="checkbox"/> No	
Paternal Grandfather	<input type="checkbox"/> Yes – age _____ <input type="checkbox"/> No	

What is your Ancestry?
<input type="checkbox"/> African-American
<input type="checkbox"/> American Indian/Native American
<input type="checkbox"/> Ashkenazi Jewish
<input type="checkbox"/> Asian-American
<input type="checkbox"/> Cajun/French Canadian
<input type="checkbox"/> Caucasian
<input type="checkbox"/> Eastern European
<input type="checkbox"/> Hispanic/Caribbean
<input type="checkbox"/> Northern European
<input type="checkbox"/> Southern European
<input type="checkbox"/> Other (specify _____)

Disorders in Your Family

	Relationship to You	
Breast cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Ovarian cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Colon cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Other cancer _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Thyroid problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Heart disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Blood clots	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Obesity	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Psychiatric problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Endometriosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Infertility	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Menopause before age 40	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Birth defects	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Cystic Fibrosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Tay-Sachs disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Canavan disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Bloom syndrome	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Gaucher disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Niemann-Pick disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Fanconi Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Familial Dysautonomia	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Muscular Dystrophy	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Neurologic (brain/spine)	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Neural Tube Defects	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Bone/Skeletal Defects	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Dwarfism	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Developmental delay	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Learning problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Polycystic kidney disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Heart defect from birth	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Down Syndrome	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Other chromosome defects	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Marfan syndrome	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Hemophilia	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Sickle Cell Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Thalassemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Galactosemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Deafness/Blindness	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Color Blindness	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Hemochromatosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know

Would you like to be screened for:		
<input type="checkbox"/> Cystic Fibrosis	Yes	No
<input type="checkbox"/> Sickle Cell Anemia	Yes	No
<input type="checkbox"/> Tay-Sachs Disease	Yes	No
<input type="checkbox"/> Thalassemia	Yes	No

<input type="checkbox"/> None of the above
<input type="checkbox"/> Other (specify _____)

PRIOR INFERTILITY TESTING AND TREATMENT

Have you had prior infertility testing or treatment elsewhere?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Prior Tests (check all that apply)

<input type="checkbox"/> Basal body temperature chart (date _____ / results _____)	<input type="checkbox"/> Ovulation test kit (date _____ / results _____)
<input type="checkbox"/> Thyroid test (date _____ / results _____)	<input type="checkbox"/> Hysterosalpingogram (HSG) (date _____ / results _____)
<input type="checkbox"/> Day 3 blood test for FSH level (date _____ / results _____)	<input type="checkbox"/> Hysteroscopy surgery (date _____ / results _____)
<input type="checkbox"/> Laparoscopy surgery (date _____ / results _____)	<input type="checkbox"/> Progesterone blood test (date _____ / results _____)
<input type="checkbox"/> Progesterone blood test (date _____ / results _____)	<input type="checkbox"/> Prolactin blood test (date _____ / results _____)

Prior Treatments (check all that apply)

	# of cycles	Dates (mo/yr)		Outcome (Circle)
		From	to	
<input type="checkbox"/> Intrauterine insemination		/	/	Pregnant, Delivered, Ectopic, Miscarriage, Not pregnant
<input type="checkbox"/> Comiphene citrate with timed intercourse Maximum # tablets per day? _____		/	/	Pregnant, Delivered, Ectopic, Miscarriage, Not pregnant
<input type="checkbox"/> Clomiphene citrate with insemination Maximum # tablets per day? _____		/	/	Pregnant, Delivered, Ectopic, Miscarriage, Not pregnant
<input type="checkbox"/> Daily fertility drug injections with insemination Maximum # vials per day? _____		/	/	Pregnant, Delivered, Ectopic, Miscarriage, Not pregnant
<input type="checkbox"/> Completed in vitro fertilization cycle(s)				
1. # eggs ___ # embryos transferred ___ # frozen ___		/		Pregnant, Delivered, Ectopic, Miscarriage, Not pregnant
2. # eggs ___ # embryos transferred ___ # frozen ___		/		Pregnant, Delivered, Ectopic, Miscarriage, Not pregnant
3. # eggs ___ # embryos transferred ___ # frozen ___		/		Pregnant, Delivered, Ectopic, Miscarriage, Not pregnant
4. # eggs ___ # embryos transferred ___ # frozen ___		/		Pregnant, Delivered, Ectopic, Miscarriage, Not pregnant
<input type="checkbox"/> Frozen embryo transfers				
1. # embryos transferred ___		/		Pregnant, Delivered, Ectopic, Miscarriage, Not pregnant
2. # embryos transferred ___		/		Pregnant, Delivered, Ectopic, Miscarriage, Not pregnant
3. # embryos transferred ___		/		Pregnant, Delivered, Ectopic, Miscarriage, Not pregnant
4. # embryos transferred ___		/		Pregnant, Delivered, Ectopic, Miscarriage, Not pregnant
<input type="checkbox"/> Canceled in vitro fertilization attempt(s)				
<input type="checkbox"/> Any other prior treatment (describe)				

:

<input type="checkbox"/> Additional information/complications

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? No Yes – For how long? _____ How often? _____
- List any antidepressant/antianxiety medications you are currently taking.

- Describe any emotional, marital, or sexual problems caused by your infertility.

PATIENT'S SIGNATURE _____	DATE _____
I confirm that I have reviewed the information above.	
PHYSICIAN'S SIGNATURE _____	DATE _____

MALE MEDICAL HISTORY AND INFORMATION

Have you been evaluated by a urologist?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you previously conceived with another woman?	<input type="checkbox"/> Yes: how many times? _____	<input type="checkbox"/> No: Birth control used? Yes / No
Have you had a semen analysis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have difficulty with erections?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have retrograde ejaculation of sperm into the bladder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any of the following sexually transmitted diseases or pelvic infections? <input type="checkbox"/> Yes (check all that apply) <input type="checkbox"/> No		
<input type="checkbox"/> Chlamydia – date()	<input type="checkbox"/> Gonorrhea – date ()	<input type="checkbox"/> Herpes – date ()
<input type="checkbox"/> Syphilis – date ()	<input type="checkbox"/> HIV/AIDS – date ()	<input type="checkbox"/> Hepatitis – date ()
<input type="checkbox"/> Genital warts/HPV – date()	<input type="checkbox"/> Other	
Have you had a history of undescended testicles?	<input type="checkbox"/> Yes – One side / Both	<input type="checkbox"/> No
Do you have a history of testicular pain?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did you have the mumps after puberty?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had prior injury to your testicles requiring hospitalization?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you been diagnosed with any of the following diseases?		
<input type="checkbox"/> Diabetes Mellitus	Yes / No	<input type="checkbox"/> Cancer
<input type="checkbox"/> Multiple Sclerosis	Yes / No	<input type="checkbox"/> Other neurologic problems
<input type="checkbox"/> Prostatic infections	Yes / No	<input type="checkbox"/> Urinary infections
<input type="checkbox"/> High Blood Pressure	Yes / No	If yes, any medications? ()

Have you had any fever in the last 3 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a vasectomy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If Yes, have you had a vasectomy reversal?	
	<input type="checkbox"/> Yes (date:)	<input type="checkbox"/> No
Have you had surgery for varicocele repair?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had hernia surgery?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did you undergo any bladder or penis surgery as a child?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you exposed to prolonged heat in the workplace?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you exposed to any radiation or harmful chemicals in the workplace?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had chemotherapy for cancer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you allergic to any medications?	<input type="checkbox"/> Yes - List and describe reactions:	<input type="checkbox"/> No

List your current medications:
List any current medical problems:

How many caffeinated beverages do you drink per day? () <input type="checkbox"/> None
Do you smoke cigarettes? <input type="checkbox"/> No <input type="checkbox"/> Yes: How many/day? () How many years? () <input type="checkbox"/> Quit: when? ()
Do you drink alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes: <input type="checkbox"/> Beer # per week () <input type="checkbox"/> Wine # per week () <input type="checkbox"/> Liquor # per week ()
Do you use marijuana, cocaine, or any other similar drug? <input type="checkbox"/> No <input type="checkbox"/> Yes: (describe)
Do you use herbal medicines/vitamins or health food store supplements? <input type="checkbox"/> No <input type="checkbox"/> Yes: (describe)
Are you aware of any radiation/toxic materials exposure? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use hot tubs regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No
Did your mother take DES during pregnancy to prevent miscarriage? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Have any of your immediate family members had difficulty conceiving a child? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please describe:

Disorders in Your Family

	Relationship to You	
Cystic Fibrosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Tay-Sachs disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Canavan disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Bloom syndrome	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Gaucher disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Niemann-Pick disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Fanconi Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Familial Dysautonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Muscular Dystrophy	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Neurologic (brain/spine)	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Neural Tube Defects	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Bone/Skeletal Defects	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Dwarfism	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Developmental delay	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Learning problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Polycystic kidney disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Heart defect from birth	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Down Syndrome	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Other chromosome defects	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Marfan syndrome	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Hemophilia	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Sickle Cell Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Thalassemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Galactosemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Deafness/Blindness	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Color Blindness	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Hemochromatosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know

What is your Ancestry?	
<input type="checkbox"/> African-American	
<input type="checkbox"/> American Indian/Native American	
<input type="checkbox"/> Ashkenazi Jewish	
<input type="checkbox"/> Asian-American	
<input type="checkbox"/> Cajun/French Canadian	
<input type="checkbox"/> Caucasian	
<input type="checkbox"/> Eastern European	
<input type="checkbox"/> Hispanic/Caribbean	
<input type="checkbox"/> Northern European	
<input type="checkbox"/> Southern European	
<input type="checkbox"/> Other (specify):	
Would you like to be screened for:	
<input type="checkbox"/> Cystic Fibrosis	Yes No
<input type="checkbox"/> Sickle Cell Anemia	Yes No
<input type="checkbox"/> Tay-Sachs Disease	Yes No
<input type="checkbox"/> Thalassemia	Yes No

<input type="checkbox"/> None of the above
<input type="checkbox"/> Other (specify)

SPOUSE/MALE PARTNER'S SIGNATURE _____ DATE _____
I confirm that I have reviewed the information above.
PHYSICIAN'S SIGNATURE _____ DATE _____