

Comprehensive History Form

Date Completed _____

What is the primary reason for your consultation? _____

Who referred you to our practice?

- _____ Former patient
- _____ Friend
- _____ Lecture series
- _____ Insurer (name)
- _____ Internet
- _____ Media article

- _____ Medical literature
- _____ Physician (name)
- _____ Self referral
- _____ Yellow pages
- _____ Other

Comments _____

Religious issues concerning conception or infertility treatment: _____

Male Patient

(name)

(date of birth) age

Occupation _____

Preferred Pharmacy _____
Tel. #. _____

Phone (day) _____
(eve) _____
(cellular) _____
(e-mail) _____
(voice mail) _____
(pager) _____

Primary Care Physician _____
(name)

Address _____
City _____
State, Zip _____
Phone _____
Medical specialty _____
Would you like a summary letter sent? _____

Female Patient

(name)

(date of birth) age

Occupation _____

Preferred Pharmacy _____
Tel. #. _____

Phone (day) _____
(eve) _____
(cellular) _____
(e-mail) _____
(voice mail) _____
(pager) _____

Primary Care Physician _____
(name)

Address _____
City _____
State, Zip _____
Phone _____
Medical specialty _____
Would you like a summary letter sent? _____

FSAC-Comprehensive History Form

Duration of relationship _____

Duration of unprotected intercourse _____

How long have you been actively attempting pregnancy? _____

Contraceptive practices

	(yes)	(no)	(dates)
Intrauterine device (IUD)	_____	_____	_____
Oral contraceptives	_____	_____	_____
Other	_____	_____	_____

	(yes)	(no)
Use of lubricants	_____	_____
Douche after intercourse	_____	_____
Painful intercourse	_____	_____
Bleeding/spotting after intercourse	_____	_____

Pregnancies (female):

Pregnancy (include all pregnancies)	When? (Year)	How long to conceive	Gender	Is current Partner the Father (Y/N)	Outcome (spontaneous miscarriage, abortion, or terminations, ectopic pregnancy, vaginal delivery, cesarean section, fetal demise or stillbirth) and list complications, if any.
First					
Second					
Third					
Fourth					
Fifth					

Male: Pregnancies from previous marriage(s) or partner(s), if any:

Pregnancy (include all pregnancies)	When? (Year)	How long to conceive	Gender	Outcome (spontaneous miscarriage, abortion, or terminations, ectopic pregnancy, vaginal delivery, cesarean section, fetal demise or stillbirth) and list complications, if any
First				
Second				
Third				
Fourth				

FSAC-Comprehensive History Form

Female History

Menstrual History:

Age at first menstrual period _____ last menstrual period _____

How often do menses occur _____ duration of menstrual flow _____

Amount/severity of menstrual flow _____

Medication taken for cramps _____ amount _____ frequency _____

Midcycle: spotting _____ pelvic pain _____ increase mucus _____

When was your last pap smear: _____ When was your last mammogram: _____

Any abnormal pap smears: _____

Do you have or have you ever had (Place a "Check Mark" by any that apply):

Infectious Problems	Gynecologic Problems	Medical Problems	
Chicken Pox (varicella)	Chlamydia	Anemia	Kidney disease
Chicken Pox vaccine	Gonorrhea	Bleeding disorders	Kidney infection
Hepatitis A, B, or C	Syphilis	Blood clots	Liver problems
German measles-rubella	Pelvic infection (PID)	Blood transfusion	Lost > 15 pounds last year
Rubella immunization	Mycoplasma/Ureaplasma	Diabetes	Lung disease
Rheumatic fever	Condyloma-venereal warts	Cancer	Asthma
Chronic bronchitis	Herpes: genital	Appendicitis	Recurrent urinary infections
	Abnormal mammogram	Heart disease	Thyroid problems
Neurological Problems	Abnormal pap smear	High blood pressure	Arthritis
Migraine headaches	Blocked fallopian tubes	Mitral valve prolapse	
Seizures (epilepsy)	Pelvic adhesions	Excess hair growth	Other Problems:
	Endometriosis	Hot flashes or night sweats	
	Uterine anomalies	Rh sensitized	
	Cervical Stenosis	Breast discharge	
	DES exposure		

Comments _____

Toxicant Exposure:	(yes)	(no)	(date)
Alcohol	_____	_____	_____
none	_____	_____	_____
weekend	_____	_____	_____
daily	_____	_____	_____
Smoking	_____	_____	_____
Pesticides	_____	_____	_____
Radiation	_____	_____	_____
Coffee/caffeine	_____	_____	_____ (amount)
Other chemicals	_____	_____	_____

FSAC-Comprehensive History Form

Female History

_____ (drug) _____ (date) _____ (dose)

_____ (drug) _____ (date) _____ (dose)

Are you taking prenatal vitamins? _____

List all allergic reactions you have had:

_____ (drug or allergen) _____ (date)

List all surgery you have had (cervix, uterus, ovarian cysts, tubes, endometriosis, appendix, etc.):

_____ (type of surgery) _____ (date)

_____ (type of surgery) _____ (date)

_____ (type of surgery) _____ (date)

List all other serious illnesses for which you have been under the care of a physician:

_____ (illness) _____ (date)

_____ (illness) _____ (date)

Weight _____ Height _____

Special dietary habits: _____

How much do you exercise? _____

FSAC-Comprehensive History Form

Family History of Female

Country of origin: Mother _____ Father _____

Ethnic background (circle): African/American Asian Asian-Indian Caucasian
 Hispanic Jewish American/Indian Mediterranean Middle Eastern Other: _____

Ethnic group (Circle all that apply)	Have you been tested for:	Yes	No	Date	Result
African, African/American	Sickle cell trait				
Asian, Mediterranean or Hispanic	Thalassemia				
Caucasian, Jewish	Cystic fibrosis				
Jewish	Tay Sachs				
Jewish	Gaucher				

Are you related to your current partner (consanguinity)? _____

Is there anyone in the family who has had any of the following illnesses:

	Yes	Who		Yes	Who
Endometriosis			Infertility		
Excess body hair			Mental retardation		
Genital abnormalities			Early menopause < 40 yrs old		
Breast cancer			Miscarriages (2 or more)		
Chromosomal disorders			Ovarian cancer		
Delayed development					
Early puberty			Hormone disorders		
Birth defects			Metabolic disorders		
Bleeding disorders			Genetic (inherited) disorders		

Comments _____

FSAC-Comprehensive History Form

Male History

Growth and development:	(yes)	(no)
Undescended testicles	_____	_____
Delayed puberty	_____	_____
Breast enlargement	_____	_____

Testicular injury:	(yes)	(no)	(date)
Varicocele	_____	_____	_____
Torsion (twisted)	_____	_____	_____
Painful swelling	_____	_____	_____
Severe trauma	_____	_____	_____

Toxicant exposure:	(yes)	(no)	(date)
Alcohol	_____	_____	_____
none	_____	_____	_____
weekend	_____	_____	_____
daily	_____	_____	_____
Smoking	_____	_____	_____
Pesticides	_____	_____	_____
Radiation	_____	_____	_____
Other chemicals	_____	_____	_____

Sexually transmitted diseases:			
Chlamydia	_____	_____	_____
Genital warts (HPV)	_____	_____	_____
Gonorrhea	_____	_____	_____
Herpes	_____	_____	_____
Syphilis	_____	_____	_____
Other	_____	_____	_____

Urinary tract:			
Bladder/kidney infection	_____	_____	_____
Prostatitis	_____	_____	_____
Other	_____	_____	_____

Frequency of hot tub use:	_____	_____	_____
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FSAC-Comprehensive History Form

Male History

List all medication you take now (prescription, vitamin, over-the-counter, alternative therapies):

_____	_____	_____
(drug)	(date)	(dose)
_____	_____	_____
(drug)	(date)	(dose)

List all allergic reactions you have had:

_____	_____
(drug or allergen)	(date)

List all surgery or blood transfusions you have had:

_____	_____
(type of surgery)	(date)
_____	_____
(type of surgery)	(date)

List all other serious illnesses for which you have been under the care of a physician:

_____	_____
(illness)	(date)
_____	_____
(illness)	(date)

(yes)

(no)

Difficulty with sexual function (male):
(please explain)

FSAC-Comprehensive History Form

Male Family History

Country of origin: Mother _____ Father _____

Ethnic background (circle): African/American Asian Asian-Indian Caucasian
 Hispanic Jewish American Indian Mediterranean Middle Eastern Other: _____

Ethnicgroup (Circle all that apply)	Have you been tested for	Yes	No	Date	Result
African, African/American	Sickle cell trait				
Asian, Mediterranean or Hispanic	Thalassemia				
Caucasian, Jewish	Cystic fibrosis				
Jewish	Tay Sachs				
Jewish	Gaucher				

Are you related to your current partner (consanguinity)? _____

Is there anyone in the family who has had any of the following illnesses:

	Yes	Who		Yes	Who
Infertility			Learning problems		
Genital abnormalities			Mental retardation		
Birth defects			Metabolic disorders		
Chromosomal disorders			Miscarriages (2 or more)		
Delayed development			Short stature		
Early puberty			Testicular cancer		
Hormone disorders			Undescended testicles		
Pituitary tumor			Abnormal breasts		
Lack of sense of smell			Genetic (inherited) disorders		

Comments _____

FSAC-Comprehensive History Form

Previous female infertility tests:	(result)	(date)
Basal body temperature	_____	_____
Ovulation predictor kits	_____	_____
Endometrial biopsy	_____	_____
Post-coital test	_____	_____
HSG	_____	_____
Chromosome studies	_____	_____
Hysteroscopy	_____	_____
Laparoscopy	_____	_____
Antisperm antibodies	_____	_____
Pelvic ultrasound	_____	_____
Other	_____	_____

Immunologic screening tests:	(result)	(date)
ANA (antinuclear antibodies)	_____	_____
Antiphospholipid antibodies	_____	_____
Lupus anticoagulant	_____	_____
Leukocyte antibody detection	_____	_____
Thyroid antibodies	_____	_____
Other immunologic testing	_____	_____

Previous male infertility tests:	(result)	(date)
Semen analyses	_____	_____
Post-coital test	_____	_____
Antisperm antibodies (semen & serum)	_____	_____
Hamster test (SPA)	_____	_____
Chromosomes	_____	_____
Other (SCSA, EFT, etc.)	_____	_____

Previous hormonal tests:		Female		Male	
	Result	Date	Result	Date	
Testosterone	_____	_____	_____	_____	
Prolactin	_____	_____	_____	_____	
TSH	_____	_____	_____	_____	
FSH (random)	_____	_____	_____	_____	
FSH (day 3)	_____	_____	_____	_____	
Estradiol (day 3)	_____	_____	_____	_____	
DHEA-S	_____	_____	_____	_____	
Progesterone	_____	_____	_____	_____	

FSAC-Comprehensive History Form

Previous Treatments:

	Yes/No	# cycles	Comments (dose, # days/cycle)
Inseminations (IUIs, without medication)	_____	_____	_____
Clomiphene (Clomid, Serophene) (with intercourse only)	_____	_____	_____
Clomiphene <u>with</u> inseminations (IUI)	_____	_____	_____
FSH * with intercourse only	_____	_____	_____
FSH * with inseminations (IUI)	_____	_____	_____
Progesterone supplements	_____	_____	_____
Dexamethasone, prednisone	_____	_____	_____
Aspirin	_____	_____	_____
Heparin	_____	_____	_____
Parlodel** - dopamine agonist	_____	_____	_____
IVIG	_____	_____	_____
Leukocyte immunization	_____	_____	_____
Other	_____	_____	_____

Comments _____

Prior in-vitro fertilization (IVF), GIFT, or intracytoplasmic sperm injection (ICSI) results, if applicable

Date of procedure	Procedure	Protocol	# of eggs obtained	# of eggs mature	# of eggs fertilized	# embryos transferred	# embryos frozen	Pregnancy outcome

Comments _____

*FSH - Pergonal, Humegon, Repronex, Metrodin, Fertinex, HMG, Gonal-F and/or Follistim
 ** - Parlodel, dopamine agonists - bromocriptine (Parlodel), cabergoline (Dostinex)