# 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 and/or Sperm Source Patient

_____
(name)

_____
(date of birth) (age)

Occupation _____

Preferred Pharmacy _____
Tel. #. _____

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

Primary Care Physician

_____
(name)

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

Female and/or Oocyte Source Patient

_____
(name)

_____
(date of birth) (age)

Occupation _____

Preferred Pharmacy _____
Tel. #. _____

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

Primary Care Physician

_____
(name)

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

# 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 and/or Oocyte Source):

| 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 and/or Sperm Source: 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 | | | | |

# Comprehensive History Form

## Female and/or Oocyte Source 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 | ____ | ____ | _____ | |

# Comprehensive History Form

## Female and/or Oocyte Source History

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

| (drug) | (date) | (dose) |
|---|---|---|
| (drug) | (date) | (dose) |

Are you taking prenatal vitamins? _____

Complete information about allergies you have had: No known allergies (circle N/A)

| Drug or Allergen | Reaction | Sensitivity (mild/moderate/severe) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

List all surgeries 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? _____

# Comprehensive History Form

## Family History of Female and/or Oocyte Source

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 _____

# Comprehensive History Form

## Male and/or Sperm Source 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: _____ _____ _____

# Comprehensive History Form

## Male and/or Sperm Source History

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

| (drug) | (date) | (dose) |
|---|---|---|
| (drug) | (date) | (dose) |

Complete information about allergies you have had: No known allergies (circle N/A)

| Drug or Allergen | Reaction | Sensitivity (mild/moderate/severe) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

List all surgeries 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) | _____ | _____ |

# Comprehensive History Form

## Male and/or Sperm Source Family History

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 |
|---|---|---|---|---|---|
| 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 _____

# Comprehensive History Form

## Previous Female and/or Oocyte Source 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 and/or Sperm Source 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 and/or Oocyte Source | | Male and/or Sperm Source | |
|---|---|---|---|---|
| | Result | Date | Result | Date |
| Testosterone | _____ | _____ | _____ | _____ |
| Prolactin | _____ | _____ | _____ | _____ |
| TSH | _____ | _____ | _____ | _____ |
| FSH (random) | _____ | _____ | _____ | _____ |
| FSH (day 3) | _____ | _____ | | |
| Estradiol (day 3) | _____ | _____ | | |
| DHEA-S | _____ | _____ | | |
| Progesterone | _____ | _____ | | |

# Comprehensive History Form

Previous Treatments:

| | Yes/No | # cycles | Comments (dose, # days/cycle) |
|---|---|---|---|
| Inseminations (IUIs, without medication) | | | |
| Clomiphene (Clomid, Serophene) (with intercourse only) | | | |
| Clomiphene with 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)