

## Comprehensive History Form

Date Completed \_\_\_\_\_

What is the primary reason for your consultation? \_\_\_\_\_

Who referred you to our practice?

- |   |   |
|---|---|
| <input type="checkbox"/> Former patient<br><input type="checkbox"/> Friend<br><input type="checkbox"/> Lecture series<br><input type="checkbox"/> Insurer (name)<br><input type="checkbox"/> Internet<br><input type="checkbox"/> Media article | <input type="checkbox"/> Medical literature<br><input type="checkbox"/> Physician (name)<br><input type="checkbox"/> Self referral<br><input type="checkbox"/> Yellow pages<br><input type="checkbox"/> Other |
|---|---|

Comments \_\_\_\_\_

Religious issues concerning conception or infertility treatment: \_\_\_\_\_

**Male and/or Sperm Source Patient**

**Female and/or Oocyte Source Patient**

\_\_\_\_\_  
(name)

\_\_\_\_\_  
(name)

\_\_\_\_\_  
(date of birth)                      (age)

\_\_\_\_\_  
(date of birth)                      (age)

Occupation \_\_\_\_\_

Occupation \_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_  
Tel. #. \_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_  
Tel. #. \_\_\_\_\_

Phone (day) \_\_\_\_\_  
 (eve) \_\_\_\_\_  
 (cellular) \_\_\_\_\_  
 (e-mail) \_\_\_\_\_  
 (voicemail) \_\_\_\_\_  
 (pager) \_\_\_\_\_

Phone (day) \_\_\_\_\_  
 (eve) \_\_\_\_\_  
 (cellular) \_\_\_\_\_  
 (e-mail) \_\_\_\_\_  
 (voicemail) \_\_\_\_\_  
 (pager) \_\_\_\_\_

Primary Care Physician  
 \_\_\_\_\_  
 (name)

Primary Care Physician  
 \_\_\_\_\_  
 (name)

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

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 <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)