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 infection	
		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(s) you take now or within the last 3 months (prescription, vitamin, supplements, over the counter, injections, Weight Loss medications such as GLP-1 Injections including Ozempic, Wegovy, Mounjaro, etc., and any other alternative therapies):

______________________	______________________	______________________
(drug)	(date)	(dose)
______________________	______________________	______________________
(drug)	(date)	(dose)
______________________	______________________	______________________
(drug)	(date)	(dose)
______________________	______________________	______________________
(drug)	(date)	(dose)
______________________	______________________	______________________
(drug)	(date)	(dose)
______________________	______________________	______________________
(drug)	(date)	(dose)
______________________	______________________	______________________
(drug)	(date)	(dose)
______________________	______________________	______________________
(drug)	(date)	(dose)
______________________	______________________	______________________
(drug)	(date)	(dose)
______________________	______________________	______________________
(drug)	(date)	(dose)

Are you taking prenatal vitamins? ________________________

I, ________________________________ certify that the above information I provided is accurate and correct and
(Last Name, First Name)
understand certain medications may impact the Anesthesia protocol and/or clearance.

Comprehensive History Form

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:

Test	(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:

Test	(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:

Test	(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

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____

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