Woman's Fertility History

Name: _____ Date: _____

PHYSICIANS

Primary Physician:_____ Ph:_____

OB/Gyn:_____ Ph:_____

Reproductive Endocrinologist:_____ Ph:_____

Other specialist:_____ Ph:_____

Please check any current or past conditions:

Current/ Recent	Past		Current/ Recent	Past	
☐	☐	Chronic vaginal discharge	☐	☐	Uterine fibroids
☐	☐	Regular yeast infections	☐	☐	Pelvic adhesions
☐	☐	Venereal disease (STDs)	☐	☐	Polyps
☐	☐	Chlamydial infection	☐	☐	Pelvic abnormality
☐	☐	Genital sores	☐	☐	Endometriosis
☐	☐	Pelvic inflammatory disease	☐	☐	PCOS/Ovarian Cysts
			☐	☐	Pain with intercourse

Date of last Pap smear: _____

Have you ever had an abnormal Pap smear? ☐Y ☐N

Have you ever had a cervical biopsy, operation, cauterization, or conization? ☐Y ☐N

Have you taken medications (other than contraceptives) for gynecological conditions? ☐Y ☐N

Medication: _____ Reason: _____ How long: _____

Was your mother exposed to diethylstilbestrol (DES) when she was pregnant with you? ☐Y ☐N

Do you ovulate on your own? ☐Y ☐N What day in your cycle?_____

Have you taken medication to aid ovulation? ☐Y ☐N

Medication: _____ Date: _____ How long: _____

Have you had any tubal operations? ☐Y ☐N When? _____

Have you taken oral contraceptives? ☐Y ☐N When? _____ How long? _____

Have you ever had an IUD? ☐Y ☐N When? _____ How long? _____

Have you had a diagnosis related to infertility? ☐Y ☐N What was it? _____

_____

Has your partner been medically evaluated? ☐Y ☐N What were the results? _____

_____

Have you been tested for MTHFR, the gene needed for folic acid metabolism? When and what were the results?
_____

What is your blood type with Rh factor (ABO +/-)? _____

OBSTETRICAL HISTORY

For how long have you been trying to conceive?: _____

Obstetrics history (Natural and ART cycles, including cancelled cycles)

Date	*Natural, IUI, IVF, ZIFT, ICSI, Other*	*Medication Used*	*# Mature Eggs/ Follicles*	*Pregnant (Y/N)*	*Week of miscarriage (if applicable)*	*Other Comments*

PREVIOUS FERTILITY EVALUATION

Please fill in any test results that you have previously completed:

Lab test	*Description*	*Date*	*Results*	*Date*	*Results*	*Date*	*Results*
CD 3 FSH	Cycle day 3 follicle stimulating hormone						
CD 3 E2	Cycle day 3 estradiol						
CD 3 LH	Cycle day 3 luteinizing hormone						
CCT	Clomid challenge test						
PRL	Prolactin						
P4	Progesterone, 7 days postovulation						
HSG	Hysterosalpingogram (evaluation of uterus & tubes)						
AFC	Antral follicle count						
EML	Endometrial lining						
AMH	anti-mullerian hormone						
Thyroid Tests	TSH, T3, T4						
Cortisol							
ANA	antinuclear antibodies						

ASA	anti sperm antibodies						

Male Fertility History

Name: _____ Date: _____

RESULTS FOR SPERM ANALYSIS

Date	Count	Morphology	Motility	Volume

OTHER PROCEDURES & DATES

Vasectomy ☐Y ☐N: When? _____ Vasectomy Reversal ☐Y ☐N: When? _____

Variococele ☐Y ☐N: When? _____ Hypo/hyperspadia ☐Y ☐N

Other _____

Do you take any of these Mediations/Supplements? Please enter # of months taken:

_____ Male Vitamins _____ Mega Man _____ Fish Oil _____ L - Carnitine

_____ L-Arginine _____ Antioxidants _____ Coast Reproductive ____ Blood pressure med

Other: _____

Have you fathered children? ☐Y ☐N: If so, how many? _____

Please check any current or past conditions

Current/ Recent	Past		Current/ Recent	Past	
☐	☐	Chlamydia	☐	☐	STDs
☐	☐	Erectile Dysfunction	☐	☐	Retrograde Ejaculation
☐	☐	Prostate Problems	☐	☐	Ejaculation Problems

Please check any conditions (DK is Do not know / Not evaluated)

☐Y ☐N ☐DK Antisperm Antibodies

☐Y ☐N ☐DK High Cholesterol

☐Y ☐N ☐DK Sperm Chromatid / DNA Integrity

☐Y ☐N ☐DK Diabetes (fasting, glucose)

Others: _____

Spouse's Name: _____

Spouse's Western Diagnosis: _____