Houston IVF

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INFERTILITY HISTORY FORM

PART 1: INFORMATION AND HISTORY

First Name: _____ Last Name: _____ (M.I.): _____

Last 4 Digits of SS #: _____ Date of Birth: (MM/DD/YY):_____/_____/_____ Age: _____

Ht: _____ Wt: _____ Occupation: _____

Please indicate which phone number to call or leave messages:

☐ Home:_____ ☐Work:_____ ☐Cell: _____

Patient - Martial Status: ☐ Married ☐ Single ☐ Divorced ☐ Other; Explain _____

Spouse/ Partner - ☐ Not Applicable

First Name: _____ Last Name: _____ (M.I.): _____

Last 4 Digits of SS #: _____ Date of Birth: (MM/DD/YY):_____/_____/_____ Age: _____

Ht: _____ Wt: _____ Occupation: _____

Please indicate which phone number to call or leave messages:

☐ Home:_____ ☐Work:_____ ☐Cell:_____

How did you hear about Houston IVF?_____

Were you referred by a physician? ☐Yes ☐No

Physician Name:_____Phone Number: _____

Address: _____

What are your expectations for this visit? _____

_____

What questions do you want answered at this visit? _____

_____

Do you have any personal, ethical, or religious objections to any of our tests or treatments such as sperm insemination, egg donation, sperm donation, or masturbation to collect a semen sample? ☐ No ☐ Yes Please explain: _____

How long have you been married? _____ **How long have you been attempting pregnancy?** _____

As you understand it, what is preventing you from getting pregnant? Circle all that apply: Unexplained, Endometriosis, Tubal Causes, Uterine Causes, Ovulatory Dysfunction, Diminished Ovarian Reserve, Male Causes, Immunologic Causes, Cervical Causes, Recurrent Pregnancy Losses, Other : _____

Physician Notes (for office use only) _____

_____

_____

_____

_____

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PART II: FEMALE MEDICAL HISTORY AND INFORMATION

Pregnancy Summary:

● Total Number of ALL pregnancies: _____ ● Number of Miscarriages: _____

● Number of Ectopic/Tubal pregnancies: _____ ● Number of Elective Terminations: _____

● Number of Full Term Deliveries: _____ ● Number of Preterm Deliveries: (less than 37 weeks): _____

● Any pregnancies with birth defects? ☐ No ☐ Yes Please explain: _____

Date Pregnancy Ended or Delivered	Pregnancy Length	Outcome (Delivery Type/ D&C/Complications)	Father (Present or Previous Partner)
1.			
2.			
3.			
4.			

Menstrual History:

● Menstrual cycle pattern (check all that apply): ☐ Regular periods ☐ Irregular periods ☐ Spotting before periods

● Age of first period _____ ☐ Light flow ☐ Heavy flow ☐ Bleeding between cycles

● Number of days between the start of one period to the start of another:

● How many days of bleeding do you have? _____ ● Do you pass clots? ☐ No ☐ Yes every cycle? ☐ No ☐ Yes

● How many periods do you have per year? _____ ● Do you have cramps? ☐ No ☐ Yes every cycle? ☐ No ☐ Yes

● When was your last period? _____ ● Can you tell when you ovulate? ☐ No ☐ Yes How? _____

● What medications do you use for pain relief? _____

Contraceptive History:

☐ None ☐ Condoms - dates of use:_____ ☐ Diaphragm - dates of use:_____

☐ IUD - dates of use:_____ ☐ Injectable contraception - dates of use:_____

☐ Birth Control Pills - dates of use:_____ ☐ Skin patch - dates of use:_____

☐ Tubal sterilization ("tubes tied") – date:_____ ☐ Any complications from any of the above? ☐ No ☐ Yes _____

Did your mother take DES when she was pregnant with you? ☐ No ☐ Yes ☐ Don't know

Sexual History:

● How many times *per month* do you have intercourse? _____ ☐ None ☐ Not applicable

● Do you have pain with intercourse? ☐ No ☐ Yes If yes, describe the pain _____

● Do you use lubricants? ☐ No ☐ Yes If yes, which type? _____

Have you had any of the following sexually transmitted or pelvic infection? (Check all that apply)

☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ Genital warts ☐ Syphilis ☐ HIV/AIDS ☐ Hepatitis

☐ Other:_____

Pap Smear History:

● When was your last PAP Smear? (month and year) _____ ☐ Normal ☐ Abnormal

● When was your last abnormal PAP Smear? (month and year) _____ ☐ Not applicable

Have you undergone any of the following procedures as a result of an abnormal PAP Smear? (Check all that apply)

☐ Colposcopy ☐ Cryosurgery (freezing) ☐ Conization ☐ Laser ☐ LEEP

Breast Screening History:

Have you ever had a mammogram? ☐ No ☐ Yes, date: _____ Result: ☐ Normal ☐ Abnormal

Medical History:

● Are you allergic to any foods or medications? ☐ No ☐ Yes (Please list and describe reaction) _____

● Please list all medications you are taking, including over the counter medications and herbal medicines/vitamins: _____

● Do you have any medical problems? ☐ No ☐ Yes (please list type, dates and treatment)

(1) _____

(2) _____

(3) _____

Surgical History:

● Have you had any surgeries? ☐ No ☐ Yes (Please list in chronological order):

Year	Reason and Type of Surgery

● Did you have any anesthesia problems? ☐ No ☐ Yes (Describe): _____

Vaccinations: (check all that apply)

☐ Chickenpox (varicella) ☐ Hepatitis A ☐ Tetanus ☐ Influenza ☐ MMR (measles mumps and rubella)

☐ BCG (tuberculosis) ☐ Hepatitis B ☐ Polio

Occupation / Leisure History: Amount per day or week

Caffeine ……. ☐ No ☐ Yes _____

Smoking ……. ☐ No ☐ Yes _____

Alcohol……...…… ☐ No ☐ Yes _____

Marijuana/Drugs……...……. ☐ No ☐ Yes _____

Nutritional supplements, herbs, etc …… ☐ No ☐ Yes _____

Exposed to chemical or x-rays in work or hobby… ☐ No ☐ Yes Dates / Comments:_____

Please describe recreation/sports activities (frequency, length of time, etc.) _____

_____

Physical Symptoms:

General:

☐ Weight loss or gain

☐ Anorexia / bulimia

☐ Lack of energy

☐ Fever / chills

☐ Other _____

Endocrine/Hormonal:

☐ Diabetes ☐ Hair loss

☐ Thyriod gland problems

☐ Rapid weight gain or loss

☐ Excessive hunger/thirst

☐ Temperature intolerance

☐ Other _____

Gastrointestinal:

☐ Nausea / vomiting

☐ Diarrhea/ constipation

☐ Hepatitis ☐ Ulcers

☐ Blood in the stools

☐ Irritable bowel syndrome

☐ Other _____

Musculoeskeletal:

☐ Unusual muscle weakness

☐ Rheumatoid arthritis

☐ Lupus erythematous

☐ Myasthenia gravis

☐ Other _____

Mental Health Problems:

☐ Depression ☐ Anxiety disorder

☐ Other _____

Head/Eyes/Ears/Nose/Throat:

☐ Dizziness ☐ Headaches

☐ Loss of sense of smell

☐ Chronic nasal congestion

☐ Blurred vision

☐ Ringing ears ☐ Hearing loss

☐ Other _____

Breast

☐ Discharge (clear, bloody or milky?)

☐ Lump ☐ Pain ☐ Cancer

☐ Abnormal mammogram

☐ Reduction

☐ Augmentation (saline or silicone)

☐ Other _____

Genito-Urinary

☐ Bladder infections

☐ Kidney infections

☐ Vaginal infections

☐ Frequent urination

☐ Blood in urine

☐ Other _____

Hematologic

☐ Blood clotting disorder

☐ Sickle cell anemia

☐ Easy bruising

☐ Swollen glands / lymph nodes

☐ Other _____

Respiratory

☐ Shortness of breath
☐ Asthma ☐ Pneumonia
☐ Bloody cough
☐ Other _____

☐ Weakness ☐ Seizures
☐ Headaches ☐ Numbness
☐ Memory loss
☐ Other _____

☐ Acne ☐ Skin cancer
☐ Burn injuries
☐ Excess hair growth
☐ Other _____

Neurological

Skin / Extremities

Family History:	**Living?**		**Cause of Death/Age of Death**
● Mother …….	☐ Yes – age _____	☐ No	_____
● Father ……...	☐ Yes – age _____	☐ No	_____
● Brother(s) …….	☐ Yes – age _____	☐ No	_____
	☐ Yes – age _____	☐ No	_____
	☐ Yes – age _____	☐ No	_____
● Sister(s)…….	☐ Yes – age _____	☐ No	_____
	☐ Yes – age _____	☐ No	_____
	☐ Yes – age _____	☐ No	_____
● Maternal Grandmother..	☐ Yes – age _____	☐ No	_____
● Maternal Grandfather…	☐ Yes – age _____	☐ No	_____
● Paternal Grandmother…	☐ Yes – age _____	☐ No	_____
● Paternal Grandfather ….	☐ Yes – age _____	☐ No	_____

Disorders in Your Family:	**Relationship to You**		**Relationship to You**
☐ Breast cancer	_____	☐ Neimann-Pick disease	_____
☐ Ovarian cancer	_____	☐ Fanconi anemia	_____
☐ Colon cancer	_____	☐ Familial Dysautonomia	_____
☐ Other cancer	_____	☐ Neurologic (brain/spine)	_____
☐ Diabetes	_____	☐ Neural tube defect	_____
☐ Thyroid problems	_____	☐ Bone/skeletal defects	_____
☐ Heart disease	_____	☐ Dwarfism	_____
☐ Blood clots	_____	☐ Developmental delay	_____
☐ Obesity	_____	☐ Learning problems	_____
☐ Psychiatric problems	_____	☐ Polycystic kidney disease	_____
☐ Tuberculosis	_____	☐ Heart defect from birth	_____
☐ Endometriosis	_____	☐ Down syndrome	_____
☐ Infertility	_____	☐ Other chromosomal problems	_____
☐ Menopause before age 40	_____	☐ Marfan syndrome	_____
☐ Birth defects	_____	☐ Hemophilia	_____
☐ Cystic fibrosis	_____	☐ Sickle cell anemia	_____
☐ Tay-sachs disease	_____	☐ Thalassemia	_____
☐ Canavan disease	_____	☐ Galactosemia	_____
☐ Bloom syndrome	_____	☐ Deafness/Blindness	_____
☐ Gaucher disease	_____	☐ Color blindness	_____
☐ Hemochromotosis	_____	☐ Other	_____

What is Your Ancestry?

☐ African American ☐ American Indian ☐ Ashkenazi
☐ Asian-American ☐ Cajun/French ☐ Caucasian
☐ Eastern European ☐ Hispanic/Caribbean ☐ Northern European
☐ Southern European ☐ Other Specify_____

PRIOR INFERTILITY TESTING AND TREATMENT:

Have you had prior infertility testing or treatment elsewhere? ☐ Yes ☐ No

Length of time currently attempting pregnancy _____ Years _____ Months

Length of time not using contraceptives _____

	Yes	No	Year	Normal	Abnormal	If yes, give dates/results
Temperature charts	☐	☐	_____	☐	☐	_____
Hysterosalpingogram (x-ray of tubes and uterus)	☐	☐	_____	☐	☐	_____
Hysteroscopy (looking inside uterus)	☐	☐	_____	☐	☐	_____
Endometrial biopsy (taking tissue from inside uterus)	☐	☐	_____	☐	☐	_____
Post-coital test (to test sperm in cervical mucus)	☐	☐	_____	☐	☐	_____
Semen Analysis	☐	☐	_____	☐	☐	_____
Laparoscopy (looking inside the abdomen)	☐	☐	_____	☐	☐	_____
Hormone Tests						
• Day 3 FSH	☐	☐	_____	☐	☐	_____
• Day 3 Estradiol	☐	☐	_____	☐	☐	_____
• Clomid Challenge	☐	☐	_____	☐	☐	_____
Thyroid tests	☐	☐	_____	☐	☐	_____
Chromosome tests	☐	☐	_____	☐	☐	_____

Other(s): _____

_____

Prior Treatment:

Ovulation Induction	With Intrauterine Inseminations?	# of cycles	Month/Year	Outcome
Clomiphene citrate (Clomid) Maximum number of tablets per day _____				
Daily fertility Injections Maximum # of vials per day_____ Name of drug sed_____				
Other (describe:				

Prior IVF Cycles (Please include frozen embryo transfers and cancelled cycles):

DATES	Medications Used and Total Dose (IU)	Peak Estradiol	# Oocytes Obtained	# Mature Oocytes	# Fertilized (2 PN)	ICSI? Yes or No	# Embryos Transferred	Embryo Grades	Outcome (Biochemical, Miscarriage, Delivery)
1.									
2.									
3.									
4.									

Any other treatment? (Explain) _____

_____

EMOTIONAL STATUS:

● On a scale from one to ten (10 being the worst), estimate the level of stress that you feel due to infertility: _____

● Are you currently seeing a counselor? ☐ Yes ☐ No

● Describe any emotional, marital or sexual problems caused by infertility: _____

_____

● Would you be interested in speaking with a counselor that specializes in this area? ☐Yes ☐ No

PART III: MALE MEDICAL HISTORY AND INFORMATION

Please complete with your male partner, if applicable.

● Have you ever been evaluated by an urologist? ☐ No ☐ Yes

● Have you previously conceived with another woman? ☐ No ☐ Yes If so, how many times? _____

● Have you had a semen analysis? ☐ No ☐ Yes

● Have you had any of the following sexually transmitted diseases or pelvic infections? (Select all that apply)

☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ Genital warts ☐ Syphilis ☐ HIV/AIDS ☐ Hepatitis

☐ Other _____

● Have you ever been diagnosed with any of the following diseases? If so, please explain.

☐ No ☐ Yes Diabetes _____

☐ No ☐ Yes Cancer _____

☐ No ☐ Yes Multiple sclerosis _____

☐ No ☐ Yes Urinary Infections _____

☐ No ☐ Yes High blood pressure; if yes, any medications? _____

☐ No ☐ Yes Prostatic Infections _____

● Have you had any of the following? If so, please explain.

☐ No ☐ Yes Retrograde ejaculation of sperm into the bladder _____

☐ No ☐ Yes History of mumps _____

☐ No ☐ Yes Difficulty with erections _____

☐ No ☐ Yes History of undescended testicles _____

☐ No ☐ Yes Fever in the last three months _____

☐ No ☐ Yes Hernia Repair _____

☐ No ☐ Yes Surgery for varicocele _____

☐ No ☐ Yes Bladder or penis surgery as a child _____

☐ No ☐ Yes Exposure to prolonged heat at the workplace _____

☐ No ☐ Yes Chemotherapy for cancer _____

☐ No ☐ Yes Exposure to radiation or chemicals at the workplace _____

- Are you allergic to any medications? ☐ No ☐ Yes If so, please list: _____
- List any medical problems: _____
- List any medications you have taken within the last three months: _____

Occupation/Leisure History (Pleas explain; give amount per day or per week)

☐ No ☐ Yes Exposed to chemical or x-rays in work or hobby (Please explain)_____

☐ No ☐ Yes Caffeine _____

☐ No ☐ Yes Smoking _____

☐ No ☐ Yes Alcohol _____

☐ No ☐ Yes Marijuana _____

☐ No ☐ Yes Nutritional supplements, herbs, etc. _____

☐ No ☐ Yes Drugs _____

Please describe recreation/sports activities (frequency, length of time, etc.) _____

Disorders in Your Family:	**Relationship to You**		**Relationship to You**
☐ Breast cancer	_____	☐ Neimann-Pick disease	_____
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☐ Southern European	☐ Other Specify_____	

PART IV: GENETIC SCREENING Please check if you, or your partner, is of one of these backgrounds:

☐ No ☐ Yes Eastern Europe Jewish Ancestry

If yes, have you been screened for Tay Sachs?…….…… ☐ No ☐ Yes

If yes, have you been screened for Canavan? …….…… ☐ No ☐ Yes

☐ No ☐ Yes African Ancestry

If yes, have you had sickle cell screening? …….…….. ☐ No ☐ Yes

☐ No ☐ Yes European Ancestry

If yes, have you been screened for cystic fibrosis? …….…….. ☐ No ☐ Yes

☐ No ☐ Yes Mediterranean or Southeast Asian Ancestry?

If yes, have you been screened for inherited forms of anemia such as thalassemia? …… ☐ No ☐ Yes