



# Houston IVF

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## INFERTILITY HISTORY FORM

### **IMPORTANT:**

Please complete this form and mail or fax it to the address at the bottom of this page PRIOR to your appointment.

This form was developed to assist us in obtaining a complete infertility history. It consists of 3 parts:

**Part I: Contact Information**

**Part II: Your medical history**

**Part III: Your spouse/partner's medical history (if applicable)**

### **PART 1: CONTACT INFORMATION**

#### *Patient -*

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_ (M.I.): \_\_\_\_\_

Social Security Number: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Date of Birth: (MM/DD/YY): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_

Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ Occupation: \_\_\_\_\_

Home Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_ Country: \_\_\_\_\_

*Please indicate which phone number to call or leave messages:*

Home: \_\_\_\_\_

Work: \_\_\_\_\_  Cell: \_\_\_\_\_

Are you married?  Yes  No  Divorced  Other

*Spouse/Male Partner -*  Not Applicable

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_ (M.I.): \_\_\_\_\_

Social Security Number: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Date of Birth: (MM/DD/YY): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_

Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ Occupation: \_\_\_\_\_

Home Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_ Country: \_\_\_\_\_

*Please indicate which phone number to call or leave messages:*

Home: \_\_\_\_\_

Work: \_\_\_\_\_  Cell: \_\_\_\_\_

#### ***Who Referred You?***

Physician

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Former Patient/Friend: Name \_\_\_\_\_

Phone # or Email (optional): \_\_\_\_\_

Web Site  Magazine

Other \_\_\_\_\_

#### ***Who is your OB/GYN?***

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

**Physician Notes (for office use only)** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PART II: FEMALE MEDICAL HISTORY AND INFORMATION**

**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, 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)

**Notes:** \_\_\_\_\_

**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.			
5.			
6.			

**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 - \_\_\_\_\_
- Complications? \_\_\_\_\_

Skin patch -- dates of use - \_\_\_\_\_  Tubal sterilization ("tubes tied") -- date \_\_\_\_\_

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) \_\_\_\_\_
- (4) \_\_\_\_\_

**Surgical History:**

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

<u>Year</u>	<u>Reason and Type of Surgery</u>
_____	_____
_____	_____
_____	_____
_____	_____

- 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

<b>Occupation/Leisure History:</b>	<b>Yes</b>	<b>No</b>	<b>Dates/Comments</b>
Exposed to chemical or x-rays in work or hobby	_____	_____	_____
Please list			Amount per day or week
Caffeine	_____	_____	_____
Smoking	_____	_____	_____
Alcohol	_____	_____	_____
Marijuana	_____	_____	_____
Nutritional supplements, herbs, etc.	_____	_____	_____
Drugs	_____	_____	_____

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 \_\_\_\_\_

**Head/Eyes/Ears/Nose/Throat:**

- Dizziness       Loss of sense of smell
- Headaches       Chronic nasal congestion
- Blurred vision    Ringing ears
- Hearing loss
- Other \_\_\_\_\_

**Respiratory:**

- Shortness of breath
- Asthma
- Pneumonia
- Bloody cough
- Other \_\_\_\_\_

**Endocrine/Hormonal:**

- Diabetes       Hair loss
- Thyroid gland problems
- Rapid weight gain or loss
- Excessive hunger/thirst
- Temperature intolerance
- Other \_\_\_\_\_

**Breasts:**

- Discharge (clear, bloody or milky?)
- Lumps    Pain    Cancer
- Abnormal mammogram
- Reduction
- Augmentation (saline or silicone)
- Other \_\_\_\_\_

**Neurological:**

- Weakness
- Seizures
- Headaches
- Numbness
- Memory loss
- Other \_\_\_\_\_

**Gastrointestinal:**

- Nausea/vomiting    Ulcers
- Hepatitis
- Blood in your stools
- Diarrhea/ constipation
- Irritable bowel syndrome
- Other \_\_\_\_\_

**Genito/Urinary:**

- Bladder infections
- Kidney infections
- Vaginal infections
- Frequent urination
- Blood in urine
- Other \_\_\_\_\_

**Skin/Extremities:**

- Acne
- Skin cancer
- Burn injuries
- Excess hair growth
- Other \_\_\_\_\_

**Musculoskeletal:**

- Unusual muscle weakness
- Rheumatoid arthritis
- Lupus erythematosus
- Myasthenia gravis
- Other \_\_\_\_\_

**Hematologic:**

- Blood clotting disorder
- Sickle cell anemia
- Easy bruising
- Swollen glands/lymph nodes
- Other \_\_\_\_\_

**Cardiovascular:**

- Palpitations
- Chest pain
- Stroke
- High blood pressure
- Mitral valve prolapse
- Other \_\_\_\_\_

**Mental Health Problems:**

Depression     Anxiety disorder     Other \_\_\_\_\_

**Family History:**

**Living?**

**Cause of Death/Age of Death**

- |                        |  |                                   |
|------------------------|--|-----------------------------------|
| ● Mother               | <input type="checkbox"/> Yes - age _____ | <input type="checkbox"/> No _____ |
| ● Father               | <input type="checkbox"/> Yes - age _____ | <input type="checkbox"/> No _____ |
| ● Brother(s)           | <input type="checkbox"/> Yes - age _____ | <input type="checkbox"/> No _____ |
|                        | <input type="checkbox"/> Yes - age _____ | <input type="checkbox"/> No _____ |
|                        | <input type="checkbox"/> Yes - age _____ | <input type="checkbox"/> No _____ |
| ● Sister(s)            | <input type="checkbox"/> Yes - age _____ | <input type="checkbox"/> No _____ |
|                        | <input type="checkbox"/> Yes - age _____ | <input type="checkbox"/> No _____ |
|                        | <input type="checkbox"/> Yes - age _____ | <input type="checkbox"/> No _____ |
| ● Maternal Grandmother | <input type="checkbox"/> Yes - age _____ | <input type="checkbox"/> No _____ |
| ● Maternal Grandfather | <input type="checkbox"/> Yes - age _____ | <input type="checkbox"/> No _____ |
| ● Paternal Grandmother | <input type="checkbox"/> Yes - age _____ | <input type="checkbox"/> No _____ |
| ● Paternal Grandfather | <input type="checkbox"/> Yes - age _____ | <input type="checkbox"/> No _____ |

**Disorders in Your Family:**

**Relationship to You**

**Disorders in Your Family:**

**Relationship to You**

- |  |       |   |       |
|--|-------|---|-------|
| <input type="checkbox"/> Breast cancer           | _____ | <input type="checkbox"/> Neimann-Pick disease       | _____ |
| <input type="checkbox"/> Ovarian cancer          | _____ | <input type="checkbox"/> Fanconi anemia             | _____ |
| <input type="checkbox"/> Colon cancer            | _____ | <input type="checkbox"/> Familia Dysautonia         | _____ |
| <input type="checkbox"/> Other cancer _____      | _____ | <input type="checkbox"/> Neurologic (brain/spine)   | _____ |
| <input type="checkbox"/> Diabetes                | _____ | <input type="checkbox"/> Neural tube defect         | _____ |
| <input type="checkbox"/> Thyroid problems        | _____ | <input type="checkbox"/> Bone/skeletal defects      | _____ |
| <input type="checkbox"/> Heart disease           | _____ | <input type="checkbox"/> Dwarfism                   | _____ |
| <input type="checkbox"/> Blood clots             | _____ | <input type="checkbox"/> Developmental delay        | _____ |
| <input type="checkbox"/> Obesity                 | _____ | <input type="checkbox"/> Learning problems          | _____ |
| <input type="checkbox"/> Psychiatric problems    | _____ | <input type="checkbox"/> Polycystic kidney disease  | _____ |
| <input type="checkbox"/> Tuberculosis            | _____ | <input type="checkbox"/> Heart defect from birth    | _____ |
| <input type="checkbox"/> Endometriosis           | _____ | <input type="checkbox"/> Down syndrome              | _____ |
| <input type="checkbox"/> Infertility             | _____ | <input type="checkbox"/> Other chromosomal problems | _____ |
| <input type="checkbox"/> Menopause before age 40 | _____ | <input type="checkbox"/> Marfan syndrome            | _____ |
| <input type="checkbox"/> Birth defects           | _____ | <input type="checkbox"/> Hemophilia                 | _____ |
| <input type="checkbox"/> Cystic fibrosis         | _____ | <input type="checkbox"/> Sickle cell anemia         | _____ |
| <input type="checkbox"/> Tay-sachs disease       | _____ | <input type="checkbox"/> Thalassemia                | _____ |
| <input type="checkbox"/> Canavan disease         | _____ | <input type="checkbox"/> Galactosemia               | _____ |
| <input type="checkbox"/> Bloom syndrome          | _____ | <input type="checkbox"/> Deafness/Blindness         | _____ |
| <input type="checkbox"/> Gaucher disease         | _____ | <input type="checkbox"/> Color blindness            | _____ |
| <input type="checkbox"/> Hemochromotosis         | _____ | <input type="checkbox"/> Other                      | _____ |

**What is Your Ancestry?**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> African American  | <input type="checkbox"/> American Indian     | <input type="checkbox"/> Ashkenazi         |
| <input type="checkbox"/> Asian-American    | <input type="checkbox"/> Cajun/French        | <input type="checkbox"/> Caucasian         |
| <input type="checkbox"/> Eastern European  | <input type="checkbox"/> Hispanic/Caribbean  | <input type="checkbox"/> Northern European |
| <input type="checkbox"/> Southern European | <input type="checkbox"/> Other Specify _____ |  |

**PRIOR INFERTILITY TESTING AND TREATMENT:**

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

**Previous Infertility Testing:**

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	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hysterosalpingogram (x-ray of tubes and uterus)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hysteroscopy (looking inside uterus)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endometrial biopsy (taking tissue from inside uterus)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Post-coital test (to test sperm in cervical mucus)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Semen Analysis	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Laparoscopy (looking inside the abdomen)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Hormone Tests</b>						
Day 3 FSH	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Day 3 Estradiol	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Clomid Challenge Test	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid tests	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chromosome tests	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

**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 used _____				
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.									
5.									
6.									

Any other treatment? \_\_\_\_\_

**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 a 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?  
 Chlamydia     Gonorrhea     Herpes     Genital warts     Syphilis     HIV/AIDS     Hepatitis  
 Other \_\_\_\_\_

● Have you ever been diagnosed with any of the following diseases?

- Diabetes  Cancer \_\_\_\_\_
- Multiple sclerosis  Urinary Infections \_\_\_\_\_
- High blood pressure  If yes, any medications? \_\_\_\_\_
- Prostatic Infections

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

- Yes  No Retrograde ejaculation of sperm into the bladder \_\_\_\_\_
- Yes  No History of mumps \_\_\_\_\_
- Yes  No Difficulty with erections \_\_\_\_\_
- Yes  No History of undescended testicles \_\_\_\_\_
- Yes  No Fever in the last three months \_\_\_\_\_
- Yes  No Hernia Repair \_\_\_\_\_
- Yes  No Surgery for Varicocele \_\_\_\_\_
- Yes  No Bladder or penis surgery as a child \_\_\_\_\_
- Yes  No Exposure to prolonged heat at the workplace \_\_\_\_\_
- Yes  No Chemotherapy for cancer \_\_\_\_\_
- Yes  No 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:	Yes	No	Dates/Comments
Exposed to chemical or x-rays in work or hobby	_____	_____	_____
Please list			Amount per day or week
Caffeine	_____	_____	_____
Smoking	_____	_____	_____
Alcohol	_____	_____	_____
Marijuana	_____	_____	_____
Nutritional supplements, herbs, etc.	_____	_____	_____
Drugs	_____	_____	_____

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

