Fertility Form

I. Contact Information

First Name _____ Middle Initial _____ Last name _____
Date of Birth (MM/ DD/YY) ___ / ___ / _____ Age _____ Cell phone: (_____) _____
Are you married? ☐ Yes ☐ No ☐ Divorced ☐ Other: _____
Sexual Orientation: _____

Spouse/ Partner's First Name _____ Middle Initial _____ Last Name _____
☐ Not applicable
Date of Birth (MM/DD/YY) ___ / ___ / _____ Age _____ Cell phone: (_____) _____

Who referred you?
Physician Name _____
Physician Address _____
City _____ State _____ Zip/ Postal Code _____
Physician Phone Number (_____) _____

Which pharmacy do you use? (*Please list name of pharmacy and location)* _____
_____

II. Obstetrical History

Pregnancy Year	Length of Time to Conceive	Miscarriage or Abortion	Current partner the same?	Complications
1.				
2.				
3.				
4.				
5.				

III. Female Medical History and Information

Reason for Visit: ☐ Infertility Evaluation ☐ Sperm Insemination ☐ Other _____
What are your expectations for this visit? _____
What questions do you want answered at this visit? _____

How many months have you been actively having intercourse without using any form of birth control? 6
How many months/years have you been actively trying to conceive? ☐ _____ months ☐ _____ years
Have you ever been evaluated for infertility? ☐ Yes ☐ No
If yes, who was your physician(s)? _____
What cause(s) of infertility was diagnosed? _____
Have you already done a semen analysis? ☐ Yes ☐ No
Please list out all previous surgeries: _____
Are you on any daily medications? ☐ Yes ☐ No
If yes, please list all medications: _____
_____

Previous Fertility Treatment

Which drugs have you taken or treatments done for infertility? ☐ None

___ Clomiphene Citrate (Clomid, Serophene)
___ Letrozole (Femara)
___ Repronex, Menopur, or Bravelle
___ Gonal-F, Follistim, or Luveris
___ HCG (Ovidrel, Pregnyl, Novarel)
___ Follicle monitoring with sonograms
___ Artificial Insemination: # cycles ___
___ Progesterone Supplements
___ Acupuncture
___ Prednisone or Dexamethasone
___ Bromocriptine (Parlodel) or Dostinex
___ Danazol (Danocrine)
___ Lupron, Antagon/Cetrotide
___ In Vitro Fertilization: # cycles ___

Comments:

_____
_____
_____

IV. Menstrual History

Menstrual cycle pattern (please check all that apply)

☐ Regular cycles ☐ Irregular cycles ☐ Spotting before cycles ☐ No cycle
☐ Heavy cycles ☐ Light cycles ☐ Bleeding between cycles

Number of days between the start of one cycle to the start of the next cycle: _____ days
How many days does your cycle last? _____ days
Date of last menstrual cycle: ___ / ___ / _____
Age when you had your first cycle: _____ years old
How many cycles do you have per year? _____
Do you need medication to start your cycle? ☐ Yes ☐ No
If yes, what type? _____
If you do not have cycles, at what age did you stop having them? _____ years old
Do you have cramping or pelvic pain with your cycles? ☐ Yes ☐ No
If yes, how frequent is the cramping? ☐ Always ☐ Sometimes ☐ In the past
Are your cramps: ☐ Mild ☐ Moderate ☐ Severe
Do you take pain medication for the cramps? ☐ Yes ☐ No
Which medications do you use? _____

V. Social History

How many caffeinated beverages (coffee, tea, soda) do you drink per day? _____
Do you smoke cigarettes? ☐ Yes ☐ No
If yes, how many per day? _____
How many years? _____
If you have quit smoking, when? _____
Do you drink alcohol? ☐ Yes ☐ No
If yes, how frequently? _____
Do you use marijuana, cocaine, or any other similar drug? ☐ Yes ☐ No
If yes, which one? _____
Do you exercise? ☐ Yes ☐ No
How many hours of moderate exercise per week (i.e. walking, yoga) _____
How many hours of vigorous exercise per week (i.e. running, strength training) _____

Are you aware of any radiation exposure other than X-rays? ☐ Yes ☐ No

If yes, please describe _____

Do you feel safe in your own home? ☐ Yes ☐ No

VI. Male Medical History and Information

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

Have you had any past surgeries/injuries? ☐ Yes ☐ No

If yes, please describe _____

Have you had any genital surgeries or infections? ☐ Yes ☐ No

If yes, please describe _____

Do you take any current medications? ☐ Yes ☐ No

If yes, please describe _____

Do you take any testosterone supplements? ☐ Yes ☐ No

Do you smoke any medical marijuana or tobacco products? ☐ Yes ☐ No

What is your current occupation? _____

Are you around any kinds of chemicals daily? ☐ Yes ☐ No