Advanced Reproductive Medicine
UNIVERSITY OF COLORADO

PLEASE FILL IN AS COMPLETELY AS POSSIBLE:

Infertility History Form **Date of visit:** _____

Name: _____ Age: _____ Birth date: _____

Address: _____
Street *City* *State* *Zip Code*

Home telephone: (_____) _____-_____ E-mail address_____

Work telephone: _____Cell phone: _____

Your occupation: _____Your employer: _____

Marital status: Married Single Separated Divorced Other

If applicable:

Your partner's name_____Partner's date of birth: _____

Partner's occupation: _____ Partner's employer: _____

Partner's work telephone: _____ Partner's cell phone_____

Partner's email address_____

Physician who referred you: _____

Referring physician address: _____
Street *City* *State* *Zip Code*

Referring physician telephone: _____ Fax: _____

Reason for your clinic visit: _____

Trying to conceive since: _____
Month *Year*

Allergies to medications:
_____
_____

Describe as thoroughly as possible the background of your present problem(s). Include all symptoms you feel may be helpful, how long you have experienced them, and indicate whether they have become worse, lessened, or stayed the same in severity over time. Please try to organize your problems by priority. List your most pressing problem as #1, your next more pressing as #2 and so on.

PREVIOUS INFERTILITY EVALUATION:

Check all that apply:		Date(s)	Results
Husband/partner semen analysis			
Temperature charts			
X-ray of tubes *(hysterosalpingogram)*			
Diagnostic laparoscopy			
Hysteroscopy			
FSH (Day 2 or 3)			
Anti-müllerian hormone			
TSH			
Progesterone			
Other hormonal tests			
Chromosomal studies	Male		
	Female		
Fertility drugs taken	Clomid		Number of cycles:
	Injectable		Number of cycles:
	IVF cycles		Number of cycles:

Medications taken:

Please feel free to use the following section for any additional information you feel may be helpful in your fertility evaluation:

MENSTRUAL HISTORY:

At what age did you begin to menstruate? _____
What were the dates of your last two menstrual periods? _____ and _____
Have you ever gone more than 3 months without having a period? YES NO
If yes, how long? _____ months _____ years
List approximate dates when this occurred: _____

Are your cycles: REGULAR IRREGULAR
If irregular, please describe: _____

What is the average length of your menstrual cycle? _____
(Interval from first day of bleeding until day before bleeding of the next cycle.)
Has this changed since puberty? YES NO
If yes, please explain: _____

How many days does your period last? _____ Is the flow: LIGHT MEDIUM HEAVY
Does this vary? YES NO
If yes, please explain: _____

Can you tell you are about to have a period before you start bleeding (breast tenderness, fullness, etc)? YES NO

Do you have a clear vaginal discharge around the time of ovulation? YES NO

Do you have pain **during** your periods? YES NO
If yes, please explain: _____

Do you have pain **between** periods? YES NO
If yes, please explain: _____

Do you bleed between periods? YES NO
If yes, please describe frequency and amount of blood loss: _____
_____

Frequency of intercourse: _____ times per week _____ times per month _____ N/A
Changes in libido (interest in sex)? YES NO N/A
Do you bleed during or after intercourse? YES NO N/A
Any pain during or after intercourse: YES NO N/A

Do you have any noticeable discharge? YES NO N/A
If yes, describe your discharge (noting color, consistency, presence of odor, itching, etc.: _____
_____

Have you had regular gynecologic exams? YES NO
Date of last exam: _____
Date and result of last Pap smear: _____

Have you had regular breast examinations? YES NO
Date of last exam: _____
Date and findings of last abnormal exam: _____
Date and findings of last mammogram: _____

Have you ever had a milky discharge from one or both breasts? YES NO
If yes, when: _____

Have you had a history of: [*If yes, please give date(s)]*

Chlamydia: _____

Gonorrhea: _____

Pelvic (tubal) infection: _____

List all **gynecologic** surgical procedures you have had, the approximate date, duration of your hospitalization, and the name of the hospital where you had your surgeries performed.

Surgery	***Date***	***Stay***	***Hospital***	***City, State***

OBSTETRICAL HISTORY: *(If not applicable, please continue onto the next section.)*

	Number	**Date(s)**	**Months to conceive**	**Sex/Weight**	**Vaginal/C-section**
Full term deliveries (36+ weeks)					
Premature deliveries (<36 weeks)					

	Number	**Date(s)**
Miscarriages		
Induced abortions		
Ectopic pregnancies		
Stillbirths		
Newborn deaths		

Were there any complications during or after your pregnancies (infection, excessive bleeding, need for a transfusion)? YES NO

If yes, state which delivery and describe the complication(s): _____

Were any of your children born with congenital defects? YES NO

If yes, state which delivery and describe the congenital defects: _____

Dates of pregnancies with your present partner: _____

Number of living children from this relationship: _____

Did you have any pregnancies/children from a previous partner? YES NO

If yes, list the dates of the pregnancies: _____

Living children? _____

If applicable, dates of pregnancies through artificial insemination (donor sperm only): _____

_____

Living children? _____

CONTRACEPTION: *(If not applicable, please continue onto next section.)*

Please check any of the following methods of contraception you are currently using and/or have used in the past. Fill in the dates of usage.

	Method		**Dates of usage:**
_____	Birth Control Pills	Type: _____	_____
_____	IUD	Type: _____	_____
_____	Diaphragm		_____
_____	Condom		_____
_____	Jellies/Foam		_____
_____	Withdrawal		_____
_____	Sterilization	___ Male ___ Female	_____
_____	Other	_____	_____

GENERAL MEDICAL HISTORY:

List current medication(s), including prenatal vitamins or supplements. State the name of the medication, indication for its use, and how long you have taken it. Include prescription and over-the-counter medications, herbs, and vitamins.

Medication	**Began**	**Used through**	**Dosage**	**Indication(s)**

List all serious medical illnesses and **non-gynecologic** surgeries/procedures with date(s). If hospitalized, list where.

_____

_____

_____

_____

_____

_____

Childhood illnesses: _____ Routine (chicken pox, measles, mumps, etc.) _____ Unusual
If unusual, please describe: _____

Have you ever been in a serious accident? YES NO
If yes, please describe: _____

Have you ever had a blood transfusion? YES NO
If yes, approximate date(s): _____

Do you drink alcohol? DAILY WEEKLY MONTHLY NEVER

Do you smoke cigarettes? YES NO
If yes, how many cigarettes per day? _____
If you smoked in the past and have since quit, please give the approximate dates of smoking: _____

Do you exercise regularly? YES NO

If you exercise regularly, describe the frequency:

Every day 5-6 days/week 2-4 days/week 1-2 days per week

If you exercise regularly, describe the type of exercise:

Cardio Weight training Yoga Team sports Other_____

If you exercise regularly, describe the length of time you exercise daily:

Up to 20 minutes 20-45 minutes 45-60 minutes More than 60 minutes

Drug usage in the past year:

Drug	**Extent of exposure**
Marijuana	_____
Cocaine	_____
Depressants	_____
Stimulants	_____
Other: _____	_____
_____	_____

Have you had any difficulty or recent change in your habits of sleep, diet, or exercise? YES NO
If yes, please describe: _____

ETHNICITY (circle all that apply)
Caucasian

Caucasian Hispanic (Latina)

Black Non-Hispanic

Black Hispanic (Latina

Mainland Asian

Asian Pacific Islander

FAMILY HISTORY:

Are you adopted	YES	NO	
	Living		**Current Age or age & cause of death**
Mother	Y	N	
Age at menopause			
Father	Y	N	
Brother(s)	Y	N	
Sister(s)	Y	N	

DISORDERS IN FAMILY:
Have any members of your family (parents, children, brothers, sisters, grandparents, uncles, aunts, or cousins) had any of the following?

Disorder			**Relationship to you**
Cancer	YES	NO	
Diabetes	YES	NO	
Thyroid disorders	YES	NO	
Blood clotting disorder	YES	NO	
Seizures	YES	NO	
Obesity	YES	NO	
Psychiatric disorders	YES	NO	
Substance Abuse	YES	NO	
Infertility	YES	NO	
Multiple miscarriages	YES	NO	
Baby born with birth defects	YES	NO	
Chromosome abnormalities	YES	NO	
Kidney disease	YES	NO	
Depression	YES	NO	
Brain or spine abnormalities *(hydrocephalus, spina bifida)*	YES	NO	
Hearing problems/deafness	YES	NO	
Cleft lip and/or cleft palate	YES	NO	
Down syndrome	YES	NO	
Muscular dystrophy	YES	NO	
Epilepsy *(convulsions/seizures)*	YES	NO	
Mental retardation	YES	NO	
Endometriosis	YES	NO	

Genetic disorders more prevalent in certain ethnic groups

Circle "YES" if you are aware that any of your family members having one of the disorders listed. The doctor seeing you will review your answers to these questions and discuss whether it is appropriate for you to have genetic testing for these disorders. The ethnic group with an increase in prevalence for these disorders is listed below the disease.

Cystic fibrosis (Caucasian)	YES	NO	_____
Thalassemia (Asian, Mediterranean, Greek, Italian)	YES	NO	_____
Tay Sachs (Jewish, Cajun, French Canadian)	YES	NO	_____
Sickle cell anemia (Black, African-American)	YES	NO	_____
Canavan syndrome (Jewish, Eastern European)	YES	NO	_____
Familial dysautonomia (Jewish)	YES	NO	_____

My physician has reviewed these disorders with me and at this time I have decided to (Accept Decline) testing to see if I am a carrier.

Name of test to be performed _____

Signature _____

REVIEW OF SYSTEMS:

Check any of the following disorders **you** currently have or have a history of:

Central Nervous System
( ) Seizures
( ) Migraine headaches
( ) Other: _____

EENT
( ) Eye disorders
( ) Double or blurry vision
( ) Problem with sense of smell
( ) Other: _____

Cardiovascular
( ) Chest pain
( ) Palpitations
( ) Diagnosed with rheumatic fever
( ) Heart valve disease
( ) High blood pressure
( ) Mitral valve prolapse
( ) Given prophylactic antibiotics
( ) Other: _____

Respiratory
( ) Shortness of breath
( ) Asthma *(date of last attack: _____)*
( ) Bronchitis
( ) Pneumonia
( ) Cough producing blood
( ) Tuberculosis
( ) Other: _____

Gastrointestinal
( ) Nausea/vomiting
( ) Blood in stool
( ) Ulcers
( ) Hepatitis
( ) Constipation
( ) Spastic colon
( ) Other: _____

Genito-urinary
( ) Bladder infections *(cystitis)*
( ) Kidney infection
( ) Vaginal infections
( ) Frequent urination
( ) Other: _____

Musculo-skeletal
( ) Unusual muscle weakness
( ) Decreased energy/stamina
( ) Rheumatoid arthritis
( ) Lupus erythematosus
( ) Other: _____

Hematologic
( ) Unusual muscle weakness
( ) Sickle cell anemia or trait
( ) Thrombophlebitis
( ) Other: _____

Endocrine

( ) Diabetes
( ) Thyroid disease
( ) Excessive growth or hair on various parts of the body
( ) Hair loss
( ) Unexplained rash
( ) Rapid weight gain
( ) Rapid weight loss
( ) Excessive hunger/thirst
( ) Other: _____

Skin/Extremities

( ) Unexplained rash
( ) Acne
( ) Skin cancer
( ) Injuries
( ) Dermatitis
( ) Other: _____

Mental Health

( ) Depression, Bipolar Disorder or other Mood Disorder
( ) Anxiety Disorders (panic attacks, general anxiety, phobias, obsessive-compulsive disorder)
( ) Psychiatric Hospitalizations or suicide attempts
( ) Eating Disorders
( ) Alcohol or other substance abuse problems
( ) Learning disabilities/ADHD
( ) Medications for depression or anxiety (please specify): _____

MALE PARTNER'S HISTORY (*if applicable*):

Present age: _____ Duration of present relationship: _____

Has your partner initiated a pregnancy in a previous relationship: YES NO
If yes, please give the dates and outcome of pregnancy: _____

Has your partner had a previous relationship where pregnancy did not occur even though no contraception was used? (or a history of infertility?) YES NO
If yes, how long a period was involved? _____

Any difficulty achieving or maintaining erection? YES NO

Any difficulty with ejaculation *(i.e. retrograde, premature)*? YES NO

Any history of possible reproductive tract problems? *(please include dates)*
_____ Prostatitis _____ Epididymitis _____ Orchitis _____ Testicular tumor _____ Injury to testes

Any history of transmissible disease?
_____ Gonorrhea _____ Chlamydia _____ Non-specific urethritis _____Syphilis

Any history of reproductive tract surgery? YES NO
If yes, please give procedure and date: _____

PARTNER MEDICAL HISTORY:

Does your partner have any allergies to medications? (please specify) _____

_____

_____

List current medication. State the name of the medication, indication for its use, and how long he has taken it. Include prescription and over-the-counter medications, herbs, and vitamins.

Medication	**Began**	**Used through**	**Dosage**	**Indication(s)**

List all surgical procedures **partner** has had, the approximate date, duration of hospitalization and the name of the hospital where partner's surgeries were performed.

Surgery	**Date(s)**	**Stay**	**Hospital**	**City, State**

List partner's serious medical illnesses with date(s). If hospitalized, please list where.

_____

_____

_____

_____

_____

_____

Partner's general health: _____ Excellent _____ Good _____ Fair _____ Poor

Childhood illnesses: _____ Routine (chicken pox, measles, mumps, etc.) _____ Unusual

If unusual, please describe: _____

Has he been in a serious accident? YES NO

If yes, please describe: _____

_____

_____

Have he had a blood transfusion? YES NO

If yes, approximate date(s): _____

Does he drink alcohol? DAILY WEEKLY MONTHLY NEVER

Does he smoke cigarettes? YES NO

If yes, how many cigarettes per day? _____

If he smoked in the past and has since quit, please give the approximate dates of smoking _____

_____

Partner's Mental Health History:

( ) Depression, Bipolar Disorder or other Mood Disorder
( ) Anxiety Disorders (panic attacks, general anxiety, phobias, obsessive-compulsive disorder)
( ) Psychiatric Hospitalizations or suicide attempts
( ) Eating Disorders
( ) Alcohol or other substance abuse problems
( ) Learning disabilities/ADHD
( ) Medications for depression or anxiety (please specify): _____
_____

Drug usage in the past year:

Drug	**Extent of exposure**
Marijuana	
Cocaine	
Depressants	
Stimulants	
Other: _____	
_____	

Has he had any difficulty or recent change in his habits of sleep, diet, or exercise? YES NO
If yes, please describe: _____
_____

Any recent illnesses or change in health? YES NO
If yes, please describe: _____

Any recent significant weight change? YES NO **Present weight:** _____ **Height:** _____

Has your partner been exposed to:
_____ High temperatures *(work, hot tubs, etc.)* _____ Radiation
_____ Chemical _____ Toxic substances

Disorders in Partner's Family
Have any members of your partner's family (parents, children, brothers, sisters, grandparents, uncles, aunts, or cousins) had any of the following?

Disorder			**Relationship to partner**
Brain or spine abnormalities *(hydrocephalus, spina bifida)*	YES	NO	
Cleft lip and/or cleft palate	YES	NO	
Down syndrome	YES	NO	
Muscular dystrophy	YES	NO	
Cystic fibrosis	YES	NO	
Mental retardation	YES	NO	
Infertility	YES	NO	
Multiple miscarriages	YES	NO	
Baby born with birth defects	YES	NO	
Chromosome abnormalities	YES	NO	
Psychiatric disorders	YES	NO	