Woman's Name: _____ Date of birth: _____/_____/_____
(first, middle initial, last)

FEMALE PATIENT HISTORY

Date:_____ Your Age:_____ What kind of work do you do (brief description): _____
What is your race/nationality and ethnic background? (please check all that apply) ☐African American ☐ Caucasian ☐Eastern European ☐ Hispanic ☐Jewish ☐Asian ☐Mediterranean (Italian/Greek)
Are you and your partner a blood relative? **Y/N** _____
How did you hear about our Center? _____Who referred you to us?_____
What is your primary problem today? _____
Are you trying to conceive?: **Y/N** _____ If Yes, for how long? _____
How long have you had sexual intercourse without using any birth control measures? ____ years ____ months
Who is your Ob/Gyn doctor? _____ Who is your primary care doctor? _____

FAMILY HISTORY

Specify the status of health of your parents (grand parents) and siblings, mention significant illnesses (cancer, heart attacks, diabetes, high blood pressure, etc). Are there any relatives with any birth defects, mental retardation, developmental problems, any hereditary conditions, genetic anomalies?:

_____
_____

Do you or any member of your family have any of the following conditions? **(please circle any that apply and specify relative):**

Autism	Cleft lip/palate
Cystic Fibrosis	Fragile X
Heart defects	Infant or Childhood Disease or Death
Kidney Disease	Sickle Cell Disease/Trait
Spina bifida	Phenylketonuria (PKU)
Muscle disease/Muscular dystrophy/Spinal muscular atrophy	Hemophilia
Down's syndrome	Thalassemia (Mediterranean/Cooley's Anemia)
Mental retardation	Other (please explain)

MEDICAL HISTORY

Weight _____ Height _____ Blood Type _____ Any recent changes in your weight? _____
Do you-follow a particular food diet? **Y/N**. If Yes, please specify: _____
Do you exercise regularly: **Y/N**. If Yes, please specify type: _____Hrs/Wk:_____
Are you or have you ever been exposed to any of the following: (Check all that apply)
☐ Extreme Heat ☐ Toxic Fumes ☐ Chemicals ☐ Nuclear Radiation

Medication Allergies? **Y/N** If Yes, please specify what drugs: _____
What kind of reaction, describe: _____
Other Allergies (Seasonal, Food, Animals, etc.): _____

Please check the one that applies: ☐ I **am** allergic to latex (rubber or condoms) ☐ I **am not** allergic to latex (rubber or condoms)
Do you smoke tobacco? **Y/N** If yes, how many cigarettes/day: _____ Have you ever smoked? **Y/N**
If yes, how many years did you smoke: _____ When did you stop? _____
Do you drink alcohol? (circle one) Daily, occasionally, rarely, never If yes, how many drinks? ___ /day or ___/week
Do you use any recreational ("street") drugs (ie marijuana, cocaine, etc)? Y/N Specify: _____
(If you would feel more comfortable not writing anything down, please discuss this directly with the physician)

Previous Surgery: **Y/N**. If Yes, please specify what type and when:_____
_____
Have you ever been hospitalized? **Y/N** If Yes, please specify:_____
_____
List **all** medications (**prescriptions, over-the-counter, herbal**) you are currently on (**please provide the dose**):
_____
_____
_____

Woman's Name: _____ Date of birth: _____/_____/_____
(first, middle initial, last)

Do you have or have you ever had (Please mark YES or NO to all):

	Yes	No		Yes	No		Yes	No
Anemia			Dizziness			Mitral Valve Prolapse		
Anesthesia reaction			Drug/Alcohol Dependency			Neurological Problems		
Anorexia/Bulimia			Epilepsy			Panic Attacks		
Arthritis			Fainting Spells			Physically Abusive Relationship		
Asthma			Gallbladder Problems			Pneumonia		
Bladder Infections			German Measles (Rubella)			Pulmonary Embolism (PE)		
Bleeding Problems			Heart Disease			Rheumatic Fever		
Blood Clots in deep veins (DVT)			Heart Murmur			Scarlet Fever		
Blood Transfusions			Hepatitis: A, B, C, non A non B			Seizures		
Breast Disease/Surgery			Hirsutism (Excess Hair)			Skin Problems		
Breast Nipple Discharge			High Blood Pressure			Stroke		
Cancer			Kidney Disease			Syphilis		
Chicken Pox			Liver Problems/Jaundice			Thyroid Problems		
Chronic Bronchitis			Loss of Balance			Tuberculosis		
Chronic Headaches			Low Blood Pressure			Ulcers		
Colitis			Lupus			Visual Disturbances		
Color Blindness			Measles(Age?)			Weight Gain		
Depression			Mental Problems			Weight Loss		
Diabetes			Migraine					

If you answered "YES" to any of the questions above, please provide details or list any other medical problems:

_____
_____
_____
_____
_____

GYNECOLOGIC HISTORY

Do you have regular vaginal intercourse? Yes/No. If Yes, approximately how many times _____/ week or ____ /month
Does the male ejaculate during vaginal intercourse? (circle one) Always, occasionally, rarely, never
Do you use any lubricant at intercourse? Yes/No If yes, what kind: _____
Do you have any pain with intercourse: Yes/No If yes, describe:_____
Date of your last PAP smear: _____ was it normal? _____
Do you menstruate? (circle one): regularly, irregularly, rarely, never Date of last period: _____
How many days apart are your menstrual periods (counting from the first day of bleeding to the first day of bleeding in your next period)? _____days; How many days do you flow? _____days; Age of your first menstruation: _____
How heavy is your flow? (circle one) heavy with blood clots, heavy, moderate, light
Do you have any pain with your period? (circle one) none, mild, moderate, severe
Do you take any pain medication during menstruation? (Circle one): always, occasionally, rarely, never
Do you have any other pelvic pain in between your periods? **Y/N** If yes, specify location, frequency, severity, whether it's worsening or improving _____
_____

Have you ever had any breast lumps? **Y/N** Breast biopsy? **Y/N** Mammograms – **Y/N**
If you answered "YES" to any of the questions above, please provide details: _____
_____

Woman's Name: ____ Date of birth: _____/______/______
(first, middle initial, last)

Do you have or have you ever had (circle all that apply):

Abnormal Pap Smear (Dysplasia)	Gonorrhea	Polyps
Adhesions (scar tissue) in Pelvis	Herpes	Syphilis
Blocked tubes	HIV (AIDS virus)	Trichomonas
Chlamydia	Mycoplasma	Ureaplasma
Ectopic (Tubal) Pregnancy	Urethritis	Vaginal Ulcers
Endometriosis	Ovarian Cysts	Vaginal infection
Fibroids	Pelvic Infection (PID)	Yeast vaginal infection

If you answered "YES" to any of the questions above, please provide details:

____

____

____

Have you ever been pregnant? Yes/No

If you circled yes, complete/circle the pregnancy information table

Year of conception	**Way of Conception**	**Father/Sperm source**	**Result of pregnancy**	**Delivery**	**Health of child/ complications**
	Spontaneous With treatment	Current partner Previous partner Donor sperm	Vaginal delivery C-section Miscarriage Abortion Ectopic (tubal)	Full-Term Pre-Term	Healthy No (specify):
	Spontaneous With treatment	Current partner Previous partner Donor sperm	Vaginal delivery C-section Miscarriage Abortion Ectopic (tubal)	Full-Term Pre-Term	Healthy No (specify):
	Spontaneous With treatment	Current partner Previous partner Donor sperm	Vaginal delivery C-section Miscarriage Abortion Ectopic (tubal)	Full-Term Pre-Term	Healthy No (specify):
	Spontaneous With treatment	Current partner Previous partner Donor sperm	Vaginal delivery C-section Miscarriage Abortion Ectopic (tubal)	Full-Term Pre-Term	Healthy No (specify):
	Spontaneous With treatment	Current partner Previous partner Donor sperm	Vaginal delivery C-section Miscarriage Abortion Ectopic (tubal)	Full-Term Pre-Term	Healthy No (specify):
	Spontaneous With treatment	Current partner Previous partner Donor sperm	Vaginal delivery C-section Miscarriage Abortion Ectopic (tubal)	Full-Term Pre-Term	Healthy No (specify):

Please provide any additional details: ____

____

____

____

____

Woman's Name: _____ Date of birth: ____/_____/_____
(first, middle initial, last)

Have you been treated for infertility before? **Y/N**. If Yes, please specify when, where and how: _____
_____
_____
_____

What cause of infertility was diagnosed? _____
_____
_____

What drugs have you taken for infertility? Check all that apply

- ☐ Clomid (clomiphene citrate)
- ☐ hCG (Novarel,Pregnyl,Ovidrel,Chorionic Gonadotropin)
- ☐ Lupron, Ganirelix acetate, Cetrotide
- ☐ Progesterone (Crinone gel, suppositories, Endometrin)
- ☐ Bromocriptine (Parlodel)
- ☐ hMG (Menopur, Repronex, Bravelle)
- ☐ FSH (Gonal-F, Follistim)
- ☐ GnRH or LHRH (Factrel)
- ☐ Estrogens (Estrace, Estraderm)
- ☐ Dostinex
- ☐ Other (Please specify):_____

Which of the following tests have you had performed? Check all that apply and the results if known:

- ☐ Basal Body Temperature Charts _____
- ☐ Urinary ovulation test _____
- ☐ Intercourse scheduled around ovulation _____
- ☐ X-ray of the uterus (dye test) Results: ☐Normal ☐ Abnormal Explain:_____
  Done at _____ When? _____

Have you ever had surgery for tubal ligation? **Y/N** If yes, have you had surgery to reverse the tubal ligation? **Y/N**
If Yes, when? _____ Results?_____

Have you ever undergone artificial insemination? **Y/N** If Yes please specify partner or donor sperm: _____
Have you ever undergone IVF (in vitro fertilization)? **Y/N** If Yes, How many attempts? _____ Results: _____
Have you ever undergone GIFT/ZIFT? **Y/N**. If Yes: How many attempts? _____ Results: _____
Have you had intracytoplasmic sperm injection into eggs (ICSI)? **Y/N**

What form of contraception do you use now or have you used in the past? Check all that apply:
O pills O IUD O Diaphragm O Foam/Jellies O Condom O Rhythm O withdrawal
For each contraceptive method specify how long it was used and when you stopped using it:
_____
_____

Has anyone close to you ever threatened to hurt you? **Y/N** Has anyone ever hit, kicked, choked, or hurt you physically? **Y/N** Has anyone, including your partner, ever forced you to have sex? **Y/N** Are you ever afraid of your partner? **Y/N** Please provide details: _____
_____

Woman's Name: _____ Date of birth: ____/_____/_____
(first, middle initial, last)

MALE PARTNER HISTORY

First Name:_____ Last Name: _____ Date of Birth: _____
What is his race/nationality or ethnic background?: ☐African American ☐ Caucasian ☐Eastern European
☐ Hispanic ☐Jewish ☐Asian ☐Mediterranean (Italian/Greek)
What kind of work does your partner do (brief description):_____
Has he ever fathered a child? **Y/N**. If Yes, was this with you or his previous partner?_____
Has he ever had a semen analysis? **Y/N** When: _____ Where_____ Was it normal? **Y/N**
Is he seeing a doctor or urologist for evaluation of infertility? **Y/N**. If Yes, please answer the following questions:
Does the doctor feel that he has an infertility problem? **Y/N**. If Yes, please specify: _____
How has he been treated? _____

FAMILY HISTORY

Specify the status of health of your parents (grand parents) and siblings, mention significant illnesses (cancer, heart attacks, diabetes, high blood pressure, etc). Are there any relatives with any birth defects, mental retardation, developmental problems; any hereditary conditions, genetic anomalies?:

_____
_____
_____

Do you or any member of your family have any of the following conditions? **(please circle any that apply and specify relative):**

Cleft lip/palate	Cystic Fibrosis
Heart defects	Kidney Disease
Spina bifida	Sickle Cell Disease/Trait
Muscle disease/Muscular dystrophy	Hemophilia
Down's syndrome	Thalassemia (Mediterranean/Cooley's Anemia)
Mental retardation	Phenylketonuria (PKU)

MEDICAL HISTORY

Does he have any medical problems? **Y/N**. If Yes, please specify: _____
Is he taking any medications (prescriptions, over-the-counter, herbal)? **Y/N** If Yes, please specify: _____
_____

Has he ever had any of the following? Circle all that apply:

Cancer (specify):	Gonorrhea	Syphillis
Chemotherapy	Hepatitis: A, B, C, non A non B	Testicular Cancer
Chlamydia	Hernia or Hernia Surgery	Testicular Pain
Drug/Alcohol Abuse	Herpes	Testicular Surgery
Ejaculation Problems	HIV (AIDS virus)	Testicular Torsion
Erectile Problems	Low Sperm Count	Varicocele/ Varicocele Surgery
Exposure to Nuclear Radiation	Mumps	Vasectomy
Exposure to Toxic Chemicals	Penile Discharge/Burning	Vasectomy Reversal
Exposure to Toxic Fumes	Prostate Problems/Surgery	Venereal Disease (VD)
Frequent Sauna/Hot tub/Steambath	Stomach Ulcers	Trauma to testis/injury

If you circled any of the above, please provide description:

_____
_____
_____
_____