Fertility Specialists
Medical Group, Inc.®

NEW PATIENT HISTORY

REFERRED BY: _____

1. IDENTIFYING INFORMATION

Name _____ DOB _____/_____/_____ Age _____

Significant Other Name_____ DOB _____/_____/_____ Age _____

Date this form completed _____/_____/_____ Primary Care MD _____

Primary GYN _____ Number of years together _____

How long have you been attempting conception? _____ Marital Status _____

Reasons you are coming to see us: _____

_____

_____

2. RACE (You)

❑ Caucasian ❑ Hispanic
❑ Asian ❑ African American
❑ Other (_____)

ETHNICITY
❑ Ashkenazi Jew ❑ Southeastern Asian
❑ Greek/Italian

Significant Other

❑ Caucasian ❑ Hispanic
❑ Asian ❑ African American
❑ Other (_____)

❑ Ashkenazi Jew ❑ Southeastern Asian
❑ Greek/Italian

3. PREGNANCY HISTORY

Times pregnant _____ Term births _____ Premature births _____ Miscarriages _____ Elective abortion _____ Adopted children ____

Date	Miscarriage	Elective Abortion	Ectopic	Months to conceive?	Infertility Treatment	Weight and Sex?	C-section?	Complications?	Is current Partner the father?
1.									
2.									
3.									
4.									

4. CONTRACEPTIVE USE

Type	From when to when	Reason discontinued
1.		
2.		
3.		

5. OPERATIONS AND HOSPITALIZATIONS

Date	Diagnosis	Operation	Where	Physician
1.				
2.				
3.				

6. MEDICATIONS

List all prescriptions and over-the-counter drugs used during the past year

Date	Dose and Frequency	From when to when	Reason
1.			
2.			
3.			

7. ALLERGIES

Drug or substance	When	Reaction
1.		
2.		

8. MENSTRUAL/HORMONAL

Height _____ Weight _____ Blood Type (if known) _____

Age at first period ..... Date of last two menstrual periods _____/_____/_____ and _____/_____/_____

Are your periods regular? ❑ yes ❑ no Do you bleed between periods? ❑ yes ❑ no

How many days from onset to onset? ..... What is the usual duration of your periods? .....days

Premenstrual symptoms occur: ❑ almost always ❑ rarely ❑ never

Vigorous exercise: type ..... hrs/week ..... type ..... hrs/week.....

If you have a hormonal disorder, please specify type and treatment: .....

Last pap smear _____/_____/_____ Last mammogram _____/_____/_____

Pelvic pain/cramps: ❑ none ❑ during menses ❑ before menses ❑ after menses ❑ at midcycle

❑ during intercourse ❑ with bowel movements ❑ with urination ❑ cause you to miss work ❑ cause you to miss usual activities

Pelvic pain/cramps are: ❑ mild ❑ moderate ❑ severe

❑ worsening ❑ improving ❑ no change ❑ in midline ❑ on right side ❑ on left side

Frequency of intercourse _____

Do you have or have you had? (Check all that apply).

❑ Hot flushes	❑ Increased facial or body hair	❑ Seizures
❑ Breast discharge	❑ Increased acne	❑ Diabetes
❑ Visual disturbance	❑ Weight increase > 10 pounds	❑ Thyroid disorder
❑ Poor sense of smell	❑ Weight loss > 10 pounds	❑ Autoimmune disease
❑ Chronic headache	❑ Special dietary habits	❑ Extraordinary stress
❑ Head trauma	❑ Vomiting	❑ Psychiatric treatment

Please explain a "Yes" answer: _____

_____

_____

9. GYNECOLOGIC / INFECTION

Do you have or have you had?

❑ Pelvic infection	❑ Appendicitis	❑ Gonorrhea	❑ Ovarian cysts
❑ Chlamydia	❑ Colitis or enteritis	❑ Syphilis	❑ Toxoplasmosis
❑ Endometriosis	❑ Uterine fibroids or myomas	❑ Mycoplasma	❑ Cytomegalovirus (CMV)
❑ Pelvic adhesions	❑ Abnormal uterus shape	❑ Ureaplasma	❑ Tuberculosis
❑ Cervicitis	❑ Recurrent vaginitis	❑ Genital warts / condyloma	❑ Trichomonas
❑ Genital herpes	❑ Abnormal Pap smears	❑ Cryo (freezing) or surgery of the cervix	

10. OTHER HISTORY

Your occupation: ..... Spouse's occupation: .....

Cigarettes - packs smoked per day:.....

Alcohol - type and number per week:.....

Marijuana - amount: .....

Other drugs - type and amount: .....

Caffeine drinks per day: .....

Video display terminal hours / day:.....

Electric blanket use:	❑ yes ❑ no	Toxic exposure:	❑ yes ❑ no
Ever used intravenous drugs?	❑ yes ❑ no	Hot tub or sauna use:	❑ yes ❑ no
Radiation exposure:	❑ yes ❑ no		

11. MEDICAL ILLNESSES

Do you have or have you had?

- ❑ Cancer
- ❑ Diabetes
- ❑ Hypertension
- ❑ High cholesterol
- ❑ Heart disease
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ Mitral valve prolapse
- ❑ Heart murmur
- ❑ Asthma
- ❑ Pneumonia
- ❑ Bronchitis
- ❑ Tuberculosis
- ❑ Hepatitis / liver disorder
- ❑ Gall bladder problems
- ❑ Ulcers
- ❑ Colitis / enteritis
- ❑ Kidney disorder
- ❑ Rubella
- ❑ Anesthetic complication
- ❑ Mumps
- ❑ Chicken pox
- ❑ Mononucleosis
- ❑ Serious injury / accident
- ❑ Blood transfusion
- ❑ Psychiatric disorder
- ❑ Seizures
- ❑ Stroke
- ❑ Blood clots
- ❑ Anemia
- ❑ Bleeding disorder
- ❑ Thyroid disorder
- ❑ Recent immunization

Please explain a "Yes" answer to any of the above:……

……

……

12. FAMILY HISTORY

	Living?	Age or age at death	Health Problems
Mother	:	:	:
Father	:	:	:
Sister(s)	:	:	:
	:	:	:
	:	:	:
Brother(s):	:	:	:
	:	:	:
	:	:	:
Daughter(s)	:	:	:
	:	:	:
Son(s)	:	:	:
	:	:	:

Which of your blood relatives have?

Cancer .....

Venous Thrombosis (blood clotting)……

Diabetes .....

Hypertension .....

High Cholesterol .....

Heart disease .....

Stroke .....

Premature menopause .....

Endometriosis .....

Uterine fibroids (myomas) .....

13. GENETIC HISTORY

Do you, your partner, or anyone in either family have? ❑ Any inherited disorders?

- ❑ Neural tube defects/spina bifida/anencephaly
- ❑ Thalassemia
- ❑ Down syndrome
- ❑ Cystic fibrosis
- ❑ Muscular dystrophy
- ❑ Huntington chorea
- ❑ Mental retardation / fragileX
- ❑ Tay-Sachs disease
- ❑ Sickle cell disease or trait
- ❑ Hemophilia
- ❑ Hormonal disorder
- ❑ Chromosomal disorder
- ❑ Genetic / inherited disorder
- ❑ Baby with birth defects
- ❑ Infertility

Please explain a "Yes" answer to any of the above:……

……

14. SYSTEMIC REVIEW

Headaches: Number per week _____ Medication used _____

- ❑ mild
- ❑ moderate
- ❑ severe
- ❑ improving
- ❑ worsening
- ❑ no change
- ❑ with visual symptoms
- ❑ with vomiting
- ❑ stress related
- ❑ migraines

- ❑ Wear glasses
- ❑ Wear contact lenses
- ❑ Sinus problems
- ❑ Hayfever
- ❑ Ringing in ears
- ❑ Hearing loss
- ❑ Denture / bridges

- ❑ Anemia
- ❑ Chest pain
- ❑ Irregular heart beat
- ❑ Fainting spells
- ❑ Leg swelling
- ❑ Calf pain
- ❑ Blood clots (venous thromboembolism)
- ❑ Cough
- ❑ Shortness of breath
- ❑ Wheezing
- ❑ Cough up blood
- ❑ Chest x-ray
- ❑ TB skin test

- ❑ Bladder/kidney infections
- ❑ Urgent / frequent / painful urination
- ❑ Blood / abnormal color of urine
- ❑ Unable to control urination
- ❑ Abnormal urinary tract
- ❑ Kidney x-ray
- ❑ Bladder cystoscopy

- ❑ Varicose veins
- ❑ Easy bruising
- ❑ Prolonged bleeding
- ❑ Bleeding from gums
- ❑ Nosebleeds
- ❑ Take aspirin/ibuprofen frequently

- ❑ Breast mass
- ❑ Fibrocystic changes
- ❑ Breast implants
- ❑ Mammogram
- ❑ Do monthly breast self-exam

- ❑ Abdominal pain
- ❑ Nausea and vomiting
- ❑ Vomiting blood
- ❑ Ulcer
- ❑ Food intolerance
- ❑ Gallstones
- ❑ Jaundice / hepatitis
- ❑ Chronic constipation
- ❑ Diarrhea
- ❑ Blood in bowel movement
- ❑ Irritable bowel
- ❑ Hemorrhoids
- ❑ Hernia
- ❑ Abnormal liver test
- ❑ Arthritis
- ❑ Back pain

- ❑ Acne
- ❑ Skin disorder
- ❑ Rash
- ❑ Hives
- ❑ Skin cancer

- ❑ Counseling
- ❑ Recent stress increase
- ❑ Recent anxiety increase

- ❑ Sensation loss / numbness
- ❑ Muscle control / weakness
- ❑ Heat or cold intolerance
- ❑ Damp skin
- ❑ Unusual hair loss
- ❑ Extraordinary fatigue

OTHER: _____

_____

_____

15. MALE HISTORY:

- ❑ Medications:
- ❑ Illnesses:
- ❑ Mumps:
- ❑ Smoker:
- ❑ Alcohol:
- ❑ Ejaculatory Disorder:
- ❑ Reproductive surgery:
- ❑ STDs:
- ❑ Testicular trauma:
- ❑ Impotence:
- ❑ Allergies: _____

Have you seen a urologist for infertility? ❑ Yes ❑ No
If yes: Physician name and location ……..

Have you ever fathered a child/pregnancy with another woman? ❑ Yes ❑ No
If yes, when? …….. years ago

Have you ever been diagnosed with an infertility diagnosis except for currently? ❑ Yes ❑ No
If yes, when? …….. years ago

Comments:_____

_____

16. HISTORY OF FERTILITY THERAPY (Fill out, if applicable).

Have you been treated for infertility previously? ❑ yes ❑ no
If yes, who was your physician? ……..

What cause of infertility was diagnosed? ……

What drugs have you taken for infertility? Please check all that apply:

❑ Clomid (Serophene)	❑ hCG Profasi	❑ Antibiotics
❑ Gonal F	❑ Progesterone	❑ Baby aspirin
❑ Follistim	❑ Lupron	❑ Heparin
❑ Repronex	❑ Microdose Lupron	❑ Steroids
❑ Pergonal	❑ Antagon	❑ Oral Contraceptives
❑ Fertinex	❑ Parlodel	❑ Other ……..……

Which of the following tests have you or your partner had performed? Please check all that apply and results, if known:

❑ BBT	When _____/_____/_____	Results ……..
❑ Postcoital Test	When _____/_____/_____	Results ……..
❑ Hormonal Assays (FSH, LH, Prolactin, Estradiol, DHEA-S, Testosterone, Progesterone)	When _____/_____/_____	Results ……..
❑ Endometrial biopsy	When _____/_____/_____	Results ……..
❑ Hysterosalpingogram	When _____/_____/_____	Results ……..
❑ Sonohystogram	When _____/_____/_____	Results ……..
❑ Ultrasound	When _____/_____/_____	Results ……..
❑ Laparoscopy, Hysteroscopy	When _____/_____/_____	Results ……..
❑ Mycoplasma culture	When _____/_____/_____	Results ……..
❑ Chlamydia culture	When _____/_____/_____	Results ……..
❑ GC Culture	When _____/_____/_____	Results ……..
❑ Thyroid tests	When _____/_____/_____	Results ……..
❑ Rubella (German measles)	When _____/_____/_____	Results ……..
❑ Varicella (Chicken pox)	When _____/_____/_____	Results ……..
❑ Cytomegalovirus (CMV)	When _____/_____/_____	Results ……..
❑ Antibody screen	When _____/_____/_____	Results ……..
❑ Blood type	When _____/_____/_____	Results ……..
❑ Chromosomes	When _____/_____/_____	Results ……..
❑ Genetic screening	When _____/_____/_____	Results ……..
❑ Hepatitis B	When _____/_____/_____	Results ……..
❑ Hepatitis C	When _____/_____/_____	Results ……..
❑ HIV	When _____/_____/_____	Results ……..
❑ HTLV	When _____/_____/_____	Results ……..
❑ RPR (Serology)	When _____/_____/_____	Results ……..
❑ Semen analysis	When _____/_____/_____	Results ……..
❑ Antisperm antibodies	When _____/_____/_____	Results ……..
❑ Varicocele repair	When _____/_____/_____	Results ……..
❑ Testicular biopsy	When _____/_____/_____	Results ……..

❑ OTHER: ……

Have you ever undergone Artificial Insemination (IUI) or In Vitro Fertilization (IVF)? ❑ yes ❑ no
If yes, ❑ partner ❑ donor sperm

Clomid ❑ yes ❑ no Fertility Shots ❑ yes ❑ no name of medications_____

#IUI's _____ Dates_____

#IVF cycles _____ Dates_____