INFERTILITY HISTORY FORM

IMPORTANT: Please complete this questionnaire as completely & honestly as possible. Please bring this form with you to your initial consultation. If you have any records from previous treatments, blood tests, semen analysis, or other evaluations previously performed, please bring these reports and/or have any other doctors fax the reports to us at 407-244-5513.

BROWN FERTILITY

CONCEIVING MIRACLES™

PART I: PERSONAL INFORMATION

First Name: _____ Last Name: _____ MI: _____

Date of Birth: (MM/DD/YY): _____ Age: _____

Social Status: ☐ Married ☐ Single ☐ Divorced ☐ Other; Explain: _____

Spouse/Male Partner - ☐ Not Applicable

First Name: _____ Last Name: _____ MI: _____

Date of Birth: (MM/DD/YY): _____ Age: _____

Who Referred You?

☐ Physician Name: _____ Phone Number: _____

Address: _____ Fax: _____

☐ Former Patient/Friend ☐ Web Site ☐ Other: _____

Who is your OB/GYN?

Name: _____ Phone Number: _____

Address: _____

Who is your Primary Care Provider (PCP)?

Name: _____ Phone Number: _____

Address: _____

PHYSICIAN NOTES (for office use only)

PART II: FEMALE MEDICAL HISTORY AND INFORMATION

What is the main reason for your visit today? ☐ Infertility ☐ Other: _____

_____

How long have you been in your current relationship? _____ Are you currently married? ☐ No ☐ Yes

How long have you been attempting pregnancy? _____ years and _____ months

As you understand it, what is preventing you from getting pregnant? _____

_____

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	Pregnancy outcome (type of delivery / termination / tubal or ectopic / complications)	Conceived with current partner?	Infertility treatment if any	No. of months to conceive
1.			☐ No ☐ Yes		
2.			☐ No ☐ Yes		
3.			☐ No ☐ Yes		
4.			☐ No ☐ Yes		
5.			☐ No ☐ Yes		

Menstrual History:

Age of first period: _____ years old When was your last period? (MM/DD/YY) _____

Menstrual cycle pattern (check all that apply): ☐ Regular periods ☐ Irregular periods ☐ Spotting before periods ☐ Light flow ☐ Heavy flow ☐ Bleeding between cycles ☐ No periods

Number of days between the start of one period to the start of another: _____ days

How many days of bleeding do you have? _____ days How many periods do you have per year? _____

Do you pass clots? ☐ No ☐ Yes Every cycle? ☐ No ☐ Yes

Do you have cramps? ☐ No ☐ Yes Every cycle? ☐ No ☐ Yes

Do you have any pre-menstrual symptoms (PMS) prior to your menses? (bloating, breast tenderness, mood changes) ☐ No ☐ Yes

Which? _____

Can you tell when you ovulate? ☐ No ☐ Yes How? _____

What medications do you use for pain relief? _____

Contraceptive History: ☐ None

☐ IUD .....dates of use: _____ ☐ Tubal sterilization ("tubes tied") .....date: _____

☐ Birth Control Pills .....dates of use: _____ ☐ Injectable contraception .....dates of use: _____

Any complications from any of the above? ☐ No ☐ Yes Explain: _____

_____

_____

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) ☐ None

☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ Genital warts ☐ Syphilis ☐ HIV/AIDS ☐ Hepatitis

☐ Other: _____

Pap Smear and Breast Screening 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) ☐ Cone biopsy ☐ Laser ☐ LEEP

• Have you ever had a mammogram? ☐ No ☐ Yes, date: _____ Result: ☐ Normal ☐ Abnormal

Medical History:

• Do you have any **allergies** to 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: ☐ None

_____

_____

• **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):

Year	Reason and Type of Surgery	Place	Surgeon

Social History:

☐ No ☐ Yes Do you drink caffeinated beverages? How many / day? _____

☐ No ☐ Yes Do you smoke cigarettes? How many / day? _____ How many years? _____

☐ Former smoker. When did you quit? _____

☐ No ☐ Yes Do you drink alcohol? How many drinks per week? _____ Type of drink: _____

☐ No ☐ Yes Do you use marijuana or similar drugs? Describe: _____

☐ No ☐ Yes Do you use nutritional supplements, herbs, sport supplements? Describe: _____

☐ No ☐ Yes Are you exposed to chemical or x-rays at work or hobby? Describe: _____

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

_____

Vaccinations: (check all that apply) ☐ None

☐ Chickenpox (varicella) ☐ Hepatitis A ☐ Hepatitis B ☐ Influenza (flu shot) ☐ MMR (measles mumps and rubella)

• Have you ever had chickenpox (varicella)? ☐ No ☐ Yes ☐ Not sure

PRIOR INFERTILITY TESTING AND TREATMENT:

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

•Which doctor or clinic? _____

Previous Infertility Testing:			Year	Results (if known)
Ovulation predictor kits (LH surge)	☐ No	☐ Yes		
Hysterosalpingogram (HSG)	☐ No	☐ Yes		
Hysteroscopy (looking inside uterus)	☐ No	☐ Yes		
Laparoscopy (looking in the abdomen)	☐ No	☐ Yes		
Endometrial biopsy (taking tissue from inside uterus)	☐ No	☐ Yes		
Semen Analysis	☐ No	☐ Yes		

Other(s): _____

Prior Ovulation Induction Cycles

Type of Treatment	With Intrauterine Inseminations?	# of cycles	Month / Year	Outcome
Clomiphene citrate (Clomid, Serophene)	☐ No ☐ Yes			
Daily fertility injections / gonadotropins (Gonal-F, Follistim, Menopur, Bravelle)	☐ No ☐ Yes			

Comments: _____

Prior IVF Cycles (Please include frozen embryo transfers and cancelled cycles):

#	Date	Name and place of IVF center	Frozen embryo cycle	Outcome
1.			☐ No ☐ Yes	
2.			☐ No ☐ Yes	
3.			☐ No ☐ Yes	
4.			☐ No ☐ Yes	

Any other treatment? (Explain): _____

Physical Symptoms and Medical History: Do you have or have you ever had? ☐ None

General: ☐ None
- ☐ Recent weight loss or gain
- ☐ Anorexia / bulimia
- ☐ Lack of energy
- ☐ Fever / chills
- ☐ Other:

Endocrine/Hormonal: ☐ None
- ☐ Diabetes
- ☐ Excessive hair growth or hair loss
- ☐ Thyroid gland problem
- ☐ Rapid weight gain or loss
- ☐ Excessive hunger/thirst
- ☐ Hot flashes
- ☐ Other:

Head/Eyes/Ears/Nose/Throat: ☐ None
- ☐ Dizziness
- ☐ Frequent headaches
- ☐ Loss of sense of smell
- ☐ Blurred vision
- ☐ Hearing loss / deafness
- ☐ Other:

Gastrointestinal: ☐ None
- ☐ Nausea / vomiting
- ☐ Diarrhea/ constipation
- ☐ Hepatitis
- ☐ Irritable bowel syndrome
- ☐ Ulcers
- ☐ Change in bowel habits
- ☐ Other:

Breast: ☐ None
- ☐ Discharge
- ☐ Lump
- ☐ Pain
- ☐ Cancer
- ☐ Abnormal mammogram
- ☐ Reduction
- ☐ Augmentation / implant
- ☐ Other:

Genito-Urinary: ☐ None
- ☐ Kidney disease or infection

Cardiovascular
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Other:

Hematologic: ☐ None
- ☐ Blood clotting disorder
- ☐ Sickle cell anemia
- ☐ Easy bruising
- ☐ Other:

Respiratory: ☐ None
- ☐ Shortness of breath
- ☐ Asthma
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Other:

Neurological: ☐ None
- ☐ Seizures, epilepsy
- ☐ Headaches
- ☐ Memory loss
- ☐ Other:

Musculoskeletal: ☐ None
- ☐ Rheumatoid arthritis
- ☐ Lupus erythematosus
- ☐ Myastenia gravis
- ☐ Weakness
- ☐ Other:

Skin / Extremities: ☐ None
- ☐ Acne
- ☐ Burn injuries
- ☐ Excess hair growth
- ☐ Other:

Cardiovascular: ☐ None
- ☐ Palpitations
- ☐ Heart attack
- ☐ Chest pain
- ☐ Stroke
- ☐ Heart murmur
- ☐ Mitral valve prolapse
- ☐ High blood pressure
- ☐ Other:

Mental Health Problems: ☐ None
- ☐ Depression
- ☐ Anxiety disorder
- ☐ Eating disorder
- ☐ Other:

Family History: Does any member of your family has or has ever had? (Check all that apply, and relationship to you) ☐ None

☐ No	☐ Yes	Breast cancer	
☐ No	☐ Yes	Ovarian cancer	
☐ No	☐ Yes	Colon cancer	
☐ No	☐ Yes	Other cancer	
☐ No	☐ Yes	Diabetes	
☐ No	☐ Yes	Kidney disease	
☐ No	☐ Yes	Thyroid problems	
☐ No	☐ Yes	Heart disease, high blood pressure, stroke	
☐ No	☐ Yes	Blood clots in lungs or legs	
☐ No	☐ Yes	Obesity	
☐ No	☐ Yes	Psychiatric problems	
☐ No	☐ Yes	Menopause before age 40	
☐ No	☐ Yes	Heart attract before age 40	
☐ No	☐ Yes	Recurrent pregnancy loss or stillbirth	
☐ No	☐ Yes	Neural tube defect (spina bifida, anencephaly)	
☐ No	☐ Yes	Familial dysautonomia	
☐ No	☐ Yes	Congenital heart defect	
☐ No	☐ Yes	Down syndrome	
☐ No	☐ Yes	Cystic fibrosis	
☐ No	☐ Yes	Tay-Sachs	
☐ No	☐ Yes	Canavan disease	
☐ No	☐ Yes	Thalassemia (Mediterranean anemia)	
☐ No	☐ Yes	Sickle cell disease or trait	
☐ No	☐ Yes	Hemophilia or other bleeding disorder	
☐ No	☐ Yes	Muscular dystrophy	
☐ No	☐ Yes	Huntington's disease	
☐ No	☐ Yes	Mental retardation or autism	
☐ No	☐ Yes	Bloom Syndrome	
☐ No	☐ Yes	Bone or skeletal defects	
☐ No	☐ Yes	Polycystic kidneys disease	
☐ No	☐ Yes	Deafness or blindness	
☐ No	☐ Yes	Hemochromatosis	
☐ No	☐ Yes	Galactosemia	
☐ No	☐ Yes	Gaucher disease	
☐ No	☐ Yes	Fanconi anemia	
☐ No	☐ Yes	Nieman-Pick disease	
☐ No	☐ Yes	Other birth defect not listed above	

What is your ethnic background?

☐ African American	☐ American Indian / Native American	☐ Ashkenazi Jewish
☐ Asian-American	☐ Cajun/French	☐ Caucasian
☐ Eastern European	☐ Hispanic/Caribbean	☐ Northern European
☐ Southern European	☐ Other Specify: _____	

Form completed by: ☐ Patient ☐ Partner ☐ Other: _____

Signature of person completing the form: _____ Date completed: _____

Signature of physician reviewing form: _____ Date Reviewed: _____

PART III: MALE PARTNER MEDICAL HISTORY AND INFORMATION

☐ No ☐ Yes Have you ever been evaluated by an urologist?

☐ No ☐ Yes Have you previously conceived with another partner? If so, how many times?: _____

☐ No ☐ Yes Have you had a semen analysis?

☐ No ☐ Yes Have you had any of the following sexually transmitted diseases or infections? (Select all that apply)

☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ Syphilis ☐ HIV/AIDS ☐ Hepatitis

☐ No ☐ Yes Do you have any **allergies** to foods or medications? (Please list and describe reaction):

_____

☐ No ☐ Yes Are you taking any **medications**, including over the counter medications and herbal medicines/vitamins?

(Please list): _____

Have you ever been diagnosed with any of the following diseases? If so, please explain.

☐ No ☐ Yes Diabetes

☐ No ☐ Yes Cancer; if yes, did you received chemotherapy? ☐ No ☐ Yes

☐ No ☐ Yes Multiple sclerosis

☐ No ☐ Yes Urinary infections

☐ No ☐ Yes High blood pressure; if yes, are you taking medications? ☐ No ☐ Yes

☐ No ☐ Yes Infections of the prostate or testicles; if yes, any antibiotics in the last 3 months? ☐ No ☐ Yes

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

☐ No ☐ Yes Retrograde ejaculation of sperm into the bladder

☐ No ☐ Yes History of mumps

☐ No ☐ Yes Difficulty with erections

☐ No ☐ Yes Difficulty achieving ejaculations

☐ No ☐ Yes History of undescended testicles

☐ No ☐ Yes Hernia Repair

☐ No ☐ Yes Surgery for varicocele

☐ No ☐ Yes Bladder or penis surgery as a child

☐ No ☐ Yes Testicular biopsy

☐ No ☐ Yes Vasectomy

☐ No ☐ Yes Vasectomy reversal

☐ No ☐ Yes Serious injuries or trauma to your genitals

☐ No ☐ Yes Episode of fever in the last 3 months

☐ No ☐ Yes Exposure to toxins, poisons, pesticides, radiation or solvents

☐ No ☐ Yes Do you have any other medical problems not listed above? If so, please list type, dates, and treatment:

_____

☐ No ☐ Yes Have you had any other surgeries not listed above? If so, please list : _____

_____

☐ No ☐ Yes Do you drink caffeinated beverages? How many / day? _____

☐ No ☐ Yes Do you smoke cigarettes? How many / day? _____ How many years? _____

☐ Former smoker. When did you quit? _____

☐ No ☐ Yes Do you drink alcohol? How many drinks per week? _____ Type of drink: _____

☐ No ☐ Yes Do you use marijuana or similar drugs? Describe: _____

☐ No ☐ Yes Do you use nutritional supplements, herbs, sport supplements? Describe: _____

☐ No ☐ Yes Are you exposed to chemical or x-rays at work or hobby? Describe: _____

☐ No ☐ Yes Are you exposed to prolonged heat at the workplace? Describe: _____

Form completed by: ☐ Patient ☐ Partner ☐ Other: _____

Signature of person completing the form: _____ Date completed: _____

Signature of physician reviewing form: _____ Date reviewed: _____

PHYSICIAN NOTES (for official use only)