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.

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: _____

PHYSICIAN NOTES (for office use only)

PART II: FEMALE MEDICAL HISTORY AND INFORMATION

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

If your visit is for infertility infertility:

- How long have you been in your current relationship? _____
- 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: _____

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		

Gynecological History:

When was the first day of your last period? (MM/DD/YY) _____

Are your menstrual periods ☐ Regular , or ☐ Irregular

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

How many days of bleeding do you have? _____ days

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? _____

Have you used Ovulation Predictor Kits? ☐ No ☐ Yes Results? _____

Do you have pain with intercourse? ☐ No ☐ Yes

Do you have history of uterine fibroids? ☐ No ☐ Yes

Do you have history of pelvic endometriosis? ☐ No ☐ Yes

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

Contraceptive History: ☐ None

☐ IUD ☐ Tubal sterilization ("tubes tied") ☐ Contraceptive implant

☐ Birth Control Pills ☐ Injectable contraception

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

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 had a mammogram? ☐ No ☐ Yes Date of last mammogram: _____ Result: ☐ Normal ☐ Abnormal

Vaccinations: Have you received the following vaccines? (check all that apply) ☐ None

- Chickenpox (varicella) - ☐ No ☐ Yes ☐ Not sure
- Hepatitis B - ☐ No ☐ Yes ☐ Not sure

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 Where? _____

Previous Infertility Testing:			**Year**	**Results (if known)**
Hysterosalpingogram (HSG)	☐ No	☐ Yes		
Hysteroscopy (looking inside uterus)	☐ No	☐ Yes		
Laparoscopy (looking in the abdomen)	☐ No	☐ Yes		
Semen Analysis	☐ No	☐ Yes		

Other(s): _____

PHYSICIAN NOTES (for office use only)

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) _____

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 smoke cigarettes? How many / day? _____ How many years? _____

☐ No ☐ Yes 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: _____

What is your occupation? _____

Physical Symptoms and Medical History: Do you have or have you ever had? (check all that apply) ☐ None

☐ Recent weight loss or gain	☐ Abnormal mammogram	☐ Seizures, epilepsy
☐ Diabetes	☐ Breast reduction	☐ Myastenia gravis
☐ Excessive hair growth or hair loss	☐ Breast augmentation / implant	☐ Acne
☐ Thyroid gland problem	☐ Kidney disease or infection	☐ Depression
☐ Dizziness	☐ Heart disease	☐ Anxiety disorder
☐ Frequent headaches	☐ High blood pressure	☐ Eating disorder
☐ Loss of sense of smell	☐ Palpitations, cardiac arrhythmia	☐ Chronic bronchitis
☐ Hepatitis	☐ Heart attack	☐ Asthma
☐ Liver problem	☐ Stroke	☐ Tuberculosis
☐ Irritable bowel syndrome	☐ Heart murmur	☐ Rheumatoid arthritis
☐ Breast discharge	☐ Mitral valve prolapse	☐ Lupus erythematosus
☐ Breast mass or lump	☐ Blood clotting disorder	☐ Sickle cell anemia

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

- ☐ Breast cancer
- ☐ Ovarian cancer
- ☐ Other cancer
- ☐ Heart disease, high blood pressure, stroke
- ☐ Blood clots in lungs or legs
- ☐ Menopause before age 40
- ☐ Diabetes
- ☐ Obesity
- ☐ Neural tube defect (spina bifida, anencephaly)
- ☐ Congenital heart defect
- ☐ Down syndrome
- ☐ Mental retardation or autism
- ☐ Any genetic disease including Cystic Fibrosis, Spinal Muscular Atrophy, Sickle Cell Disease, Tay-Sachs Disease
- ☐ Other birth defect not listed above

Comments: _____

What is your ethnic background?

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

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 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 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: _____

What is your occupation: _____

What is your ethnic background?: _____

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

Signature of physician reviewing form: _____ **Date Reviewed:** _____