Nova In Vitro Fertilization

Comprehensive Medical History Form

Date:_____

Who referred you to our practice?

- ☐ Former Patient
- ☐ Friend
- ☐ SART Data
- ☐ Self-referral
- ☐ Yelp
- ☐ Physician - please list name:
- ☐ Internet Search- please specify what search terms:

Patient Information:

	Patient	Partner
Name:		
Date of Birth:		

Fertility Evaluation:

Duration of relationship: _____ years and ____ months

Duration of unprotected intercourse: ___ years and ____ months

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

How frequently do you and your partner have intercourse? _____ per week / _____ per month

Have you ever used a method to keep you from getting pregnant? ☐ Yes ☐ No

If yes, what method(s)?_____

Pregnancies (female):

Pregnancy	1st	2nd	3rd	4th
Mo/Yr of conception				
How long did it take to conceive?				
Gender				
Did your current partner sire the pregnancy?	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
Outcome	☐ Living ☐ Miscarriage ☐ Ectopic ☐ Abortion	☐ Living ☐ Miscarriage ☐ Ectopic ☐ Abortion	☐ Living ☐ Miscarriage ☐ Ectopic ☐ Abortion	☐ Living ☐ Miscarriage ☐ Ectopic ☐ Abortion

Female History:

Current weight _____ pounds

Height _____ feet _____ inches

How old were you when your periods first started? _____ years

Did you develop regular monthly periods at that time? ☐ Yes ☐ No

Do you have monthly menstrual periods now? ☐ Yes ☐ No

If yes, what is the usual number of days *between* the start of one period to the start of the next period? _____ days

Dates of the 1st day of your last 2 menstrual periods: ___/___/___ ___/___/___

How many menstrual periods do you have per year? _____

Do you have severe cramping or pelvic pain with your menstrual periods? ☐ Yes ☐ No

Do you have pain with intercourse? ☐ Yes ☐ No

Have you been diagnosed with endometriosis? ☐ Yes ☐ No

Have you ever had a pelvic infection? ☐ Yes ☐ No

Have you ever had any of the following sexually transmitted diseases or pelvic infections?

☐ Chlamydia ☐ Gonorrhea ☐ Genital Warts/HPV
☐ Syphilis ☐ Herpes

If known, what is the cause of your infertility?_____

Please complete the following table as accurately as possible, especially the "Physician/Clinic" column.

Test	Date(s)	Physician/Clinic	Results/Findings
Thyroid Test (TSH)			
Day 3 blood test for FSH/Estrogen			
AMH			
Prolactin level			
Hysterosalpingogram (X-Ray of Tubes/HSG)			
Sonohysterography (water ultrasound)			
Hysteroscopy			
Genetic Testing			

Medical history:

When was your last pap smear (month/year)? ___ / ___ ☐ Normal ☐ Abnormal

When was your last abnormal pap smear? ___ / ___ ☐ Not applicable

Do you perform self breast exams? ☐ Yes ☐ No

Have you ever had a mammogram? ☐ Yes ☐ No

When was your last mammogram? _____ month _____ year ☐ Normal ☐ Abnormal

Besides the tests and treatments listed above, have you had any surgery on your vagina, cervix, uterus, Fallopian tubes, ovaries or your abdomen? ☐ Yes ☐ No

If yes please list all surgeries in chronological order:

Year	Reason and Type of Surgery

Social History:

How many caffeinated beverages (coffee, soda, tea) do you drink per day? _____

On average how much water are you consuming daily? _____

Do you exercise regularly? ☐ Yes ☐ No
If yes, describe: _____

Do you smoke cigarettes or have you ever used tobacco products? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

Have you ever used illicit drugs? ☐ Yes ☐ No

Are you allergic to any foods? ☐ Yes ☐ No
If yes, describe: _____

Have you had significant weight change in the last year? ☐ Yes ☐ No

Emotional Status:

On a scale of 1-10 (10 being the worst), estimate the level of stress you feel due to infertility and other pressures: _____

Do you see a counselor? ☐ Yes ☐ No

List any anti-depressant/anti-anxiety medication you are currently taking:_____

Has your infertility produced marital or sexual dysfunction? ☐ Yes ☐ No

Family History:

Have any of these illnesses occurred in your family:

☐ High blood pressure ☐ Breast cancer ☐ Infertility
☐ Diabetes ☐ Ovarian cancer

Immunization History:

Chickenpox (Varicella): ☐ No ☐ Yes (dates:) ☐ Don't Know

MMR- Measles, Mumps, Rubella (German Measles): ☐ No ☐ Yes (dates:) ☐ Don't Know

Tetanus (Tdap): ☐ No ☐ Yes (dates:) ☐ Don't Know

Hepatitis B: ☐ No ☐ Yes (dates:) ☐ Don't Know

Polio: ☐ No ☐ Yes (dates:) ☐ Don't Know

Influenza: ☐ No ☐ Yes (dates:) ☐ Don't Know

Medications/Supplements:

Are you allergic to any medications? ☐ No ☐ Yes:_____

Are you currently taking any medications or supplements?

If yes please list below:

Medication/Supplement	Start Date	Dose

Prior Treatment: please check all that apply

Treatment	# of Cycles	Dates: From (Mo/Yr) / To (Mo/Yr)	Outcome
☐ Intrauterine insemination (IUI)			☐ Pregnant: (☐ delivered ☐ ectopic) ☐ Miscarriage ☐ Not Pregnant
☐ Clomid or Femara / Letrozole with intercourse Max # tablets per day: ___			☐ Pregnant: (☐ delivered ☐ ectopic) ☐ Miscarriage ☐ Not Pregnant
☐ Clomid or Femara / Letrozole with insemination Max # tablets per day: ____			☐ Pregnant: (☐ delivered ☐ ectopic) ☐ Miscarriage ☐ Not Pregnant
☐ Daily fertility drug injections with insemination Max # vials per day: ____			☐ Pregnant: (☐ delivered ☐ ectopic) ☐ Miscarriage ☐ Not Pregnant
☐ Completed in vitro fertilization cycle(s):			
1. # eggs ____ #frozen ____ #embryos transferred ____			☐ Pregnant: (☐ delivered ☐ ectopic) ☐ Miscarriage ☐ Not Pregnant
2. # eggs ____ #frozen ____ #embryos transferred ____			☐ Pregnant: (☐ delivered ☐ ectopic) ☐ Miscarriage ☐ Not Pregnant
3. # eggs ____ #frozen ____ #embryos transferred ____			☐ Pregnant: (☐ delivered ☐ ectopic) ☐ Miscarriage ☐ Not Pregnant
4. # eggs ____ #frozen ____ #embryos transferred ____			☐ Pregnant: (☐ delivered ☐ ectopic) ☐ Miscarriage ☐ Not Pregnant
☐ Frozen embryo transfer(s):			
1. # eggs ____ #frozen ____ #embryos transferred ____			☐ Pregnant: (☐ delivered ☐ ectopic) ☐ Miscarriage ☐ Not Pregnant
2. # eggs ____ #frozen ____ #embryos transferred ____			☐ Pregnant: (☐ delivered ☐ ectopic) ☐ Miscarriage ☐ Not Pregnant
3. # eggs ____ #frozen ____ #embryos transferred ____			☐ Pregnant: (☐ delivered ☐ ectopic) ☐ Miscarriage ☐ Not Pregnant
4. # eggs ____ #frozen ____ #embryos transferred ____			☐ Pregnant: (☐ delivered ☐ ectopic) ☐ Miscarriage ☐ Not Pregnant
☐ Canceled in vitro fertilization attempt(s):			
☐ Any other prior treatment:			

Male History:

Male: pregnancies from previous marriage(s) or partner(s):

Pregnancy	1st	2nd	3rd	4th
Mo/Yr of conception				
How long did it take to conceive?				
Gender				
Outcome	☐ Living ☐ Miscarriage ☐ Ectopic ☐ Abortion	☐ Living ☐ Miscarriage ☐ Ectopic ☐ Abortion	☐ Living ☐ Miscarriage ☐ Ectopic ☐ Abortion	☐ Living ☐ Miscarriage ☐ Ectopic ☐ Abortion

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

Do you have difficulty with erections? ☐ Yes ☐ No

Do you have retrograde ejaculation of sperm into the bladder? ☐ Yes ☐ No

Have you ever had any of the following sexually transmitted diseases or pelvic infections?

- ☐ Chlamydia
- ☐ Syphilis
- ☐ Gonorrhea
- ☐ HIV/AIDS
- ☐ Herpes
- ☐ Hepatitis
- ☐ Genital Warts/HPV

Do you have a history of undescended testicles? ☐ Yes ☐ No

Do you have scrotal or testicular pain? ☐ Yes ☐ No

Have you had prior injury to your testicles requiring hospitalization? ☐ Yes ☐ No

Have you had a high fever in the last 3 months? ☐ Yes ☐ No

Have you had a vasectomy? ☐ Yes ☐ No

Have you had surgery for varicocele repair? ☐ Yes ☐ No

Have you had hernia surgery? ☐ Yes ☐ No

Did you undergo any bladder or penis surgery as a child? ☐ Yes ☐ No

Are you exposed to any radiation or harmful chemicals in the workplace? ☐ Yes ☐ No

Have you had chemotherapy for cancer? ☐ Yes ☐ No

Have you ever used testosterone, androgel or androgenic hormones? ☐ Yes ☐ No

Please complete the following table as accurately as possible, especially the "Physician/Clinic" column.

Test	Date(s)	Physician/Clinic	Results
Semen Analysis			
Chromosomes (karyotype)			
Genetic Testing			

Medications/Supplements:

Are you allergic to any medications? ☐ No ☐ Yes:_____

Are you currently taking any medications or supplements?

If yes please list below:

Medication/Supplement	Start Date	Dose