# Infertility History Form

**IMPORTANT:**
Please complete this form and bring it with you to your scheduled visit.

This form was developed by the American Society for Reproductive Medicine to assist physicians and patients in obtaining a complete infertility history. It consists of three parts:
- Part I: Contact information
- Part II: Your medical history
- Part III: Your male partner’s medical history (if applicable)

## PART I: CONTACT INFORMATION

<table>
<thead>
<tr>
<th>First Name</th>
<th>Middle Initial</th>
<th>Last Name</th>
<th>Age</th>
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<tbody>
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</tbody>
</table>

Date of Birth (MM/DD/YY) ______/_____/__________  Occupation ___________________________

Home Street Address ____________________________________________

City ___________________  State_____  Zip/Postal Code_____________ Country _______________

Indicate which number to call or leave messages.
- [ ] Home Telephone (  )_______________
- [ ] Work Telephone (  )_______________
- [ ] Cell Phone (  )______________

Do you have a male partner?  [ ] Yes  [ ] No

<table>
<thead>
<tr>
<th>Male Partner’s First Name</th>
<th>Middle Initial</th>
<th>Last Name</th>
<th>Age</th>
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</table>

Date of Birth (MM/DD/YY) ______/_____/__________  Occupation ___________________________

Home Street Address ____________________________________________

City ___________________  State_____  Zip/Postal Code_____________ Country _______________

Indicate which number to call or leave messages.
- [ ] Home Telephone (  )_______________
- [ ] Work Telephone (  )_______________
- [ ] Cell Phone (  )______________

By whom were you referred?
- [ ] Physician
  - Name ____________________________  Phone (  ) _____________
  - Address ____________________________

- [ ] Former Patient/Friend
- [ ] Web Site
- [ ] Insurance (Name of Insurance)

Who is your Ob/Gyn?
- Name ____________________________  Phone (  ) _____________
  - Address ____________________________

Who is your Primary Care Physician?
- Name ____________________________  Phone (  ) _____________
  - Address ____________________________

---

**For Office Use Only**

Physician Notes
(for office use only)

______________________________

______________________________

______________________________

______________________________

______________________________

______________________________
PART II: FEMALE MEDICAL HISTORY AND INFORMATION

Reason for Visit: □ Infertility Evaluation □ Sperm Insemination □ Other ____________________________

How many months have you been trying to conceive (unprotected intercourse or inseminations)? _____

Pregnancy Summary
• Total Number of ALL Preganancies: ______
• Number of Full Term Deliveries: ______ Of these, how many were live births? ___ How many were stillborn? ___
• Number of Premature (less than 37 weeks) Deliveries: ______ Of these, how many were live births? ___ How many were stillborn? ___
• Number of Miscarriages (less than 20 weeks): ______
• Number of Ectopic/Tubal Pregnancies: ______
• Number of Elective Terminations (Abortions): ______
• Any Pregnancies with Birth Defects? □ No □ Yes - explain _______________________________________

Menstrual History
• Menstrual cycle pattern (check all that apply): □ Regular periods □ Irregular periods □ Spotting before periods □ No periods
   □ Heavy periods □ Light periods □ Bleeding between periods
   • Number of days between the start of one period to the start of the next period: ______ days
   • How many days of bleeding do you have? ______ days
   • Dates of the 1st day of your last 2 menstrual periods: _____ / _____ / _____; _____ / _____ / _____
   • Age when you had your first period: ______ years old
   • Age when you first noticed: Breast development: ______ years old Pubic hair: ______ years old Underarm hair: ______ years old
   • How many periods do you have per year? ______
   • Do you need medication to bring on a period? □ Yes - what type? __________________________ □ No
   • If you do not have periods, at what age did you stop having them? ______ years old
   • Do you have severe cramping or pelvic pain with your periods? □ Yes: Always__ Sometimes__ Recently__ In the past__ □ No

Contraceptive History
□ None □ Condoms - dates of use__________ □ Diaphragm - dates of use__________ □ IUD - dates of use__________
□ Birth control pills - dates of use__________ - complications?________________________
□ Injectable contraception (Depo-Provera®, Lunelle™, etc.) - dates of use__________ - complications?________________________
□ Skin patch - dates of use__________ - complications?________________________
□ Foam or Jelly  □ Tubal sterilization procedure (tubes tied) - date (month/year)_____/_____
□ Tubes untied - date (month/year)_____/_____

Did your mother take DES when she was pregnant with you? □ Yes □ No □ Don’t know

Sexual History
• How many times do you have intercourse per week? ______ times per week □ None □ Not applicable
• Have you used over-the-counter ovulation kits to time intercourse? □ Yes □ No
• Do you have pain with intercourse? □ Yes □ No
• Do you use lubricants (K-Y Jelly®, etc.) during intercourse? □ Yes - what types?________________________ □ No

Any prior exposure to sexually transmitted diseases or pelvic infections?
□ Yes (check all that apply) □ No
□ Chlamydia - date______ □ Gonorrhea - date______ □ Herpes - date______  Genital warts/HPV - date______
□ Syphilis - date______ □ HIV/AIDS - date______ □ Hepatitis - date______

Physician Notes (for office use only) ____________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
Pap Smear History
• When was your last pap smear (month and year)?_____/_____ □ Normal □ Abnormal
• When was your last abnormal pap smear? _____ □ Not applicable

Have you undergone any procedures as a result of an abnormal pap smear?
□ Yes (check all that apply) □ No
□ Colposcopy □ Cryosurgery (Freezing) □ Laser treatment □ Conization □ LEEP procedure

Breast Screening History
Have you ever had a mammogram? □ No □ Yes - date_____ Result: □ normal □ abnormal - explain ________________
Do you perform self breast exams? □ Yes □ No

Medical History
• Are you allergic to any medications? □ No □ Yes (Please list and describe reactions) __________________________________________

• Are you allergic to any foods (peanuts, eggs, etc.)? □ No □ Yes (Please list and describe reactions) __________________________________________

• List any medications you are currently taking, including over the counter medicines. __________________________________________

• Do you take any herbal medicines/vitamins or health food store supplements? □ No □ Yes (Please list) __________________________

• Do you have any medical problem(s)? □ No □ Yes (Please list type, dates, and treatments.)
  (1)__________________________________________________________________________
  (2)__________________________________________________________________________
  (3)__________________________________________________________________________
  (4)__________________________________________________________________________
  (5)__________________________________________________________________________

• Did you have either of these childhood illnesses? □ Chickenpox (Varicella) □ German Measles (Rubella) □ Don’t know
Other childhood diseases: ____________________________________________________________________________

Vaccinations
• Chickenpox (Varicella): □ No □ Yes (dates_______) □ Don’t know
• MMR - Measles, Mumps, and Rubella (German Measles): □ No □ Yes (dates_______) □ Don’t know
• BCG (Tuberculosis): □ No □ Yes (dates_______) □ Don’t know
• Hepatitis B: □ No □ Yes (dates_______) □ Don’t know
• Polio: □ No □ Yes (dates_______) □ Don’t know
• Hepatitis A: □ No □ Yes (dates_______) □ Don’t know
• Tetanus: □ No □ Yes (dates_______) □ Don’t know
• Influenza: □ No □ Yes (dates_______) □ Don’t know

Social History
• How many caffeinated beverages (coffee, tea, soda) do you drink per day? _____ □ None
• Do you smoke cigarettes? □ No □ Yes How many/day?_____ How many years?______ □ Quit - when?______________
• Do you drink alcohol? □ No □ Yes
  □ Beer - # per week_____ □ Wine - # per week_____ □ Liquor - # per week_____ 
• Do you use any marijuana, cocaine, or any other similar drug? □ No □ Yes (describe____________________)
• Do you exercise? □ No □ Yes (describe____________________)
• Are you aware of any radiation exposures other than X-rays? □ No □ Yes (describe____________________)

Physician Notes (for office use only) ____________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
Surgical History

• Have you had any surgeries? □ No □ Yes (List all surgeries in chronologic order.)

<table>
<thead>
<tr>
<th>Year</th>
<th>Reason and Type of Surgery</th>
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</tbody>
</table>

• Did you have any anesthesia problems? □ No □ Yes (describe ________________________________)

Physical Symptoms

General:
□ Recent weight gain or loss
□ Anorexia/Bulimia
□ Lack of energy
□ Fever/Chills
□ Other______________________
□ None

Endocrine/Hormonal:
□ Diabetes □ Hair loss
□ Thyroid gland problems
□ Rapid weight gain or loss
□ Excessive hunger/thirst
□ Temperature intolerance–hot flashes or feeling cold
□ Other______________________
□ None

Gastrointestinal:
□ Nausea/Vomiting □ Ulcers
□ Hepatitis □ Diarrhea
□ Blood in your stools □ Constipation
□ Irritable Bowel Syndrome
□ Change in bowel habits
□ Colitis (ulcerative or Crohn’s)
□ Other______________________
□ None

Musculoskeletal:
□ Unusual muscle weakness
□ Decreased energy/stamina
□ Rheumatoid arthritis
□ Lupus Erythematosus
□ Myasthenia gravis
□ Other______________________
□ None

Mental Health Problems:
□ Depression □ Anxiety disorder
□ Schizophrenia
□ Other______________________
□ None

Head, Eyes, Ears, Nose and Throat:
□ Dizziness □ Loss of sense of smell
□ Headaches □ Chronic nasal congestion
□ Blurred vision □ Ringing ears
□ Hearing loss/deafness
□ Other______________________
□ None

Respiratory:
□ Shortness of breath
□ Asthma □ Bronchitis
□ Pneumonia □ Tuberculosis
□ Bloody cough
□ Other______________________
□ None

Neurological Problems:
□ Weakness/Loss of balance
□ Seizures/Epilepsy
□ Headaches
□ Migraine headaches
□ Numbness
□ Memory loss
□ Other______________________
□ None

Skin/Extremities:
□ Unexplained rash/inflammation
□ Acne
□ Skin cancer
□ Burn injury
□ Moles changing in appearance
□ Excess hair growth
□ Other______________________
□ None

Cardiovascular:
□ Palpitations/Skipped beats
□ Chest pain □ Heart attack
□ Stroke □ Murmurs
□ High blood pressure
□ Rheumatic fever
□ Mitral valve prolapse (Need antibiotics before dental procedures? Yes___ No___
□ Other______________________
□ None

Physician Notes (for office use only)
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Page 4
### Family History

<table>
<thead>
<tr>
<th>Relationship to You</th>
<th>Yes - age___</th>
<th>No</th>
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<tbody>
<tr>
<td>□ Mother</td>
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<tr>
<td>□ Father</td>
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<tr>
<td>□ Brother(s)</td>
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<td>□ Sister(s)</td>
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<tr>
<td>□ Maternal Grandmother</td>
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<td>□ Maternal Grandfather</td>
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<td>□ Paternal Grandmother</td>
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<td>□ Paternal Grandfather</td>
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<tr>
<td>□ Relationship to</td>
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<tr>
<td>□ Cause of Death/Age at Death</td>
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</tbody>
</table>

### Disorders in Your Family

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Relationship to You</th>
<th>Yes - age___</th>
<th>No</th>
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<tbody>
<tr>
<td>□ Breast cancer</td>
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<tr>
<td>□ Ovarian cancer</td>
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<td>□ Colon cancer</td>
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<td>□ Other cancer</td>
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<tr>
<td>□ Diabetes</td>
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<td>□ Thyroid problems</td>
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<td>□ Heart disease</td>
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<td>□ Blood clots</td>
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<td>□ Obesity</td>
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<td>□ Psychiatric problems</td>
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<td>□ Tuberculosis</td>
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<td>□ Endometriosis</td>
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<td>□ Infertility</td>
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<td>□ Menopause before age 40</td>
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<tr>
<td>□ Birth defects</td>
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<tr>
<td>□ Cystic Fibrosis</td>
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<tr>
<td>□ Tay-Sachs disease</td>
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<td>□ Canavan disease</td>
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<td>□ Bloom syndrome</td>
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<td>□ Gaucher disease</td>
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<tr>
<td>□ Niemann-Pick disease</td>
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<tr>
<td>□ Fanconi Anemia</td>
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<tr>
<td>□ Familial Dysautonmia</td>
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<tr>
<td>□ Muscular Dystrophy</td>
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<tr>
<td>□ Neurologic (brain/spine)</td>
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<tr>
<td>□ Neural Tube Defects</td>
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<td>□ Bone/Skeletal Defects</td>
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<tr>
<td>□ Dwarfism</td>
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<td>□ Developmental delay</td>
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<td>□ Learning problems</td>
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<td>□ Polycystic kidney disease</td>
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<td>□ Heart defect from birth</td>
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<tr>
<td>□ Down syndrome</td>
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<tr>
<td>□ Other chromosome defects</td>
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<tr>
<td>□ Marfan syndrome</td>
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<td>□ Hemophilia</td>
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<td>□ Sickle Cell Anemia</td>
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<tr>
<td>□ Thalasemia</td>
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<tr>
<td>□ Galectosemia</td>
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<tr>
<td>□ Deafness/Blindness</td>
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<tr>
<td>□ Color Blindness</td>
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<tr>
<td>□ Hemochromatosis</td>
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☐ None of the above ☐ Other (Specify _______________________________)

### What is your Ancestry?

- ☐ African-American
- ☐ American Indian/Native American
- ☐ Ashkenazi Jewish
- ☐ Asian-American
- ☐ Cajun/French Canadian
- ☐ Caucasian
- ☐ Eastern European
- ☐ Hispanic/Caribbean
- ☐ Northern European
- ☐ Southern European
- ☐ Other (specify__________________________)

Page 5
**PRIOR INFERTILITY TESTING AND TREATMENT**

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

**Prior Tests** (check all that apply):
- Basal body temperature chart (date__/results____________________)  
- Thyroid test (date__/results____________________)  
- Ovulation test kit (date__/results____________________)  
- Day 3 blood test for FSH level (date__/results____________________)  
- Hysterosalpingogram (HSG) (date__/results____________________)  
- Laparoscopy surgery (date__/results____________________)  
- Hysteroscopy surgery (date__/results____________________)  
- Progesterone blood test (date__/results____________________)  
- Prolactin blood test (date__/results____________________)

**Prior Treatment** (check all that apply):

<table>
<thead>
<tr>
<th>Intrauterine insemination:</th>
<th># of cycles</th>
<th>Dates (mo/year)</th>
<th>(mo/year)</th>
<th>Pregnant</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td>From__/____ to__/____</td>
<td></td>
<td>Yes___ No___</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Clomiphene citrate with timed intercourse:</th>
<th># of cycles</th>
<th>Dates (mo/year)</th>
<th>(mo/year)</th>
<th>Pregnant</th>
</tr>
</thead>
<tbody>
<tr>
<td>maximum # tablets per day?____</td>
<td></td>
<td>From__/____ to__/____</td>
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<td>Yes___ No___</td>
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</table>

<table>
<thead>
<tr>
<th>Clomiphene citrate with insemination:</th>
<th># of cycles</th>
<th>Dates (mo/year)</th>
<th>(mo/year)</th>
<th>Pregnant</th>
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<tbody>
<tr>
<td>maximum # tablets per day?____</td>
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<td>From__/____ to__/____</td>
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<td>Yes___ No___</td>
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<tr>
<th>Daily fertility drug injections with insemination:</th>
<th># of cycles</th>
<th>Dates (mo/year)</th>
<th>(mo/year)</th>
<th>Pregnant</th>
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<tbody>
<tr>
<td>maximum # vials per day?____</td>
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<td>From__/____ to__/____</td>
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<td>Yes___ No___</td>
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<tr>
<th>Completed in vitro fertilization cycle(s):</th>
<th># of cycles</th>
<th>Dates (mo/year)</th>
<th>(mo/year)</th>
<th>Pregnant</th>
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<tbody>
<tr>
<td>1. # eggs___ # embryos transferred___ # frozen___</td>
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<td>__/____</td>
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<td>Yes___ No___</td>
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<td>2. # eggs___ # embryos transferred___ # frozen___</td>
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<td>__/____</td>
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<td>Yes___ No___</td>
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<td>3. # eggs___ # embryos transferred___ # frozen___</td>
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<td>__/____</td>
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<td>Yes___ No___</td>
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<td>4. # eggs___ # embryos transferred___ # frozen___</td>
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<td>__/____</td>
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<td>Yes___ No___</td>
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<tr>
<th>Frozen embryo transfers:</th>
<th># of cycles</th>
<th>Dates (mo/year)</th>
<th>(mo/year)</th>
<th>Pregnant</th>
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<tbody>
<tr>
<td>1. # embryos transferred___</td>
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<td>__/____</td>
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<td>Yes___ No___</td>
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<td>2. # embryos transferred___</td>
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<td>Yes___ No___</td>
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<tr>
<td>3. # embryos transferred___</td>
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<td>__/____</td>
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<td>Yes___ No___</td>
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<tr>
<td>4. # embryos transferred___</td>
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<td>__/____</td>
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<td>Yes___ No___</td>
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Canceled in vitro fertilization attempt(s) ____

- Additional Information/Complications ______________________________________
  ______________________________________
  ______________________________________

**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
- Describe any emotional, marital, or sexual problems caused by your infertility. ______________________________________
  ______________________________________
  ______________________________________
  ______________________________________

**PATIENT’S SIGNATURE__________________________________________________ DATE____________________

I confirm that I have reviewed the information above.

**PHYSICIAN’S SIGNATURE____________________________________ DATE____________________
### PART III: MALE PARTNER MEDICAL HISTORY AND INFORMATION

Complete with your male partner if applicable.

- **Have you been evaluated by a urologist?**
  - Yes
  - No

- **Have you previously conceived with another woman?**
  - Yes: How many times?_____
  - No: Birth control used? Yes___  No___

- **Have you had a semen analysis?**
  - Yes
  - No

- **Do you have difficulty with erections?**
  - Yes
  - No

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

- **Any prior exposure to sexually transmitted diseases or infections?**
  - Yes (check all that apply)
    - Chlamydia - date_____
    - Gonorrhea - date_____
    - Herpes - date_____
    - Genital warts/HPV - date_____
    - Syphilis - date_____
    - HIV/AIDS - date_____
    - Hepatitis - date_____

- **Have you had a history of undescended testicles?**
  - Yes - One side___  Both___
  - No

- **Do you have scrotal or testicular pain?**
  - Yes
  - No

- **Did you have the mumps after puberty?**
  - Yes
  - No

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

- **Have you been diagnosed with any of the following diseases?**
  - Diabetes Mellitus - Yes___  No___
  - Cancer - Yes___  No___
  - Multiple Sclerosis - Yes___  No___
  - Other neurologic problems - Yes___  No___
  - Prostatic infections - Yes___  No___
  - Urinary infections - Yes___  No___
  - High Blood Pressure - Yes___  No___
  - If yes, any medications?__________________________

- **Have you had any fever in the last 3 months?**
  - Yes
  - No

- **Have you had a vasectomy?**
  - Yes (date_____)  No
  - If yes, have you had a vasectomy reversal? Yes (date_____)  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 prolonged heat in the workplace?**
  - Yes
  - No

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

- **Have you had chemotherapy for cancer?**
  - Yes
  - No

- **Are you allergic to any medications?**
  - No
  - Yes (Please list and describe reactions) ________________________________

- **List your current medications:**
  __________________________________________________________

- **List any current medical problem(s):**
  __________________________________________________________

- **How many caffeinated beverages do you drink per day?**
  - None

- **Do you smoke cigarettes?**
  - No
  - Yes (How many/day?_____
  - How many years?_____
  - Quit - when?_______________

- **Do you drink alcohol?**
  - No
  - Yes
    - Beer - # per week_____
    - Wine- # per week_____
    - Liquor - # per week_____

- **Do you use marijuana, cocaine, or any other similar drug?**
  - No
  - Yes (describe__________________________)

- **Do you use herbal medicines/vitamins or health food store supplements?**
  - No
  - Yes (describe__________________________)

- **Are you aware of any radiation/toxic materials exposure?**
  - No
  - Yes

- **Do you use hot tubs regularly?**
  - Yes
  - No

- **Did your mother take DES during pregnancy to prevent miscarriage?**
  - Yes
  - No
  - Don’t know

- **Have any of your immediate family members had difficulty conceiving a child?**
  - Yes
  - No

  If yes, please describe__________________________________

---

**Physician Notes (for office use only)**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
### Disorders in Your Family

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Relationship to You</th>
<th>Yes</th>
<th>No</th>
<th>Don’t Know</th>
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<tbody>
<tr>
<td>Cystic Fibrosis</td>
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<td>Tay-Sachs disease</td>
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<td>Bloom syndrome</td>
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<td>Gaucher disease</td>
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<td>Niemann-Pick disease</td>
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<td>Fanconi Anemia</td>
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<td>Familial Dysautonnia</td>
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<td>Neurologic (brain/spine)</td>
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<td>Bone/Skeletal Defects</td>
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☐ None of the above ☐ Other (Specify _____________________________)

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### What is your Ancestry?

- African-American
- American Indian/Native American
- Ashkenazi Jewish
- Asian-American
- Cajun/French Canadian
- Caucasian
- Eastern European
- Hispanic/Caribbean
- Northern European
- Southern European
- Other (specify_________)

---

### MALE PARTNER’S SIGNATURE __________________________ DATE __________________

I confirm that I have reviewed the information above.

PHYSICIAN’S SIGNATURE __________________________ DATE __________________

---

### Physician Notes (for office use only)

______________________________
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