ARKLATEX FERTILITY

Ark-La-Tex Fertility and Reproductive Medicine

Name___________________________________ Home Phone_____________________

Address________________________________ Work Phone______________________

DOB _______________ Age___________ Occupation__________________________

SS#________________ Married____ Single_____ Divorced_____ Widowed_____

Spouse/Partner Name_________________________

Referred by _________________ Referring physician address____________________________

Primary Care M.D.________________________

I am here today for the following reason(s):

_____ menstrual problems

_____ unable to conceive

_____ prior miscarriages

_____ reversal of tubal ligation

_____ menopause (hormonal therapy)

_____ excess hair growth

_____ breast problems

_____ other (explain below):

____

____

For Those Couples Seeking Infertility Services

How long have you been attempting to become pregnant? ___________ years.

Please circle prior testing you may have had previously:

a. Basal body temperature charts e. hysterosalpingogram b. blood hormone tests c. postcoital test

d. endometrial biopsy g. laparoscopy d. semen analysis h. hysteroscopy

What infertility diagnosis have you been given by your prior physician as to why pregnancy has not occurred? ____

Are you interested in information about adoption?____

Are you interested in counseling services or infertility/miscarriage support group? ______________

Clinician Use only Signature _____________________ Date ____________________

Menstrual History

Approximate age of 1st menstrual period_______________________________________

Starting date of last period____

Starting date of period before that____

Number of days that bleeding lasts____

Number of days from day 1 of period to day 1 of next period_______________________

Amount of menstrual bleeding (number of pads/tampons per day) ___________________

Do you ever have bleeding after intercourse? ___________________________________

Do you spot or stain before your period flow starts? ______________________________

Do you have cramps with your period? YES NO

If yes, are your cramps getting worse? ____

Is intercourse painful? ____

Do you have pelvic pain when not menstruating? ________________________________

If you have had menopause, at what age? ______________________________________

Gynecologic History

Date of: Last pelvic exam _________________________

Last pap smear __________________________, Was it normal? ___________

Have you ever had a mammogram? YES NO. If so, when and was it normal? _________

Have you ever had and abnormal of the following: (If yes, when? ________________)

Hair growth pattern	Yes________________	No_______________
Breast discharge	Yes________________	No_______________
Pap smear	Yes________________	No_______________

If yes, did you have your cervix frozen, cone resected, lasered, or LEEP resected?
____

Have you ever been treated for: (If yes, when? _________)

Gonorrhea	Yes________________	No________________
Syphilis	Yes________________	No________________
Herpes	Yes________________	No________________
Chlamydia	Yes________________	No________________

Have you been tested for the AIDS virus? ______________ If so, when? ______________

Have you ever used:	Birth Control Pills	Yes_____	No_______
	Intrauterine device	Yes_____	No_______
	Diaphragm	Yes_____	No_______

Please list dates and name of birth control pill or IUD used if you can: __________________________

____

Clinician Use only Signature _____________________ Date ____________________

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Obstetrics History

Please list all your pregnancies including miscarriages or abortions:

Date	# weeks pregnant	Miscarriage	Abortion	Type of Delivery, vaginal or C/S	Living	Complications

What is your blood type if known? __________ If you are Rh negative, did you have Rhogam with prior pregnancies? __________ Husbands blood type? ______________

Medical History

Do you have any medication or food allergies? If so, please list ______________________________
____

Please list any medications you currently or intermittently take including dosage:____
___________________ ____

Do you usually take antibiotics before surgeries or dental procedures? YES NO

Have you ever had?

Rubella (German measles)	YES	NO	Measles	YES	NO
Chicken Pox	YES	NO	Hepatitis	YES	NO

Do you have a history of (please check):

Stroke	_______	Gall bladder disease	_______
Seizure disorder	_______	Bowel problems	_______
Emotional problems	_______	Kidney infections	_______
High blood pressure	_______	Kidney stones	_______
Diabetes	_______	Bladder infections	_______
Heart disease	_______	Loss of urine	_______
Heart murmur	_______	Liver problems	_______
Asthma	_______	Arthritis	_______
Tuberculosis	_______	Easy bruising	_______
Thyroid disease	_______	Cancer	_______
Hepatitis	_______	Rheumatic fever	_______
Ulcers	_______	Other	_______

For any diseases checked, please list treatments and dates: _________________________

Surgical History

Have you had any surgery specifically on the uterus, fallopian tubes, ovaries, or bowels?

Type	Year	Reason for surgery

Have you had any other types of surgery?

Type	Year	Reason for surgery

Other hospitalizations or serious illness? _______________________________________

Family History and Genetic Screening

My ethnic background is:
- African American _______
- Italian, Greek, or Mediterranean _______
- Eastern European Jewish _______
- Philippine or Southeast Asian _______
- Northern European/Caucasian _______

Have you been tested for:
- Tay-Sachs _______
- Sickle Cell Trait _______
- Alpha-thalassemia minor _______
- Beta-thalassemia minor _______

Does anyone in your family have the following problems?

Infertility _____
Recurrent miscarriage _____
Cystic Fibrosis _____
Sickle cell trait/dis. _____
Tay-Sachs _____
any birth defect _______
Adult cystic kidney disease_______
Adult neurologic disease _______
Muscular dystrophy _______
Spinal bifida _______

Clinician Use only Signature _____________________ Date ____________________

Thalassemia _____ Neural tube defects _______

Cont. from page 4

Club foot _____ Brain or leg blood clots _______

Cleft lip or palate _____ Heart birth defects _______

Mental illness _____ Mental retardation _______

If answered yes to any of the above, how are you related to the person? _________________________

Is there a family history of cancer of the cervix, uterus, ovary, or breast? _____________

If yes, please list the type of cancer, relationship to you, treatment, and whether living or deceased
____

Did your mother take Diethylstilbestrol (DES) while pregnant with you? ____________

Have you or anyone in your family had an adverse reaction to anesthesia? ____________

Social History

Do you now or have you ever smoked cigarettes? ________________________________

If yes, how many packs per day and for how many years? __________________________

Do you drink alcohol? ______________ If so, how many drinks per week? _____________

Do you now or have you ever used recreational drugs? ____________________________

If yes, what drug, when, and how much? ____

Have you ever worked with toxic chemicals, heavy metals, or ionizing radiation? When, which, and how long? ____

Do you exercise? _____________ If so, how many hours per week? ___________________

Are you married? _____________ If so, how long? _________________________________

If not married, are you sexually active? _____________ Contraceptive type? ____________

Primary Care Surveillance

Are your childhood immunizations up to date? YES NO DON'T KNOW

Last cholesterol test: _______________

Last fecal blood test: _______________

Last tetanus shot: __________________

Domestic safety screening:

1. Do you feel safe in your home? _______ yes _______no.

2. Are you now or have you been a victim of abuse? _______ yes _______no

3. Are there issues you or your partner would like to discuss alone with a clinician?

_______ yes _______no

Clinician Use only Signature ______________________ Date ____________________

General health screening questions:

1. Has your weight changed by more than 10 pounds in the last 30 days? ___yes ___no

2. If yes, were you attempting to lose weight? _______ yes _______no

3. Do you suffer from any of the following problems?

   Chronic nausea and/or vomiting? _______ yes _______no

   Chronic constipation? _______ yes _______no

   Chronic diarrhea? _______ yes _______no

4. Do you have difficulty performing activities of daily living such as:

   Dressing yourself? ________ yes _______no

   Walking? _______ yes _______no

   Eating? _______ yes _______no

   Feeding yourself? _______ yes _______no

5. Are there any health problems that you would like to discuss with our physician or nurse today that you have not addressed with your primary care physician?

____
____
____

Clinician Use only Signature ____________________ Date ___________________

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Male's History

Name___________________________________ Home Phone_____________________________________

Address_________________________________ Work Phone______________________________________

DOB _______________ Age___________ Occupation__________________________ SS#_____________

Have you ever had:	YES	NO
Mumps involving the testicles	_______	_______
Injury to the testicles	_______	_______
Birth defects involving the penis or testicles	_______	_______
Prostate trouble	_______	_______
Diabetes or other endocrine disorder	_______	_______
Gonorrhea or syphilis	_______	_______
Surgery of the pelvis, testes, or hernia repair	_______	_______

If yes to any above, please list and explain including dates____

Have you ever fathered a pregnancy (including elective abortions or miscarriages)? ____________

If yes, when and time to conceive____

Have you tried to achieve a pregnancy with a prior partner? ________ For how long? __________

Frequency of intercourse per week? _______________

How often does intercourse result in ejaculation?

0%_______ 25%_______ 50%_______ 75%_______ > 90% of the time______

Have you had a sperm count? _________ When? ___________________

Did it show: normal results_____ decreased sperm numbers _____

abnormal sperm motility______ dead sperm_____ abnormal sperm shape____

Do you have difficulty with?

Premature ejaculations	YES	NO
Difficulty maintaining an erection	YES	NO
Difficulty penetrating the vagina	YES	NO

Male Social History

Do you now or have you ever smoked cigarettes? ________________________________

If yes, how many packs per day and for how many years? ___________________

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Do you now or have you ever used recreational drugs? _______________________________________

If yes, what drug, when, and how much? ____

Have you ever worked with toxic chemicals, heavy metals, or ionizing radiation? When, which, and how long? ____

Do you exercise? _____________ If so, how many hours per week? _________________

Male Family History and Genetic Screening

My ethnic background is?	African American	_______
	Italian, Greek, or Mediterranean	_______
	Eastern European Jewish	_______
	Philippine or Southeast Asian	_______
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Have you been tested for?	Tay-Sachs	_______
	Sickle Cell Trait	_______
	Alpha-thalassemia minor	_______
	Beta-thalassemia minor	_______

Does anyone in your family have the following problems?

Infertility	_____	Any birth defect	_______
Recurrent miscarriage	_____	Adult cystic kidney disease	_______
Cystic Fibrosis	_____	Adult neurologic disease	_______
Sickle cell trait/dis.	_____	Muscular dystrophy	_______
Tay-Sachs	_____	Spinal bifida	_______
Thalassemia	_____	Neural tube defects	_______
Club foot	_____	Brain or leg blood clots	_______
Cleft lip or palate	_____	Heart birth defects	_______
Mental illness	_____	Mental retardation	_______

If answering yes to any of the above, how are you related to the person? ___________________________

____

Did your mother take Diethylstilbestrol (DES) while pregnant with you? ___________________________

List any significant illnesses you have had____

____

List any medications taken in the last year____

Clinician Use only Signature ______________________ Date _____________________

____

Clinician Use only Signature _______________________ Date ______________________