LOS LIVOS
WOMEN'S MEDICAL GROUP

Infertility History Form

Date form completed: _____

Patient's name: _____ Partner's name:_____

Age: _____Date of Birth: _____ Age: _____Date of Birth:_____

Occupation: _____ Occupation:_____

Prior marriage: Yes__ No___ #_____ Prior marriage: Yes__ No___ #_____

Attempted pregnancy prior marriage? Yes __No___ Attempted pregnancy prior marriage? Yes___ No___

Ethnic origin_____ Ethnic Origin: _____

Woman's Medical History

1. Reason for visit: ____Infertility _____Donor Insemination _____Recurrent pregnancy Loss
   ____Other:_____
2. Duration of infertility: _____months.

Pregnancy History

1. Number of pregnancies:_____
2. Number of pregnancies greater than 20 weeks:_____
3. Number of pregnancies less than 20 weeks:_____
4. Number of tubal pregnancies (ectopic):_____
5. Number of elective termination of pregnancies:_____
6. Number of living children:_____

Date of delivery	Months to conceive	Vaginal or C-Section	Fathered by Current Partner?
_____	_____	_____	Y____N_____
_____	_____	_____	Y____N_____
_____	_____	_____	Y____N_____

7. Date of Miscarriage or termination | Months to conceive | Weeks of Pregnancy | D&C | Fathered by Current Partner?

_____	_____	_____	Y___N___	Y___ N____
_____	_____	_____	Y___N___	Y___ N____
_____	_____	_____	Y___N___	Y___ N____
_____	_____	_____	Y___N___	Y___ N____

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Menstrual History

Date of last period ____/____/____

1. Are your periods:
   ____heavy ___normal ___light
   ____regular ____irregular Days from start to start_____
2. Do you have spotting between periods? ____Yes ____No
   ____after period ____before period ____mid cycle
3. Do you have severe pain with periods?
   ____Yes ____No _____Sometimes ____Always

Sexual History

1. How often do you have intercourse during your fertile period?
   _____# times per week.
2. Do you have pain with intercourse?
   _____Yes _____No _____Sometimes _____Always
3. Do you use lubrication during intercourse?
   _____No ____Yes Name_____
4. Do you use an ovulation kit to time intercourse?
   _____Yes _____No

Medical History

1. Do you have any medical illnesses?
   _____Yes _____No
   Please list: _____
   _____
2. Do you take any routine medications, including herbal preparations? _____Yes _____No
   Please list: _____
   _____
   _____
3. Are you allergic to any medications?
   _____Yes _____No
   Please list: _____
   _____
   _____
4. Do you have any martial, sexual or emotional problems related to infertility?
   _____Yes _____No
5. Do you have any of the following medical conditions:
   Check all that apply
   ____Bleeding disorders
   ____Thrombophlebitis
   ____Pulmonary embolism (blood clot in lung)
   ____Antiphospholid syndrome
   ____Lupus
   ____Other collagen disease
   ____Diabetes
   ____High Blood Pressure
   ____Heart Disease

____Celiac Disease (gluten intolerance)
____Chronic Anemia
____Chronic Fatigue
____Osteoporosis
____Frequent Abdominal pain
____Frequent Diarrhea
____Eating Disorder
____Depression

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Surgical History

List all of your pelvic surgeries

Date	Type	Diagnosis
_____	_____	_____
_____	_____	_____
_____	_____	_____

Endocrine History

Do you have or have you had any of the following:
____Thyroid disease
____Hashimoto's disease
____Polycystic ovary disease
____Acne
____Increased facial or body hair
____Insulin resistance
____Gestational diabetes
____Hair loss
____Increased prolactin
____Inappropriate breast milk production

Social History

1. Do you smoke? ____No ____Yes: Amount? _____
2. Do you drink alcohol? ____No ____Yes: Amount? _____
3. Do you use recreational drugs? _____No ____Yes: Amount_____
   Type_____
   ___
4. Are you on a special diet? ____No ____Yes: Type?_____
   Do you exercise? _____No ____ Yes:
   Type and amount:
   _____
   _____
5. Have you had any of the following sexually transmitted infections?
   _____None
   Check all that apply
   ____Gonorrhea
   ____Chlamydia
   ____HPV (human papilloma virus)

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____Herpes
____Tubal infection (PID)
____HIV (AIDS)
____Hepatitis B
____Hepatitis C
____Mycoplasma or ureoplasma

Prior Infertility Testing

1. Blood hormone testing? _____Yes _____No ____unknown

Results:

___FSH _____
___Estradiol _____
___TSH _____
___Prolactin _____
___LH _____
___Inhibin B _____
___Anti Mullerian Hormone _____
___Fasting Glucose _____
___Fasting Insulin _____

2. Have you had any immunology or thrombophilia testing?
___Yes ___No ____unknown

3. Have you had any of the following tests?
Check all that apply:
___X-ray of tubes (HSG)
___Antral follicle count
___Sonohysterogram (saline ultrasound)
___Hysteroscopy
___Laparoscopy

Prior Infertility Treatment

1. Have you had any of the following treatments?

Clomiphene citrate: ____No ____Yes
#of cycles_____
Outcome: ____not pregnant ____pregnant ___miscarriage
Intrauterine inseminations: ___No ___Yes # of cycles____
Outcome: ___not pregnant ___pregnant ___miscarriage
Clomiphene and insemination: ____No ____Yes
# of cycles____
Outcome: ___not pregnant ____pregnant ____miscarriage
Gonadotropin and insemination: ____No ____Yes
# of cycles____
Outcome: ___not pregnant ___pregnant ____miscarriage

IVF (inVitro Fertilization) ___No ____Yes
# of cycles_____
Outcome: ___not pregnant ___pregnant ___miscarriage
Frozen Embryo Transfer: ___No ___Yes
#of cycles_____
Outcome: _____not pregnant ___pregnant ____miscarriage

Have you used donor eggs or donor sperm as part of your treatment?
____No ____Yes

Please list the names and approximate date of physicians you have seen for infertility:

_____
_____
_____

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Genetic History

1. Have you, your spouse or your families had a history of any of the following disorders? (check all that apply)
   ____Mental retardation
   ____Learning Problems
   ____Fragile X Syndrome
   ____Cystic Fibrosis
   ____Muscular dystrophy
   ____Thalassemia A or B
   ____Down's Syndrome
   ____Tay Sach's Disease
   ____Hemophilia
   ____Von Willebrand's disease
   ____Bleeding disorders
   ____Thrombophilia
   ____Blood clots in veins
   ____Celiac Disease
   ____Polycystic kidneys
   ____Hypospadias
   ____Other birth defects
   ____Cancer of breast, ovary or colon
   ____Menopause before age 40
   ____Bone defects
   ____Neural tube defects
   ____Sickle cell anemia
   ____None of the above