

# Medical History Form

**Reproductive Care Associates, PC (RCA) & Reproductive Care Center, PC (RCC)**

Date completed \_\_\_\_\_

*Please complete all sections of this questionnaire to the best of your ability. Your confidential answers will be reviewed by a clinician and will help to give you the best possible care. Mail or fax (801-878-8890) the completed form to RCA/RCC, 10150 Petunia Way (10150 S 1405 E) Sandy, UT 84092 so that it will arrive several days prior to your consult.*

What is the primary indication for your consultation (circle)? **Desire Fertility, Genetic Disease Prevention, Family gender balancing, Recurrent pregnancy loss (multiple miscarriages)** or **Other** (list) \_\_\_\_\_

What is the primary reason for your visit (circle)? **Desire: consultation, diagnostic evaluation, ovulation induction with oral agents, ovulation induction with injectable agents, IUI, IVF, ICSI, PGD, donor sperm, donor egg, donor embryo, gender selection, surgery, surrogacy, shared risk or Other** (list) \_\_\_\_\_

Please list other physicians or practices that you have consulted regarding this problem. \_\_\_\_\_

(To be completed by **both** the husband and the wife)

## Wife

## Husband

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Date of birth)                      (Age)

\_\_\_\_\_  
(Date of birth)                      (Age)

\_\_\_\_\_  
Occupation

\_\_\_\_\_  
Occupation

**Date of Marriage:** \_\_\_\_\_ **# of marriages for the wife** \_\_\_\_\_ **# for the husband** \_\_\_\_\_

**List all Pregnancies including miscarriages, abortions, ectopic pregnancies, and stillbirths (Wife):**

Pregnancy (include all)	Date Pregnancy ended or delivered MM/YY	How long to conceive? (months)	Gender	Is current husband the father? (Yes/No)	Is the child in good health?	Outcome (miscarriage, termination, ectopic, vaginal delivery, Cesarean section, or stillbirth)	Complications (high blood pressure, eclampsia, preeclampsia, diabetes, small for dates, placenta previa, infection, excessive blood loss, preterm labor, premature membrane rupture, early or late delivery, transfusion, Rh sensitization, multiples, etc.)
First							
Second							
Third							
Fourth							
Fifth							
Sixth							
Seventh							
Eighth							

**Husband:** Pregnancies from previous marriage(s) or partner(s), if any

Pregnancy (include all)	When? (Year)	How long to conceive?	Gender	Date of Birth	Is the child in good health?	Outcome (miscarriage, termination, ectopic, vaginal delivery, Cesarean section, or stillbirth) and list complications, if any
First						
Second						
Third						
Fourth						
Fifth						

**Husband and/or Wife:** All Adopted Children

Adopted Children	Gender of Child	Date of Birth of Child	Is the child in good health?
First			
Second			
Third			
Fourth			

**Contraceptive practices (past & current):**

**(yes)**

**(no)**

**(dates)**

Abstinence	_____	_____	_____
Condoms	_____	_____	_____
Cervical cap	_____	_____	_____
Depo-Provera <sup>®</sup> injection	_____	_____	_____
Diaphragm	_____	_____	_____
Foam/Jelly	_____	_____	_____
Implanon <sup>™</sup> implant	_____	_____	_____
Intrauterine device (IUD)	_____	_____	_____
Lunelle <sup>™</sup> injection	_____	_____	_____
Norplant <sup>™</sup> implant	_____	_____	_____
NuvaRing <sup>®</sup>	_____	_____	_____
Oral contraceptives/Pill	_____	_____	_____
Ortho Evra <sup>®</sup> Patch	_____	_____	_____
Rhythm	_____	_____	_____
Tubal ligation (tubes tied)	_____	_____	_____
Vasectomy (husband)	_____	_____	_____
Withdrawal	_____	_____	_____
Other methods	_____	_____	_____

# Female History

## Menstrual History

Age when you first noticed: Menses \_\_\_\_ Breast development \_\_\_\_ Pubic hair \_\_\_\_ Underarm hair \_\_\_\_

Dates of the 1<sup>st</sup> day of your last 3 menstrual periods \_\_\_\_\_

# of days from the **start** of one period to the **start** of the next (when you are not on oral contraceptives or other ovulation inducing medications): average \_\_\_\_ (28 is common) shortest \_\_\_\_ longest \_\_\_\_

Frequency of menses as a teenager or in your early 20's: average \_\_\_\_ shortest \_\_\_\_ longest \_\_\_\_

How many periods do you have per year currently? \_\_\_\_\_

Do you need medication to bring on a period? Yes No, If yes, what type \_\_\_\_\_

If you do not have periods currently, at what age did you stop? \_\_\_\_

How many days of bleeding (average) do you have? \_\_\_\_\_

	Mild/Light	Moderate	Severe/Heavy
Severity of menstrual cramps	_____	_____	_____
Amount of menstrual flow	_____	_____	_____

Medication taken for cramps: drug \_\_\_\_\_ amount \_\_\_\_\_ frequency \_\_\_\_\_

Does the cramping or bleeding prevent you from:	(yes)	(no)
going to work	_____	_____
participating in fun activities	_____	_____

Do you have midcycle:	(yes)	(no)
spotting	_____	_____
pain	_____	_____
increased cervical mucus	_____	_____

When was your last Pap smear? \_\_\_\_\_ Result \_\_\_\_\_

Have you ever undergone any procedures as a result of an abnormal pap smear (circle)?

Biopsy Colposcopy Cryosurgery (freezing) Laser treatment Cervical conization LEEP procedure

When was your last mammogram? \_\_\_\_\_ Result \_\_\_\_\_

**Sexual History:** Age at first intercourse: \_\_\_\_ Total number of prior sexual partners: \_\_\_\_

Duration of vaginal intercourse with your current husband without using any form of birth control: \_\_\_\_\_

How long have you been actively attempting pregnancy with your current husband? \_\_\_\_\_

Months of unprotected intercourse with **other** sexual partners without conceiving: \_\_\_\_ # of partners \_\_\_\_

Frequency of vaginal intercourse (circle all applicable answers):

None	less than 1/month	every 1-4 weeks	1-2/ week	2-3/ week	3-4/ week	4-5/ week	Daily	Clustered at midcycle	Weekends only
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Do you have pain with intercourse? Yes No If yes, is it: minimal moderate severe

Have you used urinary ovulation predictor kits (OPK)? Yes No What day(s) of cycle are they positive? \_\_\_\_\_

Lubricants (K-Y Jelly<sup>®</sup>, Replens<sup>®</sup>, Pre~seed<sup>®</sup>, etc) during intercourse? No Occasionally Frequently Always

**Do you have or have you ever had (check all that apply):**

<b>Infectious Problems</b>	√	<b>Medical Problems</b>	√	<b>Psychological Problems</b>	√	<b>Current Problems</b>	√
AIDS		anesthesia problems		anorexia		blood in urine	
chicken pox (varicella)		anemia		anxiety disorder		bloody cough	
chlamydia		appendicitis		bipolar disorder		blurred vision	
chronic bronchitis		arthritis		bulimia		bronchitis	
condyloma (genital warts)		asthma		depression		change in bowel habits	
cytomegalovirus (CMV)		bleeding disorders		hallucinations		chest pain	
German measles (rubella)		blood clots in legs		obsessive/compulsive		chronic nasal congestion	
gonorrhea		blood clot in lungs		psychosis		cold intolerance	
hepatitis A		blood transfusion		schizophrenia		constipation	
hepatitis B		burn injury		Other		contact with outdoor cats	
hepatitis C		cancer				diarrhea	
herpes: genital		celiac sprue		<b>Gynecologic Problems</b>	√	dizziness	
herpes: oral (cold sores)		colitis -ulcerative		abnormal mammogram		easy bruising	
HIV test positive		colitis – Crohn’s		abnormal pap smear		excessive thirst	
HPV – high risk types		deafness		blocked fallopian tube(s)		fever/chills	
human papilloma virus		diabetes		cervical stenosis		frequent urination	
nongonococcal urethritis		gained ≥15 lbs last year		DES exposure		heat intolerance	
pelvic infection (PID)		unusual/excessive hair loss		endometriosis		lack of energy/stamina	
PPD positive		hearing loss		Fibroids (myoma), uterine		memory loss	
rheumatic fever		heart attack		FSH, elevated		moles changing appearance	
Sexually transmitted disease		heart disease		hot flashes or night sweats		nausea/vomiting	
syphilis (RPR)		heart murmur		polycystic ovarian syndrome		numbness	
toxoplasmosis		high blood pressure		>12 small follicles/ovary		palpitations/skipped beats	
		irritable bowel syndrome		polyp, endometrial		rash/inflammation	
<b>Immunizations - common</b>	√	kidney infection		pelvic adhesions		ringing ears	
chickenpox (varicella)		liver problems		Rh negative blood type		shortness of breath	
hepatitis B (usually 3)		lost ≥15 lbs last year		intrauterine adhesions		swollen glands/lymph nodes	
influenza (yearly)		lung disease		uterine anomalies		unusual muscle weakness	
MMR		lupus erythematosus				weakness/loss of balance	
measles		mitral valve prolapse		<b>Obstetric Problems</b>	√		
mumps		myasthenia gravis		3 or more miscarriages		<b>Androgen Excess</b>	√
rubella (German Measles)		pneumonia		baby with birth defect		acne, mild	
polio		rheumatoid arthritis		gestational diabetes		acne, moderate	
DTP		sickle cell anemia/carrier		early delivery (<36 weeks)		acne, severe	
diphtheria		thalassemia		Eclampsia (seizure)		facial hair growth, mild	
tetanus (lock jaw)		thrombophlebitis		excessive blood loss		facial hair growth, moderate	
pertussis		thyroid problems		high blood pressure		facial hair growth, severe	
<b>Less common vaccines</b>		tuberculosis		infection		lower abdominal hair, mild	
pneumococcal		ulcers		late delivery		abdominal hair, moderate	
meningococcal				multiples		lower abdominal hair, severe	
BCG (tuberculosis – Asia)		<b>Genital-Urinary Problems</b>	√	placenta previa			
hepatitis A (usually 2)		leaking urine		preeclampsia		<b>Breast Problems</b>	√
HPV (Gardasil® or Cervarix®)		recurrent urinary infections		premature membrane rupture		augmentation	
		kidney disease		preterm labor		discharge	
<b>Neurological Problems</b>	√	recurrent vaginal infections		Rh sensitization		lumps	
lack of sense of smell				small for dates		pain	
migraine headaches				stillbirth		reduction	
seizures (epilepsy)				transfusion			
severe headaches							

Comments: \_\_\_\_\_

**Female History (cont.)**

Weight \_\_\_\_\_ Height \_\_\_\_\_ BMI (Body Mass Index) \_\_\_\_\_

Particular food diet or any special dietary habits? \_\_\_\_\_

How many times each week do you exercise? \_\_\_\_\_ What type of exercise do you do? \_\_\_\_\_

<b>Toxicant exposure:</b>	(yes)	(no)	(date last exposed)
caffeine	_____ drinks/day	_____	_____
alcohol	_____ drinks/week	_____	_____
marijuana	_____ joints/week	_____	_____
cocaine	_____ gm/week	_____	_____
other recreational "drugs"	_____	_____	_____
prescription narcotics	_____ pills/day	_____	_____
smoking	_____ packs/day	_____	_____
pesticides	_____	_____	_____
other chemicals	_____	_____	_____
radiation (other than x-rays)	_____	_____	_____

**List all prescription medication you take now (include hormones and fertility pills):**

(drug)	(date)	(dose)
_____	_____	_____
_____	_____	_____
_____	_____	_____

**List all prescription medications you have taken for more than 1 month in the past 5 years:**

(drug)	(date)	(dose)
_____	_____	_____
_____	_____	_____

**List all herbal medicines/vitamins, health food store supplements and over the counter preparation you take now:**

(drug)	(date)	(dose)
_____	_____	_____
_____	_____	_____

**Are you taking prenatal vitamins with at least 1 mg of folate (folic acid)?** \_\_\_\_\_

**List all allergic reactions you have had:**

(drugs or allergens such as food, pollens, animals, latex, iodine or tape)	(date)
_____	_____
_____	_____

**List all surgery you have had (cervix, uterus, ovarian cysts, tubes, endometriosis, fibroids, appendix, etc.):**

(type of surgery)	(date)
_____	_____
_____	_____
_____	_____

**List all serious illnesses, hospitalizations or accidents:**

(illness)	(date)
_____	_____
_____	_____

## Family History of Female

Countries of origin: Mother's family \_\_\_\_\_ Father's family \_\_\_\_\_

**Ethnic background (circle):** African-American American-Indian/Native American Asian Asian-Indian Caribbean  
Caucasian Cajun/French Canadian Eastern European Hispanic/Latina Jewish Ashkenazi Jewish Mediterranean  
Middle East Northern European Pacific Islands Southern European Other \_\_\_\_\_

Ethnic group (Check all that apply)	Have you been tested for?	Yes	No	Date	Result
African, African/American	sickle cell trait				
Chinese, Southeast Asian, Mediterranean (Greek or Italian) or Hispanic/Latina	thalassemia				
Caucasian	cystic fibrosis				
Jewish	Cystic fibrosis, Bloom Syndrome, Canavan, Familial Dysautonomia (FD), Fanconi Anemia (type c), Gaucher Disease (type I), Glycogen Storage (type 1a), Maple Syrup Urine Disease, Mucopolidosis (Type IV - ML IV), Niemann-Pick Type A, Tay Sachs				

Would you like to be tested for the tests recommended for your specific ethnic group (circle)? **Yes** **No**  
Are you related to your current spouse (consanguinity)? \_\_\_\_\_

Relative	Living		Age or age at Death	Major illnesses and diseases and cause of death if applicable
	Yes	No		
Mother	Yes	No		
Father	Yes	No		
Brother #1	Yes	No		
Brother #2	Yes	No		
Brother #3	Yes	No		
Brother #4	Yes	No		
Brother #5	Yes	No		
Brother #6	Yes	No		
Brother #7	Yes	No		
Brother #8	Yes	No		
Brother #9	Yes	No		
Brother #10	Yes	No		
Sister #1	Yes	No		
Sister #2	Yes	No		
Sister #3	Yes	No		
Sister #4	Yes	No		
Sister #5	Yes	No		
Sister #6	Yes	No		
Sister #7	Yes	No		
Sister #8	Yes	No		
Sister #9	Yes	No		
Sister #10	Yes	No		
Maternal Grandmother	Yes	No		
Maternal Grandfather	Yes	No		
Paternal Grandmother	Yes	No		
Paternal Grandfather	Yes	No		

**Is there anyone in the family who has had any of the following illnesses?**

	Yes	Relationship		Yes	Relationship
abnormal genitals			hormone disorders		
antiphospholipid antibody syndrome			hydrocephalus (water on the brain)		
alcoholism			Huntington disease		
balanced translocation			infertility		
bipolar disorder			kidney disease		
birth defects			lack of sense of smell		
bleeding disorders			learning problems/disability		
blindness			Maple Syrup Urine Disease		
Bloom Syndrome			Marfan syndrome		
bone/Skeletal defects			mental retardation*		
breast cancer			metabolic disorder		
Canavan disease			mucopolidosis (Type IV)		
cancer			muscle disease		
chromosomal disorders			muscular dystrophy		
cleft lip or palate			neural tube defects		
colon cancer			neurologic (brain/spine)		
color blindness			Niemann-Pick Type A		
cystic fibrosis			obesity		
deafness or hearing loss			other chromosome defects		
deep vein thrombosis (blood clot in legs)			PCOS – polycystic ovarian syndrome		
delayed development			ovarian cancer		
depression			other inherited disorders		
diabetes			pituitary tumor		
Down syndrome			polycystic kidneys		
dwarfism			other psychiatric problems		
early menopause (<age 40)			pulmonary embolus (blood clot in lungs)		
early puberty (<age 8)			recurrent miscarriages (>2)		
endometriosis			schizophrenia		
excess body hair			short stature		
familial dysautonia (FD)			sickle cell anemia		
Fanconi Anemia (type c)			sickle cell trait (carrier)		
Fragile X syndrome			spina bifida (opening in spine)		
galactosemia			Tay Sachs		
Gaucher Disease (type I)			testicular cancer		
glycogen storage (type 1a)			thalassemia (Cooley's anemia)		
heart defect from birth			thyroid problems		
heart disease			tuberculosis		
hemochromatosis			Y chromosome microdeletion		
hemophilias					

\*Fragile X testing is recommended if the exact etiology of the mental retardation is unknown. Would you like this testing performed (circle)? **Yes No**

Comments if yes to any of the above: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

# Male History

Do you have or have you ever had any of the following diseases or problems (check all that apply):

<b>Erectile Function difficulties</b>	√	<b>Medical Problems</b>	√	<b>Testicular injury</b>	√	<b>Current Problems</b>	√
collecting semen for testing		acne, mild		painful swelling		blood in urine	
initiating an erection		acne, moderate		pelvic surgery		bloody cough	
ejaculating		acne, severe		radiation therapy		blurred vision	
low ejaculate volume		anesthesia problems		severe testicular trauma		bronchitis	
retrograde ejaculation		angina		testicular cancer		change in bowel habits	
sustaining an erection		arthritis		testicular mumps		chest pain	
vaginal penetration		asthma		torsion (twisted testicle)		chronic nasal congestion	
inability to ejaculate in the vagina		deep vein thrombosis (blood clot in legs)				cold intolerance	
		bleeding disorders		<b>Urinary tract infections</b>	√	constipation	
<b>Infectious Problems</b>	√	blood clot in lungs		bladder infection		diarrhea	
AIDS		blood transfusion		blood in semen		dizziness	
chlamydia		cancer		blood in urine		easy bruising	
condyloma (warts or HPV)		colitis -ulcerative		epididymitis		excessive thirst	
cytomegalovirus (CMV)		colitis – Crohn’s		groin pain		fever/chills	
gonorrhea		diabetes		kidney infection		frequent urination	
hepatitis A		gained ≥15 lbs last year		painful urination		heat intolerance	
hepatitis B		genetic (inherited) disorders		prostatitis		lack of energy/stamina	
hepatitis C		heart attack		scrotal or testicular pain		memory loss	
hepatitis A vaccination		heart disease		unusual penile discharge		moles changing appearance	
hepatitis B vaccination		hearing loss				nausea/vomiting	
herpes: genital		heart murmur		<b>Surgery</b>	√	numbness	
herpes: oral (cold sores)		high blood pressure		bladder surgery		palpitations/skipped beats	
HIV test - positive		hormone disorders		hernia repair		rash/inflammation	
mumps affecting testicles		irritable bowel syndrome		orchiopexy		ringing ears	
nongonococcal urethritis		kidney disease		penis surgery		shortness of breath	
PPD positive		kidney infection		testicular surgery		swollen glands/lymph nodes	
sexually transmitted disease		liver problems		varicocele		unusual muscle weakness	
syphilis (RPR)		lost ≥15 lbs last year		vasectomy		weakness/loss of balance	
tuberculosis		lung disease		vasectomy reversal			
		metabolic disorder				<b>Psychological Problems</b>	√
<b>Growth &amp; Development</b>	√	pituitary tumor		<b>Neurological Problems</b>	√	anxiety disorder	
abnormal genitals		rheumatoid arthritis		lack of sense of smell		bipolar disorder	
birth defects		thalassemia		migraine headaches		depression	
breast enlargement		thyroid problems		myotonic dystrophy		hallucinations	
DES exposure		thrombophlebitis		multiple sclerosis		obsessive/compulsive	
early or delayed puberty		sickle cell anemia		seizures/epilepsy		psychosis	
FSH, elevated		sickle cell carrier		severe headaches		schizophrenia	
hypospadias						Other	
Klinefelter’s syndrome							
small testicles							
undescended testicles							
varicocele							
Y chromosome microdeletion							

Comments: \_\_\_\_\_

\_\_\_\_\_

At what age did you start shaving? \_\_\_\_\_ How many times per week do you shave currently? \_\_\_\_\_  
 Months of unprotected intercourse with **other** sexual partners without conceiving: \_\_\_\_\_ # of partners \_\_\_\_\_

<b>Toxicant exposure:</b>	<b>(yes)</b>	<b>(no)</b>	<b>Dates</b>
caffeine	_____ drinks/day	_____	_____
alcohol	_____ drinks/week	_____	_____
marijuana	_____ joints/week	_____	_____
cocaine	_____ gm/week	_____	_____
other recreation drugs	_____	_____	_____
prescription narcotics	_____ pills/day	_____	_____
smoking	_____ packs/day	_____	_____
pesticides	_____	_____	_____
other chemicals	_____	_____	_____
radiation (other than x-rays)	_____	_____	_____
steroids (androgens)	_____	_____	_____

**Date of most recent high fever (>101°):** \_\_\_\_\_

**Hot tub/sauna/steam bath use:** \_\_\_\_\_ **times/week**

## Male History (cont.)

Weight \_\_\_\_\_ Height \_\_\_\_\_ BMI (Body Mass Index) \_\_\_\_\_

**List all prescription medication you take now (include fertility pills, hormones (such as testosterone), etc):**

(drug)

(date)

(dose)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**List all prescription medications you have taken for more than 1 month in the past 5 years:**

(drug)

(date)

(dose)

_____	_____	_____
_____	_____	_____
_____	_____	_____

**List all herbal medicines, vitamins, health food store supplements, androgens (such as DHEA or androstenedione) and over the counter preparation you take now:**

(drug)

(date)

(dose)

_____	_____	_____
_____	_____	_____
_____	_____	_____

**List all allergic reactions you have had:**

(drug or allergen such as food, pollens, animals, latex, iodine or tape)

(date)

_____	_____
_____	_____

**List all surgery you have had:**

(type of surgery)

(date)

_____	_____
_____	_____
_____	_____

Did you have any anesthesia problems? Yes No

**List all other serious illnesses for which you have been under the care of a physician:**

(illness)

(date)

_____	_____
_____	_____

# Male Family History

Countries of origin: Mother's family \_\_\_\_\_ Father's family \_\_\_\_\_

**Ethnic background (circle all that apply):** African-American American-Indian/Native American Asian Asian Indian Caribbean Caucasian Cajun/French Canadian Eastern European Hispanic/Latino Jewish Ashkenazi Jewish Mediterranean Middle East Northern European Pacific Islands Southern European Other \_\_\_\_\_

Ethnic group (Check all that apply)	Have you been tested for?	Yes	No	Date	Result
African, African/American	sickle cell trait				
Chinese, Southeast Asian, Mediterranean (Greek or Italian) or Hispanic/Latino	thalassemia				
Caucasian	cystic fibrosis				
Jewish	Cystic fibrosis, Bloom Syndrome, Canavan, Familial Dysautonomia (FD), Fanconi Anemia (type c), Gaucher Disease (type I), Glycogen Storage (type 1a), Maple Syrup Urine Disease, Mucopolysaccharidosis (Type IV - ML IV), Niemann-Pick Type A, Tay Sachs				

Would you like to be tested for the tests recommended for your specific ethnic group (circle)? **Yes** **No**  
 Are you related to your current wife (consanguinity)? \_\_\_\_\_

Relative	Living		Age or age at Death	Major illnesses and diseases and cause of death if applicable
	Yes	No		
Mother	Yes	No		
Father	Yes	No		
Brother #1	Yes	No		
Brother #2	Yes	No		
Brother #3	Yes	No		
Brother #4	Yes	No		
Brother #5	Yes	No		
Brother #6	Yes	No		
Brother #7	Yes	No		
Brother #8	Yes	No		
Brother #9	Yes	No		
Brother #10	Yes	No		
Sister #1	Yes	No		
Sister #2	Yes	No		
Sister #3	Yes	No		
Sister #4	Yes	No		
Sister #5	Yes	No		
Sister #6	Yes	No		
Sister #7	Yes	No		
Sister #8	Yes	No		
Sister #9	Yes	No		
Sister #10	Yes	No		
Maternal Grandmother	Yes	No		
Maternal Grandfather	Yes	No		
Paternal Grandmother	Yes	No		
Paternal Grandfather	Yes	No		

**Is there anyone in the family who has had any of the following illnesses?**

	Yes	Relationship		Yes	Relationship
abnormal genitals			hormone disorders		
alcoholism			hydrocephalus (water on the brain)		
antiphospholipid antibody syndrome			Huntington disease		
balanced translocation			infertility		
bipolar disorder			kidney disease		
birth defects			lack of sense of smell		
bleeding disorders			learning problems/disability		
blindness			Maple Syrup Urine Disease		
Bloom Syndrome			Marfan syndrome		
bone/Skeletal defects			mental retardation*		
breast cancer			metabolic disorder		
Canavan disease			mucopolidosis (Type IV)		
cancer			muscle disease		
chromosomal disorders			muscular dystrophy		
cleft lip or palate			neural tube defects		
colon cancer			neurologic (brain/spine)		
color blindness			Niemann-Pick Type A		
cystic fibrosis			obesity		
deafness or hearing loss			other chromosome defects		
deep vein thrombosis (blood clot in legs)			PCOS – polycystic ovarian syndrome		
delayed development			ovarian cancer		
depression			other inherited disorders		
diabetes			pituitary tumor		
Down syndrome			polycystic kidneys		
dwarfism			other psychiatric problems		
early menopause (<age 40)			pulmonary embolus (blood clot in lungs)		
early puberty (<age 8)			recurrent miscarriages (>2)		
endometriosis			schizophrenia		
excess body hair			short stature		
familial dysautonia (FD)			sickle cell anemia		
Fanconi Anemia (type c)			sickle cell trait (carrier)		
Fragile X syndrome			spina bifida (opening in spine)		
galactosemia			Tay Sachs		
Gaucher Disease (type I)			testicular cancer		
glycogen storage (type 1a)			thalassemia (Cooley's anemia)		
heart defect from birth			thyroid problems		
heart disease			tuberculosis		
hemochromatosis			Y chromosome microdeletion		
hemophilias					

\*Fragile X testing is recommended if the exact etiology of the mental retardation is unknown. Would you like this testing performed (circle)? **Yes No**

Comments if yes to any of the above: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## Prior Testing

Whenever possible we try not to repeat tests that have been performed recently. To assist us in reviewing and interpreting any prior tests, please complete this section to the best of your ability. Pertinent records should be obtained so the results can be confirmed.

**Previous female fertility tests:** (result) (date)

basal body temperature \_\_\_\_\_  
 hysterosalpingogram HSG \_\_\_\_\_  
 saline sonogram (SSG) \_\_\_\_\_  
 hysteroscopy \_\_\_\_\_  
 laparoscopy \_\_\_\_\_  
 ultrasound, pelvic \_\_\_\_\_

**Male fertility tests - semen analysis:**

Volume	Concentration	Motility	Morphology	Kruger	Lab location	Date

**Other male fertility tests:** (result) (date/lab location)

sperm penetration assay (SPA) \_\_\_\_\_  
 antisperm antibodies \_\_\_\_\_  
 Urology consult/physical \_\_\_\_\_  
 scrotal ultrasound \_\_\_\_\_  
 SCSA (DNA integrity) \_\_\_\_\_

**Immunologic screening tests (female):** (result) (date)

Anti-phospholipid antibodies (APA or ACA) \_\_\_\_\_  
 Lupus anticoagulant (LAC) \_\_\_\_\_  
 Anti-β2 Glycoprotein I \_\_\_\_\_  
 Anti-microsomal antibodies (AMA) \_\_\_\_\_  
 Anti-thyroglobulin antibodies (ATG) \_\_\_\_\_  
 Thyroid stimulating antibodies (TSIG) \_\_\_\_\_  
 HLA DQα \_\_\_\_\_

**Previous hormonal tests:**

Male

Female

	Result	Date	Result	Date
testosterone, total	_____	_____	_____	_____
testosterone (% free)	_____	_____	_____	_____
prolactin	_____	_____	_____	_____
TSH	_____	_____	_____	_____
Free T4	_____	_____	_____	_____
FSH (random)	_____	_____	_____	_____
FSH/Estradiol (day 3)	_____	_____	_____	_____
FSH (day 10)	_____	_____	_____	_____
AMH/MIS	_____	_____	_____	_____
progesterone	_____	_____	_____	_____
DHEAS	_____	_____	_____	_____
17 OH Progesterone	_____	_____	_____	_____

**Genetic screening tests:**

Cystic fibrosis mutations \_\_\_\_\_  
 Karyotype/Chromosomes \_\_\_\_\_  
 Y microdeletion assay \_\_\_\_\_  
 Fragile X \_\_\_\_\_

**Infectious disease****Male****Female**

Result

Date

Result

Date

HIV-1 \_\_\_\_\_

HIV-2 \_\_\_\_\_

HTLV 1 &amp; 2 Ab \_\_\_\_\_

HIV-1 (PCR) \_\_\_\_\_

Chlamydia \_\_\_\_\_

Gonorrhea \_\_\_\_\_

Mycoplasma \_\_\_\_\_

Syphilis (RPR, VDRL) \_\_\_\_\_

hepatitis B surface Antigen \_\_\_\_\_

hepatitis B surface antibody \_\_\_\_\_

hepatitis B core antibody \_\_\_\_\_

hepatitis C antibody \_\_\_\_\_

hepatitis C by PCR \_\_\_\_\_

cytomegalovirus (CMV) \_\_\_\_\_

rubella IgG (German measles) \_\_\_\_\_

varicella IgG (Chicken Pox) \_\_\_\_\_

toxoplasmosis IgG \_\_\_\_\_

**Medical screening tests:**

blood group and Rh \_\_\_\_\_

CBC \_\_\_\_\_

chemistry panel \_\_\_\_\_

chest x-ray (CXR) \_\_\_\_\_

cholesterol (lipid profile) \_\_\_\_\_

EKG \_\_\_\_\_

fasting glucose \_\_\_\_\_

fasting insulin \_\_\_\_\_

2 hour GTT glucose \_\_\_\_\_

Hgb A1C \_\_\_\_\_

PT/PTT \_\_\_\_\_

urinalysis \_\_\_\_\_

**Thrombophilia screening tests:**

Leiden Factor V \_\_\_\_\_

R506Q PCR \_\_\_\_\_

aPTT \_\_\_\_\_

Protein S Activity \_\_\_\_\_

Free Antigen \_\_\_\_\_

Protein C activity \_\_\_\_\_

Antigen \_\_\_\_\_

Antithrombin Activity \_\_\_\_\_

Fasting Homocysteine \_\_\_\_\_

MTHFR (C677T/A1298C PCR) \_\_\_\_\_

Prothrombin (G20210A PCR) \_\_\_\_\_

PAI-1 Activity \_\_\_\_\_

Antigen \_\_\_\_\_

Previous fertility treatments:	(yes)	(no)	# cycles	Outcome/Comments/Dates
Clomiphene (Clomid)	_____	_____	_____	_____
Maximum # of tablets per day	_____			
letrozole (Femara)	_____	_____	_____	_____
insulin sensitizing agent*	_____	_____	_____	_____
dopamine agonist**	_____	_____	_____	_____
glucocorticoids (Dex)	_____	_____	_____	_____
insemination (IUI)	_____	_____	_____	_____
clomiphene and IUI	_____	_____	_____	_____
letrozole and IUI	_____	_____	_____	_____
FSH*** and IUI	_____	_____	_____	_____
Max # of vials (or IU) per day	_____			
IVF or ICSI	_____	_____	_____	_____
aspirin	_____	_____	_____	_____
heparin	_____	_____	_____	_____
progesterone	_____	_____	_____	_____
donor sperm	_____	_____	_____	_____
donor egg	_____	_____	_____	_____
donor embryo	_____	_____	_____	_____
Comments:	_____			
	_____			
	_____			

\* Insulin sensitizing agents - Glucophage (Metformin), Avandia, Avandamet  
 \*\* dopamine agonist - bromocriptine (Parlodel), pergolide mesylate (Permax), cabergoline (Dostinex)  
 \*\*\* FSH (follicle stimulating hormone) - Repronex, Menopur, Bravelle, Gonal-F, and/or Follistim

**Prior in vitro fertilization (IVF), intracytoplasmic sperm injection (ICSI) or frozen embryo transfer results**

Date of procedure	Program location	Protocol	# of eggs obtained	# of mature eggs	IVF or ICSI	# of eggs fertilized	# of embryos transferred	# of embryos frozen	Pregnancy outcome

Comments: \_\_\_\_\_

On a scale of 1-10 (10 worst), estimate the level of stress you feel due to infertility and other pressures. \_\_\_\_\_  
 Do you see a counselor (circle)? No Yes – For how long? \_\_\_\_\_ How often? \_\_\_\_\_  
 Would you like a referral to see a psychologist or counselor (circle)? No Yes  
 Describe any emotional, marital or sexual problems caused by your infertility. \_\_\_\_\_

Do you prefer treatment that is (circle): Faster but more expensive Slower but less expensive Unsure  
 Do you have any personal, ethical, or religious objections to any of the tests or treatments mentioned (circle)?  
 Yes No Comments: \_\_\_\_\_