MEDICAL AND REPRODUCTIVE HISTORY

Today's date_____/_____/_____ Date of appointment_____/_____/_____

FEMALE PATIENT:
(Legal) Last name:_____ **(Legal)** First name:_____ Middle initial _____

Age: _____Date of Birth: _____/_____/_____ Soc. Security #: _____-_____-_____

Marital Status: _____single _____married _____domestic partner Length of Relationship: _____years

PARTNER:
(Legal) Last name:_____ **(Legal)** First name:_____ Middle initial _____

Age: _____Date of Birth: _____/_____/_____ Soc. Security #: _____-_____-_____

MAILING ADDRESS:
Street:_____ City: _____

State/Providence: _____ Zip/Postal Code: _____ Country: _____

	OK to leave message?		Best # to reach you:
Home Phone Number: (_____)_____-_____	☐ Yes	☐ No	☐
Female Work Phone Number: (_____)_____-_____	☐ Yes	☐ No	☐
Partner Work Phone Number: (_____)_____-_____	☐ Yes	☐ No	☐
Female Cell Phone Number: (_____)_____-_____	☐ Yes	☐ No	☐
Partner Cell Phone Number: (_____)_____-_____	☐ Yes	☐ No	☐

Female Email Address: _____ Partner Email Address: _____

How did you hear about SRM?
- ☐ Family/Friend
- ☐ Internet
- ☐ Radio
- ☐ Medical office/physician referral
  - o Name of office/physician: _____
- ☐ Other _____

Would you like medical notes sent to your other healthcare providers
- ☐ Yes
- ☐ No

If yes, please indicate which provider(s) you would like us to send medical notes to:

Provider Name	Address	Please indicate provider type: Primary care	OB/Gyn	Other

Reason for visit:_____

FERTILITY HISTORY

Do you have any theories as to why you have been unable to conceive?_____

PREGNANCY HISTORY: List all pregnancies, specifying under outcome whether liveborn, stillborn, ectopic, miscarriage or elective termination (abortion).

Pregnancy #	Preg. Ended (mo./yr.)	Preg. Length (weeks, months)	Outcome	FATHER (check one)	
				Present partner	Previous partner

Time since contraception last used? _____

How long have you been trying to conceive? _____

If you previously have been pregnant, how long has it been since the most recent pregnancy? _____

Have you experienced any difficulty conceiving for a year or more with any man other than your current partner? ☐Yes ☐No

PREVIOUS FERTILITY EVALUATION:

Have you had any of the following tests performed?

Fertility Test:	Yes	No	Date	Result normal? Yes	No	If no, describe:
Day 3 FSH level	☐	☐	____/____/____	☐	☐	_____
Day 3 Estradiol level	☐	☐	____/____/____	☐	☐	_____
Antimullerian hormone	☐	☐	____/____/____	☐	☐	_____
Antral Follicle Count (AFC)	☐	☐	____/____/____	☐	☐	_____
Progesterone level(s)	☐	☐	____/____/____	☐	☐	_____
Endometrial Biopsy	☐	☐	____/____/____	☐	☐	_____
Hysterosalpingogram (HSG)	☐	☐	____/____/____	☐	☐	_____
Sonohysterogram (SHG or SIS)	☐	☐	____/____/____	☐	☐	_____
Hysteroscopy	☐	☐	____/____/____	☐	☐	_____
Thyroid blood test	☐	☐	____/____/____	☐	☐	_____
Prolactin blood test	☐	☐	____/____/____	☐	☐	_____
Fasting blood glucose	☐	☐	____/____/____	☐	☐	_____
Testosterone level	☐	☐	____/____/____	☐	☐	_____
Post Coital Test	☐	☐	____/____/____	☐	☐	_____

PRIOR TREATMENTS: (check all that apply)

Treatment	#of cycles	Dates: (mo./year) to (mo./year)	Outcome (baby, miscarriage, etc.)
Intrauterine inseminations (no medication):	_____	from:____/____ to:____/____	
Clomid-maximum # of tablets per day_____ with timed intercourse with intrauterine inseminations with Metformin	 _____ _____ _____	 from:____/____to:____/_____ from:____/____to:____/_____ from:____/____to:____/_____	
Letrozole/Femara-maximum # per day_____ with timed intercourse with intrauterine inseminations	 _____ _____	 from:____/____to:____/_____ from:____/____to:____/_____	
Gonadotropins (Follistim, Gonal F, Menopur, Bravelle) with intrauterine inseminations	_____	from:____/____to:_____/_____	
Acupuncture	_____	from:____/____to:____/_____	
Chinese Herbs	_____	from:____/____to:____/_____	
Complete in vitro fertilization (IVF) cycle(s): 1. # eggs _____ # fertilized _____ # transferred_____ # frozen _____ 2. # eggs_____ # fertilized_____ # transferred ____ # frozen _____ 3. # eggs _____ # fertilized _____ # transferred ____ # frozen _____	_____	 from:____/____to:____/_____ from:___/____ to: ____/_____ from:___/____ to: ___/_____	
Frozen embryo transfers: 1. #embryos transferred _____ 2. #embryos transferred _____ 3. #embryos transferred _____	 _____ _____ _____	 _____/_____ _____/_____ _____/_____	
Canceled in vitro fertilization attempt(s)	_____	from:____/____to:____/_____	

REPRODUCTIVE HEALTH HISTORY-FEMALE PARTNER

MENSTRUAL HISTORY:

Age when you had your first menstrual period: _____ years old

The first day of your most recent menstrual period: _____ / _____ / _____

Menstrual cycle pattern without hormones or oral contraceptive pills (OCP's)-- (check all that apply):

☐ Regular periods ☐ Irregular periods ☐ No periods
☐ Spotting between periods ☐ Heavy periods ☐ Light periods

How many days from the first day of one period to the first day of the next? _____days

How many days of bleeding do you usually have? _____days

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

Do you have cramping or pelvic pain with your periods? (check one)

☐ Always ☐ Sometimes ☐ Recently ☐ In the past ☐ No

Degree of pain (1 to 10, with 10 being most severe): _____

Over the past few years, is the pain: ☐ getting better ☐ getting worse ☐ staying the same

If you do not have periods, at what age did you stop having them? _____ years old

When was your last Pap smear? _____ / _____ Was it normal? ☐ Yes ☐ No
Have you ever had an abnormal Pap smear? ☐Yes ☐No If "Yes," date and treatment:_____

Did your mother take DES while pregnant with you? ☐Yes ☐No ☐Don't know

Have you ever had a mammogram? ☐Yes ☐No If yes, when was the last one? _____/_____
Was your mammogram normal? ☐Yes ☐No

CONTRACEPTIVE METHOD HISTORY:

Type	Years Used
☐ Birth Control Pill / Patch	
☐ Depo-Provera, Lunelle	
☐ Nuva Ring	
☐ Norplant/Implanon	
☐ Diaphragm	
☐ IUD	
☐ Condoms	
☐ Tubal Sterilization	
☐ Vasectomy	
☐ Rhythm (natural method)	
☐ Other	

SEXUAL HISTORY:

How many times per week do you have intercourse?_____

How many times do you have intercourse mid-cycle?_____

Any pain with intercourse? ☐Yes ☐No

Do you regularly use lubricant with intercourse? ☐Yes ☐No If yes, what type?_____

Have you ever had any sexually transmitted infections? (please check all that apply)

☐ Chlamydia	☐ Gonorrhea	☐ Herpes	☐ Other
☐ Syphilis	☐ Genital Warts	☐ Trichomonas	_____
☐ HIV	☐ HPV	☐ Hepatitis	

Have you ever had pelvic inflammatory disease? ☐Yes ☐No

If yes, when?_____ Were you hospitalized?_____

GENERAL MEDICAL HISTORY-FEMALE PARTNER

Have you and/or your partner traveled to a country, territory, or city where there has been active Zika virus transmission in the last 6 months? If so, please specify place(s) and dates. _____

Are you and/or your partner planning travel to a country, territory, or city where there has been active Zika virus transmission? If so, please specify place(s) and dates. _____

What is your current weight? _____ Height? _____ Usual weight? _____

Recent weight loss or gain in the past 6 months? _____

Approximately how much did you weigh at age 18?_____

Are you currently being treated or being seen for any medical condition(s)? ☐Yes ☐No
If yes, please describe: _____

_____

REVIEW OF SYSTEMS:

Check any of the following that you are presently having or have had in the past:

Eye problems ☐	Gall bladder problems ☐	Excessive thirst ☐
Stuffy nose, hay fever ☐	Liver disease ☐	Temperature intolerance ☐
Frequent nose bleeds ☐	Frequent urination at night ☐	Headaches ☐
Fast or irregular heartbeat ☐	Vaginal discharge,itching,pain ☐	Shaking, tremor ☐
Heart murmur ☐	Pelvic pain ☐	Anxiety ☐
Mitral valve prolapse ☐	Sexual problems ☐	Depression ☐
Dizziness, fainting ☐	Endometriosis ☐	Bulimia or anorexia ☐
Shortness of breath ☐	Ovarian tumor ☐	Anemia ☐

Lung disease ☐	Dark skin on neck, armpits ☐	Easy bleeding or bruising ☐
Asthma ☐	Acne or pimples ☐	Poor circulation ☐
Tuberculosis ☐	Enlarged or painful breasts ☐	Blood transfusion ☐
Heartburn, indigestion ☐	Discharge from nipples ☐	Fatigue ☐
Gas, cramps, pain ☐	Breast lumps ☐	Low energy ☐
Blood in stool or black stool ☐	Breast disease ☐	Past history of IV drug use ☐
Nausea, vomiting ☐	Hot flashes ☐	Rubella (German Measles) ☐
Constipation ☐	Excessive face or body hair ☐	Other ☐
Diarrhea ☐	Hair thinning or loss ☐	☐
Hernia ☐	Fever, sweats, chills ☐	☐

Please explain any positive responses:

_____

_____

SURGICAL HISTORY:

Please list any major surgeries or hospitalizations in the table below. Include elective termination (abortion), ectopic pregnancy, tubal surgery or any other surgeries:

	Mo. / Year	Procedure	Reason
1			
2			
3			

ALLERGIES:

Latex? ☐Yes ☐No If yes, specify reaction: _____

Iodine? ☐Yes ☐No If yes, specify reaction: _____

Medications? ☐Yes ☐No Which meds, specify reaction:_____

_____

MEDICATIONS INCLUDING: VITAMINS / HERBS / OVER THE COUNTER MEDICATION (OTC'S)

Please list all medications or treatments you are currently taking:

Medication	Dosage	Frequency	Reason

SOCIAL HISTORY-FEMALE PARTNER

Current Occupation: _____

Prior Occupation(s): _____

Have you or do you use any of the following?

	Never	Not in the last 3 months	Yes	List amount, type and frequency (how often-per day / per week)
Tobacco	☐	☐	☐	
Marijuana	☐	☐	☐	
Alcohol	☐	☐	☐	
Social drugs	☐	☐	☐	
Exercise	☐	☐	☐	

EMOTIONAL STATUS:

On a scale of 1 to 10, (10 being the highest) what do you estimate your average level of stress to be? _____

In the past month, have there been times when you felt down, depressed, or hopeless? ____ Yes ____ No

Were there times during the past month when you experienced little interest or pleasure in doing things? ____ Yes ____ No

FAMILY AND GENETIC HEALTH HISTORY-FEMALE PARTNER

Are there any known genetic diseases or conditions that run in your family? _____Yes _____No

If yes, which one(s) and whom?_____

Are you adopted? _____Yes _____No

Are you and your partner related? _____Yes _____No

Personal and Family History

Are you or your partner of the following ethnic backgrounds? *Please check all that apply.*

Female	**Male**	
_____	_____	Asian (Chinese, Japanese, Filipino, Indian)
_____	_____	Mediterranean
_____	_____	Middle Eastern
_____	_____	Ashkenazi Jewish
_____	_____	African
_____	_____	Hispanic or Caribbean

_____ _____ French Canadian or Cajun

_____ _____ Caucasian

Have you or your partner had a blood test to see if you were a genetic carrier for:

Condition	Female	Female Result	Male	Male Result
α (Alpha) Thalassemia	**Yes No**		**Yes No**	
ß (Beta) Thalassemia	**Yes No**		**Yes No**	
Sickle Cell Anemia	**Yes No**		**Yes No**	
Tay Sach's Disease	**Yes No**		**Yes No**	
Cystic Fibrosis	**Yes No**		**Yes No**	
Spinal Muscular Atrophy	**Yes No**		**Yes No**	

If you and your partner is of Eastern European Jewish ancestry (Ashkenazi), have you or your partner had blood tests to see if you were a genetic carrier for:

Condition	Female	Female Result	Male	Male Resutlt
Canavan Disease	**Yes No**		**Yes No**	
Familial Dysautonomia	**Yes No**		**Yes No**	
Fanconi Anemia	**Yes No**		**Yes No**	
Neimann-Pick Disease	**Yes No**		**Yes No**	
Mucolipodisis Type IV	**Yes No**		**Yes No**	
Bloom Syndrome	**Yes No**		**Yes No**	
Gaucher Disease	**Yes No**		**Yes No**	

Please indicate which of the following conditions may be found in your family:

MEDICAL PROBLEM	Yourself	PARENTS		SIBLINGS		MATERNAL GRANDPARENTS		PATERNAL GRANDPARENTS		YOUR	OTHER
		Mother	Father	Sisters	Brothers	GM	GF	GM	GF	Children	Relatives
Autoimmune disorder, such as lupus or rheumatoid arthritis											
Birth defects requiring surgery (cleft lip, etc)											
Bleeding disorders (hemophilia, etc.)											
Blindness											
Bone disorders											
Cancer before age 50 (specify)											
Chromosome Problems (Down syndrome, Klinefelter syndrome)											
Clotting disorders (Factor V Leiden, etc.)											
Deafness											
Diabetes (Insulin dependent)											
Endocrine Disorders (adrenal gland, parathyroid, thyroid disorders, Adrenal Hyperplasia)											
Epilepsy (seizures)											
Heart defects ("hole in the heart", etc)											
Heart Disease											
High Blood Pressure											
High Cholesterol											
Hydrocephaly ("water on the brain")											

Kidney Disease											
Limb defects (missing or extra fingers, toes, shorten arms or legs)											

MEDICAL PROBLEM	Yourself	PARENTS		SIBLINGS		MATERNAL GRANDPARENTS		PATERNAL GRANDPARENTS		YOUR	OTHER
		Mother	Father	Sisters	Brothers	GM	GF	GM	GF	Children	Relatives
Marfan Syndrome											
Mental Illness (schizophrenia, bipolar, etc)											
Mental retardation, autism or learning disabilities											
Muscular Dystrophy											
Neurofibromatosis											
Neurologic or neurodegenerative diseases (Alzheimer, Huntington, etc)											
Neuromuscular diseases (muscular dystrophies, etc.)											
Phenylketonuria (PKU)											
Polycystic Kidney disease											
Skin Diseases (eczema, melanoma)											
Stillbirth or children who have died as infants											
Stroke											
Thalassemia (Cooley's anemia)											
Unusual genitals in boys or girls											
Urinary Tract abnormalities											
Women who have had multiple miscarriage											
Other serious health issues											

Please explain any positive answers:_____
_____

REPRODUCTIVE HEALTH HISTORY—MALE PARTNER

Do you have any theories as to why you have been unable to conceive? _____

List all pregnancies you have fathered, specifying under outcome whether liveborn, stillborn, ectopic, miscarriage or elective termination (abortion).

Pregnancy #	Preg. Ended (mo./yr.)	Preg. Length (weeks, months)	Outcome	MOTHER (check one)	
				Present partner	Previous partner

Have you previously conceived with another woman? _____ Yes _____ No

Have you ever been unable to conceive with anyone other than your current partner? _____ Yes _____ No

Have you ever had a serious exposure to radiation or toxins (e.g. pesticides, toxic chemicals, poisons, herbicides, plastics, organic chemicals, lead, cadmium, industrial by-products, etc.)? _____ Yes _____ No

Have you ever consulted a urologist or male infertility specialist? _____ Yes _____ No

If yes: Year: _____ Reason: _____

Findings / Recommendations: _____

PREVIOUS FERTILITY EVALUATION:
Have you had any of the following tests performed?

Fertility Test:	Yes	No	Date	Result normal? Yes	No	If no, describe:
Semen Analysis	☐	☐	___/___/___	☐	☐	_____
Hormone Blood tests	☐	☐	___/___/___	☐	☐	_____

GENERAL MEDICAL HISTORY—MALE PARTNER

What is your current weight? _____ Height? _____ Usual weight? _____

Recent weight loss or gain in the past 6 months?_____

Place a check by any of the following that have been a problem for you during the last 6 months

Eye problems ☐	Diarrhea ☐	Headaches ☐
Stuffy nose, hay fever ☐	Hemorrhoids ☐	Shaking, tremor ☐
Frequent nose bleeds ☐	Hernia ☐	Anxiety ☐
Fast or irregular heartbeat ☐	Gall bladder problems ☐	Depression ☐
Heart murmur ☐	Hepatitis ☐	Anemia ☐
Dizziness, fainting ☐	Frequent urination at night ☐	Bleeding/bruising from minor injury ☐
Shortness of breath ☐	Sexual problems ☐	Poor circulation ☐
Lung disease ☐	Herpes (oral or genital) ☐	Blood clots ☐
Asthma ☐	Genital or groin injuries ☐	Blood transfusions ☐
Tuberculosis ☐	Pain in joints, arthritis ☐	Fatigue ☐
Heartburn, indigestion ☐	Acne or pimples ☐	Low energy ☐

Gas, cramps, pain ☐	Elevated prolactin ☐	Past history of IV drug use ☐
Blood in stool or black stool ☐	Fever, sweats, chills ☐	Other ☐
Nausea, vomiting ☐	Excessive thirst ☐	☐
Constipation ☐	Temperature intolerance ☐	☐

Please give detail and dates: _____

_____

Please list any major surgeries or hospitalizations in the table below. Include vasectomy, vasectomy reversal, varicocele repair, or any other surgeries:

	Mo. / Year	Procedure	Reason
1			
2			
3			
4			

Please list all medications including: vitamins/herbs/over the counter medication (OTC's):

Medication	Dosage	Frequency	Reason

Do you or have you taken any steroids, performance enhancing agents, or testosterone? _____ Yes _____ No

If yes, please explain: _____

ALLERGIES:

Latex? _____ Yes _____ No If yes, specify reaction: _____

Medications? _____ Yes _____ No Which meds, specify reaction:_____

FAMILY AND GENETIC HEALTH HISTORY—MALE PARTNER

Are there any known genetic diseases or conditions that run in your family? _____Yes _____No

If yes, which one(s) and whom?_____

Have any of your blood relatives (siblings, children, aunts, uncles, etc.) had birth

defects, [e.g., heart, mental retardation, neural tube defect (e.g., spina bifida)], or other? _____Yes _____No

Are you adopted? _____Yes _____No

Ethnic Background: _____

Are you any of the following ethnic groups?			**There is increased risk for:**	**Tested?:**
Caucasian	____ Yes	____ No	Cystic Fibrosis	___Y ____N
English, Irish	____ Yes	____ No	Neural Tube Defects	N/A
Mediterranean (Greek, Italian, Middle Eastern)	____ Yes	____ No	Thalassemia	___Y ____N
Ashkenazi Jewish	____ Yes	____ No	Tay Sachs	____Y ____N
French Canadian	____ Yes	____ No	Tay Sachs	____Y ____N
Cajun	____ Yes	____ No	Tay Sachs	____Y ____N
Asian (Southeast Asian, Chinese, Taiwanese, Filipino, Indian, etc.)	____ Yes	____ No	Thalassemia	____Y ____N
African descent	____ Yes	____ No	Sickle Cell Anemia, Thalassemia	___Y ____N

Please indicate which of the following conditions may be found in your family:

MEDICAL PROBLEM	Yourself	PARENTS		SIBLINGS		MATERNAL GRANDPARENTS		PATERNAL GRANDPARENTS		YOUR	OTHER
		Mother	Father	Sisters	Brothers	GM	GF	GM	GF	Children	Relatives
Neural tube defects (spina bifida, “open spine”, anencephaly)											
Heart defects (“hole in the heart”, etc.)											
Any birth defects requiring surgery (cleft lip, etc.)											
Unusual genitals in boys or girls											
Limb defects (missing or extra fingers, toes, shorten arms or legs)											
Diabetes											
Blindness											
Deafness											
Bone disorders											
Skin Diseases (eczema, melanoma)											
Cancer before age 50 (specify)											
Heart Disease											
Kidney Disease											
High Blood Pressure											
High Cholesterol											
Epilepsy (seizures)											
Clotting disorders (Factor V Leiden, etc.)											
Bleeding disorders (hemophilia, etc.)											
Thalassemia (Cooley’s anemia)											
Mental Illness (schizophrenia, bipolar, etc)											
Mental retardation, autism or learning disabilities											
Neurologic or neurodegenerative diseases (Alzheimer, Huntington, etc)											

Endocrine Disorders (adrenal gland, parathyroid, thyroid disorders, Adrenal Hyperplasia)											

MEDICAL PROBLEM	Yourself	PARENTS		SIBLINGS		MATERNAL GRANDPARENTS		PATERNAL GRANDPARENTS		YOUR	OTHER
		Mother	Father	Sisters	Brothers	GM	GF	GM	GF	Children	Relatives
Neuromuscular diseases (muscular Dystrophies, etc.)											
Other genetic disorders (Cystic fibrosis, marfan syndrome, neurofibromatosis, sickle cell anemia, PKU, Tay-Sachs disease, Canavan disease, etc.)											
Chromosome Problems (Down syndrome, Klinefelter syndrome)											
Other serious health issue											

Please explain any positive answers:_____

_____

SOCIAL HISTORY—MALE PARTNER

Current Occupation: _____

Prior Occupation(s): _____

Have you or do you use any of the following?

	Never	Not in the last 3 months	Yes	List amount, type and frequency (how often-per day / per week)
Tobacco	☐	☐	☐	
Marijuana	☐	☐	☐	
Alcohol	☐	☐	☐	
Social drugs	☐	☐	☐	
Exercise	☐	☐	☐	

EMOTIONAL STATUS:

On a scale of 1 to 10, (10 being the highest) what do you estimate your average level of stress to be? _____

Were there times during the past month when you experienced little interest in doing things? ☐Yes ☐No

In the past month, have there been times when you felt down, depressed, or hopeless? ☐Yes ☐No

Please comment: _____

_____