Stanford HEALTH CARE

Los Olivos Women's Medical Group

INFERTILITY HISTORY

Date: _____

Your Name: _____ Occupation: _____

Partner's Name: _____ Occupation: _____

How long have you not used contraception? _____
How long have you been attempting pregnancy? _____
Were you married previously? _____
Attempted pregnancy previously? _____
Was your current partner married previously? _____
Has he fathered a pregnancy? _____
Duration of current marriage? _____
Has a cause of infertility been previously identified? _____
Name of physician (s) who have treated you for infertility: _____
_____
How frequently do you have intercourse? _____
How frequent is intercourse at the time of ovulation? _____
Is intercourse painful or difficult for you? _____
Do you use lubrication for intercourse? _____
Do you douche before or after intercourse? _____
Do you or your partner use hot tubs? _____
Have you had any chromosomal or genetic testing? _____

A. PREVIOUS INFERTILITY EVALUATION (date and copies of tests if possible)

Male	**Don't know**	**Normal**	**Abnl**	**Date**	**Not done**
Semen Analysis	❑	❑	❑	_____	❑
Hamster egg penetration assay	❑	❑	❑	_____	❑
Sperm antibodies	❑	❑	❑	_____	❑
Female					
FSH	❑	❑	❑	_____	❑
LH	❑	❑	❑	_____	❑
Prolactin	❑	❑	❑	_____	❑
TSH	❑	❑	❑	_____	❑
T4	❑	❑	❑	_____	❑
Chlamydia antibodies	❑	❑	❑	_____	❑
Sperm antibodies	❑	❑	❑	_____	❑
Chlamydia cervical culture	❑	❑	❑	_____	❑
Mycoplasma / ureoplasma cult.	❑	❑	❑	_____	❑

Basal body temperature	❑	❑	❑	_____	❑
Urine ovulation tests	❑	❑	❑	_____	❑
Post coital test	❑	❑	❑	_____	❑
Endometrial biopsy	❑	❑	❑	_____	❑
Serum progesterone levels	❑	❑	❑	_____	❑
Ultrasound	❑	❑	❑	_____	❑
Hysterosalpingogram (HSG)	❑	❑	❑	_____	❑
Hysteroscopy	❑	❑	❑	_____	❑
Laparoscopy	❑	❑	❑	_____	❑
Laparotomy	❑	❑	❑	_____	❑

B. PARTNER'S HISTORY Age of partner: _____

List all serious injuries or illness of partner: _____

_____

What medications does he take? _____

Cigarettes - Number per day: _____ Marijuana – amount: _____

Alcohol - type and amount per day / week: _____

Other recreational drug use: _____ Radiation or toxic chemical exposure: _____

Has a semen analysis ever been abnormal? _____

Has partner seen a doctor for infertility? _____

Has partner had a varicocele? _____

Has partner had any sexually transmitted diseases? _____

Has partner had any testicular injury or haveundescended testicles? _____

C. PREVIOUS INFERTILITY TREATMENT

	Approx. date	**Dose**	**How many months**
Antibiotics	_____	_____	_____
Clomid / Serophene	_____	_____	_____
Gonadotropins	_____	_____	_____
HCG	_____	_____	_____
Progesterone	_____	_____	_____
Lupron / Synarel	_____	_____	_____
Dostinex	_____	_____	_____
Parlodel	_____	_____	_____
	Date	**Physician**	**Diagnosis**
Operative laparoscopy	_____	_____	_____
Pelvic laparotomy	_____	_____	_____
Operative hysteroscopy	_____	_____	_____
	Date	**Physician**	**How many months**
Intrauterine inseminations	_____	_____	_____
Insemination with donor	_____	_____	_____
Clomid with IUI	_____	_____	_____
Gonadotropins with IUI	_____	_____	_____
GIFT / ZIFT	_____	_____	_____
In vitro fertil. (IVF)	_____	_____	_____