LOS OLIVOS
WOMEN'S MEDICAL GROUP

Infertility History Form

Date form completed: ___________________

Patients name: ______________________________ Partner's name:_____________________________

Age: ________Date of Birth: __________________ Age: _______Date of Birth:_________________

Occupation: ________________________________ Occupation:________________________________

Prior marriage: No ☐ Yes ☐ #_____ Prior marriage: No ☐ Yes ☐ #______

Attempted pregnancy prior marriage? No ☐ Yes ☐ Attempted pregnancy prior marriage? No ☐ Yes ☐

Ethnic origin_______________________________ Ethnic Origin: ________________________________

Women'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?
_______________	_________________	__________________	No ☐ Yes ☐
_______________	_________________	___________________	No ☐ Yes ☐
_______________	_________________	___________________	No ☐ Yes ☐

7.

Date of Miscarriage or termination	Months to conceive	Weeks of Pregnancy	D&C	Fathered by Current Partner?
_________________	_________________	_________________	No ☐ Yes ☐	No ☐ Yes ☐
_________________	_________________	_________________	No ☐ Yes ☐	No ☐ Yes ☐
_________________	_________________	_________________	No ☐ Yes ☐	No ☐ Yes ☐
_________________	_________________	_________________	No ☐ Yes ☐	No ☐ Yes ☐

Menstrual History

For Doctor's Use Only

Date of last period ____/____/____

1. How often do you have a period? (from start to start)
   _________days
2. Are your periods:
   ☐ heavy ☐ normal ☐ light
   ☐ regular ☐ irregular days from start to start_____
3. Do you have spotting between periods? ☐ Yes ☐ No
   ☐ after period ☐ before period ☐ mid cycle
4. 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?
   ☐ No ☐ Yes ☐ Sometimes ☐ Always
3. Do you use lubrication during intercourse?
   ☐ No ☐ Yes Name_________________________
4. Do you use an ovulation kit to time intercourse?
   ☐ No ☐ Yes How long? ______ months
5. Do you have any sexual concerns that you would like to discuss?
   ☐ No ☐ Yes ☐ With Partner ☐ In Private

Medical History

1. Do you have any medical illnesses?
   ☐ No ☐ Yes
   Please list: __________________________________
   ____
2. Do you take any routine medications, including herbal preparations? ☐ No ☐ Yes
   Please list: __________________________________
   ____
   ____
3. Are you allergic to any medications?
   ☐ No ☐ Yes
   Please list: _________________________________
   ____
   ____
4. Do you have any martial, sexual or emotional problems related to infertility?
   ☐ No ☐ Yes
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

For Doctor's Use Only

____Heart Disease
____Celiac Disease (gluten intolerance)
____Chronic Anemia
____Chronic Fatigue
____Osteoporosis
____Frequent Abdominal pain
____Frequent Diarrhea
____Eating Disorder
____Depression
____None of the above

Gynecological History

____Uterine Myoma (fibroid)
____Endometriosis
____Pelvic Adhesions
____Tubal Obstruction

Surgical History

☐ None

List all of your pelvic or abdominal 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
____None of the above

Social History

1. Do you smoke? ☐ No ☐ Yes Amount? ____________________
2. Do you drink alcohol? ☐ No ☐ Yes Amount? ______________
   Type:____
3. Do you use recreational drugs? ☐ No ☐ Yes Amount?_________
   Type:____
4. Are you on a special diet? ☐ No ☐ Yes Type:______________
   ____
5. Do you exercise? ☐ No ☐ Yes
   Type and amount:____
   ____

6. Have you had any of the following sexually transmitted infections?

☐ None

Check all that apply

____Gonorrhea
____Chlamydia
____HPV (human papilloma virus)
____Herpes
____Tubal infection (PID)
____HIV (AIDS)
____Hepatitis B
____Hepatitis C
____Mycoplasma or ureoplasma

For Doctor's Use Only

Prior Infertility Testing

Blood hormone testing Unknown ☐ Yes ☐ No ☐

Results:

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

Have you had any immunology or thrombophilia testing?

Unknown ☐ Yes ☐ No ☐

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

Have you seen other doctors for infertility? No ☐ Yes ☐

Please list the doctors and the approximate dates you saw them:

________________________________ __________________
________________________________ __________________
________________________________ __________________
________________________________ __________________

Have you had any of the following treatments? (If no, go to the next section).

1. Clomiphene citrate: No ☐ Yes ☐ #of cycles________
   Outcome: not pregnant ☐ pregnant ☐ miscarriage ☐

2. Intrauterine inseminations: No ☐ Yes ☐ # of cycles______
   Outcome: ☐ not pregnant ☐ pregnant ☐ miscarriage

3. Clomiphene and insemination: No ☐ Yes ☐ # of cycles____
   Outcome: ☐ not pregnant ☐ pregnant ☐ miscarriage

4. Gonadotropin and insemination: No ☐ Yes ☐ # of cycles____
   Outcome: ☐ not pregnant ☐ pregnant ☐ miscarriage

5. IVF (inVitro Fertilization) No ☐ Yes ☐ # of cycles_______
   Outcome: ☐ not pregnant ☐ pregnant ☐ miscarriage

6. Frozen Embryo Transfer: No ☐ Yes ☐ #of cycles_______
   Outcome: ☐ not pregnant ☐ pregnant ☐ miscarriage

7. Have you used donor eggs or donor sperm as part of your treatment?
   No ☐ Yes ☐

Genetic History

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

Los Olivos Male Infertility History

For Doctor's Use Only

1. Have you had a semen analysis? No ☐ Yes ☐
   How many? ______________
2. Has the analysis been normal? No ☐ Yes ☐
3. Have you fathered a pregnancy? No ☐ Yes ☐
4. Do you have any medical illnesses? No ☐ Yes ☐
   Please list: ______________________________
   ____
   ____
5. Do you take regular prescription medication? No ☐ Yes ☐
   Please list: ______________________________
   ____
   ____
6. Do you take herbal medications? No ☐ Yes ☐
   Please list: ______________________________
   ____
   ____
7. Have you had mumps after you reached puberty? No ☐
   Yes ☐
8. Have you had any injuries to your testicles? No ☐ Yes ☐
9. Have you had any surgery to your genital organs? No ☐
   Yes ☐ Please list: ______________________________
   ____
   ____
10. Have you seen a urologist in the past for any reason?
    No ☐ Yes ☐
    Reason:
    ____
    ____
    ____
11. Do you have difficulty having an erection? No ☐ Yes ☐
12. Do you use hot tubs regularly? No ☐ Yes ☐
    How often: ______________________________
13. Do you smoke? No ☐ Yes ☐
    Type and amount?
    ____
    ____
14. Do you use recreational drugs? No ☐ Yes ☐
    Type and amount:
    ____
    ____
15. Do you drink alcohol? No ☐ Yes ☐
    Amount? ______________________________
16. Have you been exposed to radiation, chemicals, pesticides or other toxins in the work place? No ☐ Yes ☐
    Type:
    ____
    ____
    ____
    ____