AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE

Infertility History Form

FOR OFFICE USE ONLY

IMPORTANT:
Please complete this form and return in the postage paid envelope.

This form was developed by the American Society for Reproductive Medicine to assist physicians and patients in obtaining a complete infertility history. It consists of three parts:

Part I: Contact information
Part II: Your medical history
Part III: Your spouse/male partner's medical history (ifapplicable)

PART I: CONTACT INFORMATION

First Name_____ **Middle Initial** _____ **Last Name** _____

Date of Birth (MM/DD/YY) ____/____/____ Age

Spouse/Male Partner's First Name ☐ NA **Middle Initial** **Last Name** _____

Spouse/Partner's Email _____

Date of Birth (MM/DD/YY) ____/____/____ Age

Who referred you?

☐ Physician
Name _____ Phone
☐ Former Patient/Friend
☐ Web Site
☐ Insurance (Name of Insurance)

Who is your Ob/Gyn?
Name Phone

Who is your Primary Care Physician?
Name Phone _____

Physician Notes
(for office use only)

_____
_____
_____
_____
_____
_____
_____

PART II: FEMALE MEDICAL HISTORY AND INFORMATION

Reason for Visit: Infertility Evaluation Sperm Insemination Other

What are your expectations for this visit?

What questions do you want answered at this visit?

Do you have any personal, ethical, or religious objections to any of our tests or treatments such as insemination, in vitro fertilization, egg donation, sperm donation, masturbation to collect a semen sample, etc.? No Yes

How many months have you been having intercourse without using any form of birth control?

Pregnancy Summary

- Total Number of ALL Pregnancies: ____
- Number of Miscaniages (less than 20 weeks):
- Number of Ectopic/Tubal Pregnancies:
- Number of Elective Terminations (Abortions):
- Number of Full Term Deliveries: Of these, how many were live births? How many were stillborn?
- Number of Premature (less than 37 weeks) Deliveries: Of these, how many were live births? How many were stillborn?
- Any Pregnancies with Birth Defects? No Yes explain

Date Pregnancy Ended or Delivered	Months to Conception	Treatments to Conceive	Delivery Type/D&C/ Complications	Current Partner?
1.				Y N
2.				Y N
3.				Y N
4.				Y N
5.				Y N
6.				Y N

Menstrual History

- Menstrual cycle pattern (check all that apply): Regular periods Irregular periods Spotting before periods No periods Heavy periods Light periods Bleeding between periods
- Number of days between the start of one period to the start of the next period: days
- How many days of bleeding do you have? days
- Dates of the 1" day of your last 2 menstrual periods: / / ; / /
- Age when you had your first period: years old
- Age when you first noticed: Breast development: years old Pubic hair: ____ years old Underarm hair: years old
- How many periods do you have per year?
- Do you need medication to bring on a period? Yes - what type? _____ No
- If you do not have periods, at what age did you stop having them? years old
- Do you have severe cramping or pelvic pain with your periods? Yes: Always Sometimes Recently In the past No

Contraceptive History

None Condoms - dates of use Diaphragm - dates of use IUD - dates of use
Birth control pills - dates of use complications? Never used birth control pills
Injectable contraception (Depo-Provera', Lunelle™, etc.)- dates of use complications?
Skin patch - dates of use complications? Foam or Jelly
Tubal sterilization procedure (tubes tied) - date (month/year) / Tubes untied - date (month/year) /

- Did your mother take DES when she was pregnant with you? Yes No Don't know

Sexual History

- How many times do you have intercourse per week? times per week None Not applicable
- Have you used over-the counter ovulation kits to time intercourse? Yes No
- Do you have pain with intercourse? Yes No
- Do you use lubricants (K-Y Jelly', etc.) during intercourse? Yes - what types? No

Have you had any of the following sexually transmitted diseases or pelvic infections? Yes (check all that apply) No

Chlamydia - date Gononhea - date Herpes - date Genital warts/HPV - date
Syphilis - date HIV/AIDS - date Hepatitis - date Other - date

Pap Smear History

- When was your last pap smear (month and year)? ___/___ ☐ Normal ☐ Abnormal
- When was your last abnormal pap smear? ☐ Not applicable

Have you undergone any procedures as a result of an abnormal pap smear?

☐ Yes (check all that apply) ☐ No

☐ Colposcopy ☐ Cryosurgery (Freezing) ☐ Laser treatment ☐ Conization ☐ LEEP procedure

Breast Screening History

Have you ever had a mammogram? ☐ No ☐ Yes - date Result: ☐ normal ☐ abnormal - explain

Do you perform breast self exams? ☐ Yes ☐ No

Medical History

- Are you allergic to any medications? ☐ No ☐ Yes (Please list and describe reactions)

- Are you allergic to any foods (peanuts, eggs, etc.)? ☐ No ☐ Yes (Please list and describe reactions)

- List any medications you are currently taking, including over-the-counter medicines.

- Do you take any herbal medicines/vitamins or health food store supplements? ☐ No ☐ Yes (Please list)

- Do you have any medical problem(s)? ☐ No ☐ Yes (Please list type, dates, and treatments.)

(1)
(2)
(3)
(4)
(5)

- Did you have either of these childhood illnesses? ☐ Chickenpox (Varicella) ☐ German Measles (Rubella) ☐ Don't know

Other childhood diseases: _____

Vaccinations

• Chickenpox (Varicella):	☐ No	☐ Yes (dates	☐ Don't know
• MMR - Measles, Mumps, and Rubella (German Measles):	☐ No	☐ Yes (dates	☐ Don't know
• BCG (Tuberculosis):	☐ No	☐ Yes (dates	☐ Don't know
• Hepatitis B:	☐ No	☐ Yes (dates	☐ Don't know
• Polio:	☐ No	☐ Yes (dates	☐ Don't know
• Hepatitis A:	☐ No	☐ Yes (dates	☐ Don't know
• Tetanus:	☐ No	☐ Yes (dates	☐ Don't know
• Influenza:	☐ No	☐ Yes (dates	☐ Don't know

Social History

- How many caffeinated beverages (coffee, tea, soda) do you drink per day? ☐ None
- 52 ë2dz ăY2ʔŜ ŏλ∃I·NJŜúúŜăK ☐ b2 ☐ ¸Ŝă I2ø Y I·yêkŘI·èK I2ø Y I·yê èŜI·NJăK ___ ☐ vdzλú π øKŜyK
- Do you drink alcohol? ☐ No ☐ Yes
  ☐ . ŜŜNJ π I LJŜNJ øŜŜʔ ☐ ² λyŜπ I LJŜNJ øŜŜʔ ☐ ⌈λIjdz2NJ π I LJŜNJ øŜŜʔ
- 52 ë2dz dzăŜ Y I·NJλ2dzI·yI·Σ ŏ2ŏI·λyŜΣ 2NJ I·yê 2úKŜNJ ăλY λ⌈I·NJ ŘNJdz∃K ☐ b2 ☐ ¸Ŝă óŘŜăŏNJλōŜ)
- 52 ë2dz ŜÈŜNJŏλăŜK ☐ b2 ☐ ¸Ŝă)
  (describe)
  ! NJŜ ë2dz I·øI·NJŜ 2ʇ I·yê NJI·ŘλI·úλ2y ŜÈLJ2ădzNJŜă 2úKŜNJ úKI·y · πNJI·èăK ☐ b2 ☐ ¸Ŝă óŘŜăŏNJλōŜNJ

Physician Notes (for office use only) _____

Surgical History

• Have you had any surgeries? ☐ No ☐ Yes (List all surgeries in chronologic order.)

Year	Reason and Type of Surgery
(1)	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	

• Did you have any anesthesia problems? ☐ No ☐ Yes (describe

Physical Symptoms

General:
- ☐ Recent weight gain or loss
- ☐ Anorexia/Bulimia
- ☐ Lack of energy
- ☐ Fever/Chills
- ☐ Other
- ☐ None

Endocrine/Hormonal:
- ☐ Diabetes ☐ Hair loss
- ☐ Thyroid gland problems
- ☐ Rapid weight gain or loss
- ☐ Excessive hunger/thirst
- ☐ Temperature intolerance- hot flashes or feeling cold
- ☐ Other
- ☐ None

Gastrointestinal:
- ☐ Nausea/Vomiting ☐ Ulcers
- ☐ Hepatitis ☐ Diarrhea
- ☐ Blood in your stools ☐ Constipation
- ☐ Irritable Bowel Syndrome
- ☐ Change in bowel habits
- ☐ Colitis (ulcerative or Crohn's)
- ☐ Other
- ☐ None

Musculoskeletal:
- ☐ Unusual muscle weakness
- ☐ Decreased energy/stamina
- ☐ Rheumatoid arthritis
- ☐ Lupus Erythematosus
- ☐ Myasthenia gravis
- ☐ Other
- ☐ None

Mental Health Problems:
- ☐ Depression ☐ Anxiety disorder
- ☐ Schizophrenia
- ☐ Other
- ☐ None

Head, Eyes, Ears, Nose, and Throat:
- ☐ Dizziness ☐ Loss of sense of smell
- ☐ Headaches ☐ Chronic nasal congestion
- ☐ Blurred vision ☐ Ringing ears
- ☐ Hearing loss/deafness
- ☐ Other ☐ None

Breasts:
- ☐ Discharge (clear ☐ bloody ☐ milky ☐)
- ☐ Lumps ☐ Pain ☐ Cancer
- ☐ Abnormal mammogram
- ☐ Reduction
- ☐ Augmentation/Breast implants (saline? ☐ silicone? ☐
- ☐ Other
- ☐ None

Genito-Urinary:
- ☐ Bladder infections
- ☐ Kidney infections
- ☐ Vaginal infections
- ☐ Frequent urination ☐ Leaking urine
- ☐ Blood in the urine
- ☐ Herpes
- ☐ Other
- ☐ None

Hematologic:
- ☐ Blood clotting disorder/Blood clot
- ☐ Sickle cell Anemia ☐ Thrombophlebitis
- ☐ Easy bruising
- ☐ Swollen glands/lymph nodes
- ☐ Blood transfusions (dates & reason)
- ☐ Other
- ☐ None

Respiratory:
- ☐ Shortness of breath
- ☐ Asthma ☐ Bronchitis
- ☐ Pneumonia ☐ Tuberculosis
- ☐ Bloody cough
- ☐ Other
- ☐ None

Neurological Problems:
- ☐ Weakness/Loss of balance
- ☐ Seizures/Epilepsy
- ☐ Headaches
- ☐ Migraine headaches
- ☐ Numbness
- ☐ Memory loss
- ☐ Other
- ☐ None

Skin/Extremities:
- ☐ Unexplained rash/inflammation
- ☐ Acne
- ☐ Skin cancer
- ☐ Burn injury
- ☐ Moles changing in appearance
- ☐ Excess hair growth
- ☐ Other
- ☐ None

Cardiovascular:
- ☐ Palpitations/Skipped beats
- ☐ Chest pain ☐ Heart attack
- ☐ Stroke ☐ Murmurs
- ☐ High blood pressure
- ☐ Rheumatic fever
- ☐ Mitral valve prolapse (need antibiotics before dental procedures Yes No)
- ☐ Other
- ☐ None

Physician Notes (for office use only)_____

Family History

	Living		Cause of Death/Age at Death
• Mother	☐ Yes - age	☐ No	
• Father	☐ Yes - age	☐ No	
• Brother(s)	☐ Yes - age	☐ No	
	☐ Yes - age	☐ No	
• Sister(s)	☐ Yes - age	☐ No	
	☐ Yes - aag	☐ No	
• Maternal Grandmother	☐ Yes - age	☐ No	
• Maternal Grandfather	☐ Yes - age	☐ No	
• Paternal Grandmother	☐ Yes - age	☐ No	
• Paternal Grandfather	☐ Yes - age	☐ No	

What is your Ancestry?

- ☐ African-American
- ☐ American Indian/Native American
- ☐ Ashkenazi Jewish
- ☐ Asian-American
- ☐ Cajun/French Canadian
- ☐ Caucasian
- ☐ Eastern European
- ☐ Hispanic/Caribbean
- ☐ Northern European
- ☐ Southern European
- ☐ Other (specify

Would you like to be screened for:

☐ Cystic Fibrosis:	☐ Yes	☐ No
☐ Sickle Cell Anemia:	☐ Yes	☐ No
☐ Tay-Sachs Disease:	☐ Yes	☐ No
☐ Thalasemia:	☐ Yes	☐ No

Disorders in Your Family

	Relationship to You		
• Breast cancer	☐ Yes	☐ No	☐ Don't know
• Ovarian cancer	☐ Yes	☐ No	☐ Don't know
• Colon cancer	☐ Yes	☐ No	☐ Don't know
• Other cancer	☐ Yes	☐ No	☐ Don't know
• Diabetes	☐ Yes	☐ No	☐ Don't know
• Thyroid problems	☐ Yes	☐ No	☐ Don't know
• Heart disease	☐ Yes	☐ No	☐ Don't know
• Blood clots	☐ Yes	☐ No	☐ Don't know
• Obesity	☐ Yes	☐ No	☐ Don't know
• Psychiatric problems	☐ Yes	☐ No	☐ Don't know
• Tuberculosis	☐ Yes	☐ No	☐ Don't know
• Endometriosis	☐ Yes	☐ No	☐ Don't know
• Infertility	☐ Yes	☐ No	☐ Don't know
• Menopause before age 40	☐ Yes	☐ No	☐ Don't know
• Birth defects	☐ Yes	☐ No	☐ Don't know
• Cystic Fibrosis	☐ Yes	☐ No	☐ Don't know
• Tay - Sachs disease	☐ Yes	☐ No	☐ Don't know
• Canavan disease	☐ Yes	☐ No	☐ Don't know
• Bloom syndrome	☐ Yes	☐ No	☐ Don't know
• Gaucher disease	☐ Yes	☐ No	☐ Don't know
• Niemann-Pick disease	☐ Yes	☐ No	☐ Don't know
• Fanconi Anemia	☐ Yes	☐ No	☐ Don't know
• Familial Dysautonia	☐ Yes	☐ No	☐ Don't know
• Muscular Dystrophy	☐ Yes	☐ No	☐ Don't know
• Neurologic (brain/spine)	☐ Yes	☐ No	☐ Don't know
• Neural Tube Defects	☐ Yes	☐ No	☐ Don't know
• Bone/Skeletal Defects	☐ Yes	☐ No	☐ Don't know
• Dwarfism	☐ Yes	☐ No	☐ Don't know
• Developmental delay	☐ Yes	☐ No	☐ Don't know
• Learning problems	☐ Yes	☐ No	☐ Don't know
• Polycystic kidney disease	☐ Yes	☐ No	☐ Don't know
• Heart defect from birth	☐ Yes	☐ No	☐ Don't know
• Down syndrome	☐ Yes	☐ No	☐ Don't know
• Other chromosome defect	☐ Yes	☐ No	☐ Don't know
• Marfan syndrome	☐ Yes	☐ No	☐ Don't know
• Hemophilia	☐ Yes	☐ No	☐ Don't know
• Sickle Cell Anemia	☐ Yes	☐ No	☐ Don't know
• Thalassemia	☐ Yes	☐ No	☐ Don't know
• Galactosemia	☐ Yes	☐ No	☐ Don't know
• Deafness/Blindness	☐ Yes	☐ No	☐ Don't know
• Color Blindness	☐ Yes	☐ No	☐ Don't know
• Hemochromatosis	☐ Yes	☐ No	☐ Don't know
☐ none of the above	☐ Other (Specify		

PRIOR INFERTILITY TESTING AND TREATMENT

- Have you had prior infertility testing or treatment elsewhere? ☐ Yes ☐ No

Prior Tests (check all that apply) ☐ Basal body temperature chart (date

☐ Thyroid test (date _____) ☐ Ovulation test kit (date

☐ Day 3 blood test for FSH level (date) ☐ Hysterosalpingogram (HSG) (date

☐ Laparoscopy surgery (date) ☐ Hysteroscopy surgery (date

☐ Progesterone blood test (date _____) ☐ Prolactin blood test (date

Prior Treatment (check all that apply):

	# of cycles	Dates (mo/year)	Outcome
☐ Intrauterine insemination:		From	Select From Dropdown
☐ Clomiphene citrate with timed intercourse: maximum # tablets per day?		From	Select From Dropdown
☐ Clomiphene citrate with insemination: maximum # tablets per day?		From	Pregnant
☐ Daily fertility drug injection with insemination:		From	Select From Dropdown
☐ Completed in vitro fertilization cycle(s):			Select From Drop Down OTHER NOTES ABOUT COMPLETED IVF CYCLES:
☐ Frozen embao transfers: 1. # embryos transferred 2. # embryos transferred 3. # embryos transferred 4. # embryos transferred			Select From Dropdown OTHER NOTES ABOUT FET:
Canceled in vitro fertilization attempt(s):			
☐ Any other prior treatment (describe):			

- Additional Information/Complications:

EMOTIONAL STATUS

- On a scale of I-10 (10 being the worst). estimate the level of stress you feel due to infertility and other pressures.
- Do you see a counselor? ☐ No ☐ Yes - For how long? How often?
- List any antidepressant/anti-anxiety medications you are currently taking.
- Describe any emotional, marital, or sexual problems caused by your infertility.

PATIENT'S SIGNATURE _____ DATE _____

I confirm that I have reviewed the infonnation above.

PHYSICIAN'S SIGNATURE _____ DATE _____

PART III: MALE MEDICAL HISTORY AND INFORMATION

Complete with your male partner if applicable.

- Have you been evaluated by a urologist? ☐ Yes ☐ No
- Have you previously conceived with another woman? ☐ Yes: How many times? ☐ No: Birth control used? Yes ☐ No ☐
- Have you had a semen analysis? ☐ Yes ☐ No
- Do you have difficulty with erections? ☐ Yes ☐ No
- Do you have retrograde ejaculation of sperm into the bladder? ☐ Yes ☐ No
- Have you had any of the following sexually transmitted diseases or pelvic infections?
  ☐ Yes (check all that apply) ☐ No
  ☐ Chlamydia - date ☐ Gonorrhea - date ☐ Herpes - date ☐ Genital warts/HPV - date
  ☐ Syphilis - date ☐ HIV/AIDS date ☐ Hepatitis date ☐ Other
- Have you had a history of undescended testicles? ☐ Yes - One side Both ☐ No
- Do you have scrotal or testicular pain? ☐ Yes ☐ No
- Did you have the mumps after puberty? ☐ Yes ☐ No
- Have you had prior injury to your testicles requiring hospitalization? ☐ Yes ☐ No

- Have you been diagnosed with any of the following diseases?
  ☐ Diabetes Mellitus - Yes ☐ No ☐ ☐ Cancer - Yes ☐ No ☐
  ☐ Multiple Sclerosis - Yes ☐ No ☐ ☐ Other neurologic problems - Yes ☐ No ☐
  ☐ Prostatic infections - Yes ☐ No ☐ ☐ Urinary infections - Yes ☐ No ☐
  ☐ High Blood Pressure - Yes ☐ No ☐ If yes, any medications?

- Have you had any fever in the last 3 months? ☐ Yes ☐ No
- Have you had a vasectomy? ☐ Yes ☐ No
  If yes, have you had a vasectomy reversal? ☐ Yes ☐ No
- Have you had surgery for varicocele repair? ☐ Yes ☐ No
- Have you had hernia surgery? ☐ Yes ☐ No
- Did you undergo any bladder or penis surgery as a child? ☐ Yes ☐ No
- Are you exposed to prolonged heat in the workplace? ☐ Yes ☐ No
- Are you exposed to any radiation or harmful chemicals in the workplace? ☐ Yes ☐ No
- Have you had chemotherapy for cancer? ☐ Yes ☐ No
- Are you allergic to any medications? ☐ No ☐ Yes (Please list and describe reactions)

List your current medications:

List any current medical problem(s):

- How many caffeinated beverages do you drink per day? ☐ None
- Do you smoke cigarettes? ☐ No ☐ Yes How much/day? How many years? ☐ Quit - when?
- Do you drink alcohol? ☐ No ☐ Yes
  ☐ Beer - # per week ☐ Wine - # per week ☐ Liquor - # per week
- Do you use marijuana, cocaine, or any other similar drug? ☐ No ☐ Yes (describe _____
- Do you use herbal medicines/vitamins or health food store supplements? ☐ No ☐ Yes (describe)
- Are you aware of any radiation/toxic materials exposure? ☐ Yes ☐ No

- Do you use hot tubs regularly? ☐ Yes ☐ No
- Did your mother take DES during pregnancy to prevent miscarriage? ☐ Yes ☐ No ☐ Don't know
- Have any of your immediate family members had difficulty conceiving a child? ☐ Yes ☐ No
  If yes. please describe

Physician Notes (for office use only) _____

Disorders in Your Family	Relationship to You	Please Choose From Dropdown Select Yes, No, I Don't Know
• Cystic Fibrosis		Select
• Tay - Sachs disease		Select
• Canavan disease		Select
• Bloom syndrome		Select
• Gaucher disease		Select
• Niemann-Pick disease		Select
• Fanconi Anemia		Select
• Familial Dysautonia		Select
• Muscular Dystrophy		Select
• Neurologic (brain/spine)		Select
• Neural Tube Defects		Select
• Bone/Skeletal Defects		Select
• Dwarfism		Select
• Developmental delay		Select
• Learning problems		Select
• Polycystic kidney disease		Select
• Heart defect from birth		Select
• Down syndrome		Select
• Other chromosome defects		Select
• Marfan syndrome		Select
• Hemophilia		Select
• Sickle Cell Anemia		Select
• Thalassemia		Select
• Galactosemia		Select
• Deafness/Blindness		Select
• Color Blindness		Select
• Hemochromatosis		Select
☐ None of the above	☐ Other (Specify	

What is your Ancestry?

- ○ African-American
- ○ American Indian/Native American
- ○ Ashkenazi Jewish
- ○ Asian-American
- ○ Cajun/French Canadian
- ○ Caucasian
- ○ Eastern European
- ○ Hispanic/Caribbean
- ○ Northern European
- ○ Southern European
- ◉ Other (specify

Would you like to be screened for:

- ☐ Cystic Fibrosis: Select
- ☐ Sickle Cell Anemia: Select
- ☐ Tay-Sachs Disease: Select
- ☐ Thalasemia: Select

SPOUSE/MALE PARTNER'S SIGNATURE,_____ DATE_____

I confirm that I have reviewed the information above.

PHYSICIAN'S SIGNATURE_____ DATE_____

Physician Notes (for office use only) _____