Wake Forest™ Baptist Health

AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE

INFERTILITY HISTORY FORM

IMPORTANT:

Please complete this form prior to your scheduled visit.
This form was developed by the American Society for Reproductive Medicine (ASRM) and The Center for Fertility, Endocrine and Menopause (CFEM) at Wake Forest Baptist Health to assist physicians and patients in obtaining a complete infertility history. It consists of three parts:
PART I: Contact Information and Demographics
PART II: Medical History
PART III: Male Partner History and Information

PART I: CONTACT INFORMATION AND DEMOGRAPHICS

First Name: _____ **Middle Initial:** ____ **Last Name**: _____

Age: _____ **Date of Birth (MM/DD/YY):** _____/_____/_____

Gender Identity: ☐ **Female** ☐ **Male** **Sex Assigned at Birth:** ☐ **Female** ☐ **Male**

Occupation: _____

Home Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **Country:** _____

Home Phone: _____ **Cell Phone:** _____ Email**:** _____

Height: _____ **Weight:** _____

Do you have a partner? ☐ **Yes** ☐ **No**

Are you married? ☐ **Yes** ☐ **No**

Partner's First Name: _____ **Middle Initial:** ____ **Last Name**: _____

Age: _____ **Date of Birth (MM/DD/YY):** _____/_____/_____

Gender Identity: ☐ **Female** ☐ **Male** **Sex Assigned at Birth:** ☐ **Female** ☐ **Male**

Occupation: _____

Home Street Address *(If Different)*:_____

City: _____ **State:** _____ **Zip Code:** _____ **Country:** _____

Home Phone: _____ **Cell Phone:** _____ Email**:** _____

Who is your OBGYN? Name: _____

Address: _____ **Phone Number:** _____

Who is your Primary Care Physician? Name: _____

Address: _____ **Phone Number:** _____

By whom were you referred?

- ☐ **Physician**: _____
- ☐ **Former Patient/Friend**: _____
- ☐ **Web Site:** _____
- ☐ **Other:** _____

Preferred Pharmacy:
Pharmacy Name: _____
Pharmacy Address: _____
Pharmacy Phone Number: _____

PART II: FEMALE MEDICAL HISTORY AND INFORMATION:

Reason for visit: ☐ **Infertility** ☐ **Recurrent Pregnancy Loss** ☐ **Other** _____

How many months have you been trying to conceive (unprotected intercourse/inseminations)? _____

Pregnancy Summary

- Total Number of ALL Pregnancies: _____ Total number of living children: _____
- Number of Full Term Deliveries (>37 weeks): _____ of these, how many were live births? _____ Stillborn? _____
- Number of Premature (<37 weeks) Deliveries: _____ of these, how many were live births? _____ Stillborn? _____
- Number of Miscarriages (<20 weeks): _____
- Number of Ectopic/Tubal Pregnancies: _____
- Number of Elective Terminations (Abortions): _____
- 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 ☐ No periods ☐ Spotting before 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 bleeding do you have? _____ days
- Dates of the 1st day of your last 2 menstrual periods: _____/_____/_____; _____/_____/_____
- 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? ☐ No ☐ Yes: Always ___ Sometimes ___ Recently ___ In the past ___
- Do you have bowel changes with menses? ☐ No ☐ Yes: Always ___ Sometimes ___ Recently ___ In the past ___

Contraceptive History

☐ None ☐ IUD- dates of use _____ ☐ Diaphragm ☐ Birth control pills – dates of use _____
☐ Never used birth control pills
☐ Injectable Contraception (Depo-Provera®, Nexplanon®, etc.) - dates of use _____
☐ Tubal sterilization procedure – date (month/year) _____/_____ ☐ Tubal reversal procedure – date (month/year) _____/_____

Sexual History

- How many times do you have intercourse per week? _____ times per week ☐ None ☐ N/A
- Have you used over-the-counter ovulation kits to time intercourse ☐ Yes ☐ No
- Do you use lubricants during intercourse? ☐ Yes – what types? _____ ☐ No
- Do you have pain with intercourse? ☐ Yes ☐ Sometimes ☐ No
- Any prior exposure to 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 _____

Pap Smear History

- When was your last pap smear (month and year)? _____/_____ ☐ Normal ☐ Abnormal
- When was your last abnormal pap smear? _____ ☐ N/A

Have you undergone any procedures as a result of an abnormal pap smear? ☐ Yes (check all that apply) ☐ No
☐ Colposcopy ☐ Cryosurgery ☐ Laser Treatment ☐ Conization ☐ LEEP procedure

Breast Screening History

- Have you ever had a mammogram? ☐ No ☐ Yes – date _____ Result: ☐ Normal
  ☐ Abnormal – explain _____
- Do you perform self breast exams? ☐ Yes ☐ No

Medical History

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

  _____

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

  *_____

  *_____

  *_____

  *_____
- 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):

  _____

  _____

Vaccination History

- Chickenpox (Varicella): ☐ No ☐ Yes ☐ Unknown
- MMR (Measles, Mumps, Rubella): ☐ No ☐ Yes ☐ Unknown
- Tuberculosis: ☐ No ☐ Yes ☐ Unknown
- Hepatitis B: ☐ No ☐ Yes ☐ Unknown
- Polio: ☐ No ☐ Yes ☐ Unknown
- Hepatitis A: ☐ No ☐ Yes ☐ Unknown
- Tetanus: ☐ No ☐ Yes ☐ Unknown
- Influenza: ☐ No ☐ Yes ☐ Unknown

Social History

- Do you smoke cigarettes? ☐ No ☐ Yes How many/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 exercise? ☐ No ☐ Yes If yes, how often: _____
- Are you aware of any radiation exposure other than X-rays? ☐ No ☐ Yes - Describe _____
  _____

Surgical History

Have you had any surgeries? ☐ No ☐ Yes (List all surgeries in chronological order):

Year **Reason and Type of Surgery**

_____ 1. _____

_____ 2. _____

_____ 3. _____

_____ 4. _____

_____ 5. _____

_____ 6. _____

- Did you have any anesthesia problems? ☐ No ☐ Yes - Describe _____

  _____

Physical Symptoms

General:	Endocrine/Hormonal:	Breasts:
☐ Recent weight gain/loss ☐ Anorexia/Bulimia ☐ Lack of energy ☐ Other _____ ☐ None	☐ Diabetes ☐ Hair loss ☐ Thyroid gland problems ☐ Rapid weight gain or loss ☐ Excessive hunger/thirst ☐ Temperature intolerance (hot flashes or feeling cold) ☐ Other _____ ☐ None	☐ Discharge- if yes, describe _____ ☐ Pain ☐ Cancer ☐ Augmentation/Breast implants – if yes, date _____ ☐ Breast Reduction – if yes, date _____ ☐ Other _____ ☐ None
Gastrointestinal:	**Genito-Urinary:**	**Hematologic:**
☐ Hepatitis ☐ Nausea/vomiting ☐ Blood in stool ☐ Diarrhea/Constipation ☐ Change in Bowel Habits ☐ Other _____ ☐ None	☐ Bladder/Kidney infections ☐ Vaginal infections ☐ Frequent urination ☐ Blood in urine ☐ Other _____ ☐ None	☐ Blood clotting disorder/Blood clots ☐ Sickle cell Anemia ☐ Blood transfusions ☐ Easy bruising ☐ Other _____ ☐ None
Cardiovascular:	**Mental Health Problems:**	
☐ Palpitations/Skipped beats ☐ High blood pressure ☐ Heart murmur ☐ Heart attack or Stroke ☐ Other _____ None	☐ Depression ☐ Anxiety Disorder ☐ Bipolar Disorder ☐ Schizophrenia ☐ Other _____ ☐ None	

What is your Ancestry?

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

Family History

	Living	Cause of Death/Age
Mother	☐ Yes- age ___	☐ No _____
Father	☐ Yes- age ___	☐ No _____
Brother(s)	☐ Yes- age ___	☐ No _____
	☐ Yes- age ___	☐ No _____
Sister(s)	☐ Yes- age ___	☐ No _____
	☐ Yes- age ___	☐ No _____

Disorders in your Family

	Relationship to You		
Breast cancer	☐ Yes _____	☐ No	☐ Unknown
Ovarian cancer	☐ Yes _____	☐ No	☐ Unknown
Other cancer _____	☐ Yes _____	☐ No	☐ Unknown
Diabetes	☐ Yes _____	☐ No	☐ Unknown
Thyroid Problems	☐ Yes _____	☐ No	☐ Unknown
Blood clots	☐ Yes _____	☐ No	☐ Unknown
Psychiatric problems	☐ Yes _____	☐ No	☐ Unknown
Endometriosis	☐ Yes _____	☐ No	☐ Unknown
Infertility	☐ Yes _____	☐ No	☐ Unknown
Menopause before age 40	☐ Yes _____	☐ No	☐ Unknown
Birth defects	☐ Yes _____	☐ No	☐ Unknown
Cystic Fibrosis	☐ Yes _____	☐ No	☐ Unknown
Tay-Sachs disease	☐ Yes _____	☐ No	☐ Unknown
Muscular Dystrophy	☐ Yes _____	☐ No	☐ Unknown
Neural Tube Defects	☐ Yes _____	☐ No	☐ Unknown
Dwarfism	☐ Yes _____	☐ No	☐ Unknown
Bone/Skeletal Defects	☐ Yes _____	☐ No	☐ Unknown
Polycystic kidney disease	☐ Yes _____	☐ No	☐ Unknown
Heart defect from birth	☐ Yes _____	☐ No	☐ Unknown
Down syndrome	☐ Yes _____	☐ No	☐ Unknown
Hemophilia	☐ Yes _____	☐ No	☐ Unknown
Sickle Cell Anemia	☐ Yes _____	☐ No	☐ Unknown
Other chromosome defects	☐ Yes _____	☐ No	☐ Unknown

If yes, explain _____

☐ None of the Above

Prior Infertility Testing and Treatment

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

Prior Tests (check all that apply):

- ☐ Thyroid test (date/results) _____
- ☐ Ovulation Predictor Kit (results) _____
- ☐ Progesterone level to confirm ovulation (date/results) _____
- ☐ Day 2/3 FSH or AMH (date/results) _____
- ☐ Hysterosalpingogram (HSG) (date/results) _____
- ☐ Saline Infusion Sonogram (SIS) (date/results) _____
- ☐ Laparoscopy (date/results) _____
- ☐ Hysteroscopy (date/results) _____
- ☐ Other _____

Prior Treatment (check all that apply):

	# of cycles	Dates (Mo./Yr.) (Mo./Yr.)	Pregnant
☐ **Clomid/Femara with timed intercourse** Where? _____	_____	From _____/_____ to _____/_____	☐ Yes ☐ No
☐ **Clomid/Femara with IUI** Where? _____	_____	From _____/_____ to _____/_____	☐ Yes ☐ No
☐ **IUI without fertility drugs** Where? _____	_____	From _____/_____ to _____/_____	☐ Yes ☐ No
☐ **Daily fertility drug injections with IUI** Where? _____	_____	From _____/_____ to _____/_____	☐ Yes ☐ No
☐ **Completed IVF cycle(s)** Where? _____ 1. # eggs ___ # embryos transferred ___# frozen ___ 2. # eggs ___ # embryos transferred ___# frozen ___ 3. # eggs ___ # embryos transferred ___# frozen ___ 4. # eggs ___ # embryos transferred ___# frozen ___	_____	_____/_____ _____/_____ _____/_____ _____/_____	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
☐ **Frozen embryo transfer(s):** Where? _____ 1. # embryos transferred _____ 2. # embryos transferred _____ 3. # embryos transferred _____ 4. # embryos transferred _____	_____	_____/_____ _____/_____ _____/_____ _____/_____	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
Cancelled IVF attempt(s) Where? _____	_____		

Additional information/complications: _____

_____

_____

PART III: MALE PARTNER MEDICAL HISTORY AND INFORMATION (IF APPLICABLE)

- Have you been evaluated by a urologist? ☐ Yes ☐ No
- Have you previously conceived with another woman? ☐ Yes - How many times? _____ ☐ 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
- Any prior exposure to sexually transmitted diseases or infections? ☐ Yes (check all that apply) ☐ No
  ☐ Chlamydia – date _____ ☐ Gonorrhea – date _____ ☐ Herpes – date _____
  ☐ Genital Warts/HPV – date _____ ☐ Syphilis – date _____ ☐ HIV/AIDS – date _____
  ☐ Hepatitis – date _____
- 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 been diagnosed with any of the following disease?

  ☐ Diabetes ☐ Yes ☐ No ☐ Cancer ☐ Yes ☐ No ☐ Multiple Sclerosis ☐ Yes ☐ No
  ☐ Prostatic Infection ☐ Yes ☐ No ☐ High Blood Pressure ☐ Yes ☐ No ☐ Urinary Infection ☐ Yes ☐ No
  ☐ Other Neurologic problems ☐ Yes ☐ No
- Have you had prior injury to your testicles requiring hospitalization? ☐ Yes ☐ No

- Have you had any fever in the last 3 months? ☐ Yes ☐ No
- Have you had a vasectomy? ☐ Yes (Date: _____) If yes, have had a reversal? ☐ Yes (Date: _____) ☐ No
- Have you had a 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
- Have you had any other surgeries? ☐ No ☐ Yes - _____
- 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
- Do you use hot tubs regularly? ☐ Yes ☐ No
- Have any of your immediate family members had difficulty conceiving a child? ☐ No ☐ Yes (Please describe) _____

_____

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

_____

- Do you smoke cigarettes? ☐ No ☐ Yes How many/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 _____

_____

Disorders in your Family

	Relationship to You		
Other cancer _____	☐ Yes _____	☐ No	☐ Unknown
Diabetes	☐ Yes _____	☐ No	☐ Unknown
Psychiatric problems	☐ Yes _____	☐ No	☐ Unknown
Infertility	☐ Yes _____	☐ No	☐ Unknown
Birth defects	☐ Yes _____	☐ No	☐ Unknown
Cystic Fibrosis	☐ Yes _____	☐ No	☐ Unknown
Tay-Sachs disease	☐ Yes _____	☐ No	☐ Unknown
Muscular Dystrophy	☐ Yes _____	☐ No	☐ Unknown
Neural Tube Defects	☐ Yes _____	☐ No	☐ Unknown
Dwarfism	☐ Yes _____	☐ No	☐ Unknown
Bone/Skeletal Defects	☐ Yes _____	☐ No	☐ Unknown
Polycystic kidney disease	☐ Yes _____	☐ No	☐ Unknown
Heart defect from birth	☐ Yes _____	☐ No	☐ Unknown
Down syndrome	☐ Yes _____	☐ No	☐ Unknown
Hemophilia	☐ Yes _____	☐ No	☐ Unknown
Sickle Cell Anemia	☐ Yes _____	☐ No	☐ Unknown
Other chromosome defects	☐ Yes _____	☐ No	☐ Unknown

If yes, explain _____

☐ None of the Above

What is your Ancestry?

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