the CENTER for REPRODUCTIVE HEALTH
the CENTER for ASSISTED REPRODUCTIVE TECHNOLOGIES

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Subspecialty in Reproductive Endocrinology & Infertility

The following form should be completed prior to your appointment.

Patient Name: _____ **DOB:** _____

Partner: _____ **DOB:** _____

PREVIOUS PREGNANCY:

Year	Weeks of Gestation @ Outcome	Outcome: Live Birth Still Birth Spontaneous Abortion Ectopic Elective Abortion	Type of Delivery: Vaginal C-Section	Complications

MENSTRUAL HISTORY:

1. Shortest interval between cycles _____
2. Longest interval between cycles _____
3. Number days of flow _____
4. Do you ever have bleeding between cycles? _____
5. Do you take medication to regulate your cycles presently? Yes No
6. Have you taken medications to regulate your cycles in the past? Yes No
   If yes, what medication did you take? _____

CONTRACEPTION: Please list all methods of contraception and dates used:

_____

_____

_____

INFERTILITY HISTORY:

1. Previous Testing:
   a. Temperature charts Yes No Date_____ Outcome _____
   b. Ovulation predictor Yes No Date_____ Outcome _____
   c. Post coital test Yes No Date_____ Outcome _____
   d. SonoHysterosalpingogram Yes No Date_____
      Outcome _____
   e. Laparoscopy Yes No Date_____
      Outcome _____

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2. If you have had any previous infertility treatments, please complete the following:

Medication (dosage)	Treatment: Timed Intercourse (TI) Intrauterine Insemination (IUI) In Vitro Insemination (IVF)	Date	Outcome

SURGICAL HISTORY:

Year	Type of Surgery	Year	Type of Surgery

MEDICATIONS: Please list all medications you are currently taking as well as allergies.

Medications	Dosage

Allergen	Reaction

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PATIENT NAME: _____

Additional Patient History

Please answer the following questions and return to the receptionist at your initial appointment.

1. Have you had or do you have a prolonged cough greater than two weeks?
2. Have you had or do you have a cough with production of sputum or blood?
3. Are you experiencing fatigue, loss of appetite, weight loss, or fever? If yes. please specify.
4. Have you ever been diagnosed or treated for Tuberculosis (TB)?
   Have any of your friends or family been diagnosed or treated?
5. Have you ever had a positive result to Tuberculosis (TB) skin testing?

Thank you for taking the time to answer these important medical questions.

_____ _____

Signature Date

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In order to complete the necessary paperwork needed for your appointment please answer the following questions:

1. Is your menstrual cycle regular? ☐ Yes ☐ No
2. Have you had a tubal ligation/tubal reversal? ☐ Yes ☐ No
3. Has your partner had a vasectomy/vasectomy reversal? ☐ Yes ☐ No
4. Have you or your partner had any infertility testing (i.e., blood work, semen analysis, etc.)? ☐ Yes ☐ No
5. Have you ever been treated with fertility drugs (i.e., Clomid, etc.) ☐ Yes ☐ No
6. Have you had any infertility treatment such as IVF, IUI, etc.? ☐ Yes ☐ No
7. Have you been diagnosed as "infertile" by another physician? ☐ Yes ☐ No