Cooper Institute For Advanced Reproductive Medicine, Houston, TX

INFERTILITY HISTORY

Date:_____ Years of infertility:_____

Female's name (patient):_____Date of birth:_____Age:_____

Male's name (partner)_____Date of birth:_____Age:_____

Marital status: ☐ Married [ ] Common law ☐ Single ☐ Divorced ☐ Widowed [ ] Separated

Female: is this your first marriage? [ ] Yes, if no how many times have you been married:_____How long____

Partner: is this your first marriage? [ ] Yes, if no how many times have you been married:_____How long____

How long have you been married/living together:_____

MENSTRUAL HISTORY:

Date of last menstrual cycle:_____

Age of onset of menses:_____year old Duration of menses:_____days

Number of days between the first day of period to the first day of next period:_____days

Amount of menstrual flow: ☐ < 6 ☐ >6 pads or tampons/day

Spotting prior to flow: ☐ Yes ☐ No

Cramps during period: ☐ Yes ☐ No If **YES** ☐ Mild ☐ Moderate ☐ Severe

Medication for menstrual cramps (if any)?_____

FEMALE MEDICAL HISTORY:

Have you ever been pregnant: ☐ Yes ☐ No

PREGNANCY DATA:

Date	Infertility treatment (Indicate type)	# months needed to conceive	Type of delivery Vag, C-sec	Full Term 37 weeks	Pre term < 37	Sex	With current husband	Age of child
	Y N					M F	Y N	
	Y N					M F	Y N	
	Y N					M F	Y N	
	Y N					M F	Y N	

Spontaneous Abortions (miscarriages):_____Month/Year:_____

Elected (Volunteer termination of pregnancy)_____Month/Year:_____

#Therapeutic Abortions:_____Reason:_____Month/Year:_____

Entopic pregnancies:_____(Right or Left) _____Month/Year_____

Endometriosis ☐ Yes ☐ No Year diagnosed:_____

Tubal Occlusion/Disease ☐ Yes ☐ No Year diagnosed:_____

Pelvic Adhesions ☐ Yes ☐ No Year diagnosed:_____

Contraception: Have you ever used the following methods of birth control:

Birth Control pills ☐ Yes ☐ No Type:_____Length of use:_____Side Effects:_____

IUD ☐ Yes ☐ No Type:_____Length of use:_____Side Effects:_____

Diaphragm ☐ Yes ☐ No Type:_____Length of use:_____Side Effects:_____

Foam/condom ☐ Yes ☐ No Type:_____Length of use:_____Side Effects:_____

Withdrawal ☐ Yes ☐ No Type:_____Length of use:_____Side Effects:_____

Other: ☐ Yes ☐ No Type:_____Length of use:_____Side Effects:_____

Other Reproductive organ problems / disease:_____

Frequency of intercourse per week:_____

Pain with intercourse: ☐ Yes ☐ No _____

Lack of sexual desire: ☐ Yes ☐ No _____

Lack of vaginal lubrication ☐ Yes ☐ No _____

Bleeding with intercourse ☐ Yes ☐ No _____

Pelvic infections ☐ Yes ☐ No _____

Cervical treatment with cautery or cryosurgery ☐ Yes ☐ No _____

REVIEW OF SYTEM: (**If you answer <u>YES</u> to any of the questions please explain):**

Frequent headaches ☐ Yes ☐ No _____

Seizures ☐ Yes ☐ No _____

Weight gain ☐ Yes ☐ No _____

Weight loss ☐ Yes ☐ No _____

Excessive sweating ☐ Yes ☐ No _____

Intolerance to cold ☐ Yes ☐ No _____

Excessive hair growth (Face/chest/abdomen) ☐ Yes ☐ No _____

Breast secretions ☐ Yes ☐ No _____

Acne ☐ Yes ☐ No _____

Oily skin ☐ Yes ☐ No _____

Heart disease ☐ Yes ☐ No _____

High Blood pressure ☐ Yes ☐ No _____

Pneumonia ☐ Yes ☐ No _____

Chronic cough ☐ Yes ☐ No _____

Gall bladder disease ☐ Yes ☐ No _____

Tuberculosis ☐ Yes ☐ No _____

Jaundice ☐ Yes ☐ No _____

Hepatitis ☐ Yes ☐ No _____

Anemia ☐ Yes ☐ No _____

Blood transfusion ☐ Yes ☐ No _____

Arthritis ☐ Yes ☐ No _____

Recurrent Kidney infections ☐ Yes ☐ No _____

Kidney disease ☐ Yes ☐ No _____

Persistent swelling of the ankles ☐ Yes ☐ No _____

FAMILY HISTORY:

Breast, colon or ovarian cancer in family? ☐ Yes ☐ No _____

Any females with infertility problems? ☐ Yes ☐ No _____

Any females with excessive hair growth? ☐ Yes ☐ No _____

Any males with infertility problems? ☐ Yes ☐ No _____

HUSBAND/PARTNER HISTORY:

Have you ever fathered any children before? ☐ Yes ☐ No _____

Male factor involved? ☐ Yes ☐ No _____

Frequent premature ejaculation? ☐ Yes ☐ No _____

Difficulty achieving or maintaining erection? ☐ Yes ☐ No _____

Genital injury? ☐ Yes ☐ No _____

Mumps as a child? ☐ Yes ☐ No _____

Chemotherapy? ☐ Yes ☐ No _____

Alcohol Intake? ☐ Yes ☐ No Amount per week? _____

Smoke cigarettes ☐ Yes ☐ No Amount per week? _____

High blood pressure ☐ Yes ☐ No _____

List all medication you have been one since the last six month and what are you taking it for:

_____

Have the following test been performed?

Semen analysis? ☐ Yes ☐ No Year:_____ Results:_____

Semen cultures? ☐ Yes ☐ No Year:_____ Results:_____

Sperm antibody testing? ☐ Yes ☐ No Year:_____ Results:_____

Sperm penetration assay? ☐ Yes ☐ No Year:_____ Results:_____

PREVIOUS INFERTILITY STUDIES/WORK-UP:

Basal body temperature ☐ Yes ☐ No Year:________Results:____

Post coital test? ☐ Yes ☐ No Year:________Results:____

Hysterosalpingogram? ☐ Yes ☐ No Year:________Results:____

Endometrial biopsy? ☐ Yes ☐ No Year:________Results:____

Hormone tests? ☐ Yes ☐ No Year:________ Results:____

Laparoscopy? ☐ Yes ☐ No Year:________Results:____

Chromosomal analysis? ☐ Yes ☐ No Year:________Results:____

Other studies ? (list below)____

____

INFERTILITY TREATMENTS:

[ ] Natural cycle

[ ] Clomid cycles With current spouse/partner [ ] Yes [ ] No [ ] Donor sperm

Cycle # 1 Mon/year ________ # pills______[ ] Intercourse [ ] IUI Outcome:______________________________

Cycle # 2 Mon/year ________ # pills______[ ] Intercourse [ ] IUI Outcome:______________________________

Cycle # 3 Mon/year ________ # pills______[ ] Intercourse [ ] IUI Outcome:______________________________

Cycle # 4 Mon/year ________ # pills______[ ] Intercourse [ ] IUI Outcome:______________________________

[ ] Injectible fertility With current spouse/partner [ ] Yes [ ] No [ ] Ex-partner [ ] Donor sperm

Cycle # 1 Mon/year ________Medication:_______________ [ ] IUI Outcome:____________________

Cycle # 2 Mon/year ________Medication:_______________ [ ] IUI Outcome:____________________

Cycle # 3 Mon/year ________Medication:_______________ [ ] IUI Outcome:____________________

Cycle # 4 Mon/year ________Medication:_______________ [ ] IUI Outcome:____________________

[ ] ART cycle With current spouse/partner [ ] Yes [ ] No [ ] Ex-partner [ ] Donor sperm

Attempt # 1 Mon/year___________[ ] IVF [ ] ICSI [ ] own eggs [ ] Donor eggs [ ] Fresh transfer [ ] Frozen cycle outcome:_______

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Comments:____

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