Seattle Reproductive Medicine®
AN INTEGRAMED® AFFILIATE

MEDICAL AND REPRODUCTIVE HISTORY—INFERTILITY

Today's date: _____/_____/_____ Date of appointment: _____/_____/_____

FEMALE PATIENT:

Last name: ____________________ First name: ________________ Middle Initial: ____

Age: ________ Date of Birth: ____/____/____ Soc. Security #: _______-_______-_________

Marital Status: ____single ____married ____divorced ____widowed Length of Relationship: _____ years

PARTNER:

Last name: ____________________ First name: ________________ Middle Initial: ____

Age: ________ Date of Birth: ____/____/____ Soc. Security #: _______-_______-_________

Day phone: ( ) _______- _________ (of partner)

MAILING ADDRESS:

Street: ______________________________City: ____________________

State/Province: ___________ Zip/ Postal code: ____________ Country: ____________

		OK to leave message?		Best # to reach you:
Home Phone Number:	( ) _______- _________	☐ Yes	☐ No	☐
Work Phone Number:	( ) _______- _________	☐ Yes	☐ No	☐
Cell Phone Number:	( ) _______- _________	☐ Yes	☐ No	☐

Email Address: ______________________

REFERRING PHYSICIAN or HEALTH CARE PROVIDER:

Last name: ____________________ First name: ______________________

Address: ____

Phone: ( ) ________- __________ FAX: ( ) ________- __________

Do you wish for SRM to send copies of your medical notes to your referring provider?_____ Yes _____ No

Why are you coming to see us? ______________________________________

REPRODUCTIVE HEALTH HISTORY—FEMALE PATIENT

MENSTRUAL HISTORY:

Age when you had your first menstrual period: ________ years old

The first day of your last menstrual period: _____ / ______ / _______

Menstrual cycle pattern (check all that apply):

☐ Regular periods ☐ Irregular periods ☐ No periods

☐ Spotting between periods ☐ Heavy periods ☐ Light periods

How many days of bleeding do you usually have? _____days

How many days from the first day of one period to the first day of the next? ______days

Do you need medication to bring on a period? ______ If yes, what type? ___________________________

Do you have cramping or pelvic pain with your periods? (check one)

☐ Always ☐ Sometimes ☐ Recently ☐ In the past ☐ No

Degree of pain (1 to 10, with 10 being most severe): _____

Over the past few years, is the pain: ☐ getting better ☐ getting worse ☐ staying the same

If you do not have periods, at what age did you stop having them? _____ years old

PREGNANCY HISTORY: List all pregnancies, specifying under outcome whether liveborn, stillborn, ectopic, miscarriage or abortion.

Pregnancy #	Preg. Ended (mo./yr.)	Preg. Length (weeks, months)	Outcome	FATHER (check one)	
				Present partner	Previous partner

When was your last Pap smear? _____ / _____ / _____ Was it normal? ☐ Yes ☐ No

Have you ever had an abnormal Pap smear? _____Yes _____No If "Yes," date and treatment:____________________

Did your mother take DES while pregnant with you? _____Yes _____No _____Don't know

Have you ever had a mammogram? _____Yes _____No If yes, when was the last one? _____/_____/______

REPRODUCTIVE HEALTH HISTORY—FEMALE PATIENT (continued)

CONTRACEPTIVE METHOD HISTORY:

Type	Years Used
☐ Birth Control Pill / Patch	
☐ Depo-Provera, Lunelle	
☐ Norplant	
☐ Diaphragm	
☐ IUD	
☐ Condoms	
☐ Tubal Sterilization	
☐ Vasectomy	
☐ Rhythm (natural method)	
☐ Other	

SEXUAL HISTORY:

How often do you have intercourse (number of times per week)?

Usually ______________ Mid-cycle ______________

Any pain with intercourse? ______________

Do you use a lubricant with intercourse? ______________

Have you ever had any sexually transmitted diseases? (please check all that apply)

☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ Other
☐ Syphilis ☐ Genital Warts ☐ Trichomonas ______________
☐ HIV ☐ HPV ☐ Hepatitis

Have you ever had pelvic inflammatory disease? _____Yes _____No

If yes, when? ______________ Were you hospitalized? ______________

FERTILITY HISTORY

Please complete this section if you are being seen for fertility:

a. How long have you been trying to conceive? ______________

b. Time since contraception last used? ______________

c. If you previously have been pregnant, how long has it been since the most recent pregnancy? __________

d. Have you experienced any difficulty conceiving for a year or more with any man other than your current partner? _____Yes _____No

FERTILITY HISTORY (continued)

PREVIOUS FERTILITY EVALUATION:

Have you had any of the following tests performed?

Fertility Test:	Yes	No	Date	Result normal? Yes	No	If no, describe:
Day 3 FSH level	☐	☐	____/____/____	☐	☐	____________
Post Coital Test	☐	☐	____/____/____	☐	☐	____________
Progesterone level(s)	☐	☐	____/____/____	☐	☐	____________
Hysterosalpingogram (HSG)	☐	☐	____/____/____	☐	☐	____________
Sonohysterogram (SHG)	☐	☐	____/____/____	☐	☐	____________
Hysteroscopy	☐	☐	____/____/____	☐	☐	____________
Thyroid blood test	☐	☐	____/____/____	☐	☐	____________
Prolactin blood test	☐	☐	____/____/____	☐	☐	____________
Fasting blood glucose	☐	☐	____/____/____	☐	☐	____________
Endometrial biopsy	☐	☐	____/____/____	☐	☐	____________
Testosterone level	☐	☐	____/____/____	☐	☐	____________

PRIOR TREATMENTS: **(check all that apply)**

Treatment	**# of cycles**	**Dates: (mo./year) to (mo./year)**	**Outcome (baby, miscarriage, etc.)**
Intrauterine insemination:	____	from: ____/____ to: ____/____	
Clomiphene citrate with timed intercourse: maximum # tablets per day?	____	from: ____/____ to: ____/____	
Clomiphene citrate with insemination: maximum # tablets per day?	____	from: ____/____ to: ____/____	
Gonadotropins (injections) with insemination?	____	from: ____/____ to: ____/____	
Complete in vitro fertilization (IVF) cycle(s): 1. # eggs ____ # fertilized ____ # transferred ____ # frozen ____ 2. # eggs ____ # fertilized ____ # transferred ____ # frozen ____ 3. # eggs ____ # fertilized ____ # transferred ____ # frozen ____	____	____/____ ____/____ ____/____	

FERTILITY HISTORY (continued)

Treatment	# of cycles	Dates: (mo./year) to (mo./year)	Outcome (baby, miscarriage, etc.)
Frozen embryo transfers: 1. #embryos transferred _____ 2. #embryos transferred _____ 3. #embryos transferred _____	____	____/____ ____/____ ____/____	
Canceled in vitro fertilization attempt(s)	____	from: ____/____ to: ____/____	

GENERAL MEDICAL HISTORY

What is your current weight? ______ Height? ______ Usual weight? _______

Recent weight loss or gain? ________________________________

Approximately how much did you weigh at age 18?_____ 25?_____ 30?_____ 35?_____ 40?_____

Check any of the following that have been a problem for you during the past 6 months:

Eye problems ☐	Anxiety ☐	Nausea, vomiting ☐
Stuffy nose, hay fever ☐	Shaking, tremor ☐	Constipation, diarrhea ☐
Frequent nosebleeds ☐	Dizziness, fainting ☐	Hemorrhoids ☐
Anemia ☐	Fevers, sweats, chills ☐	Hernia ☐
Easy bleeding or bruising ☐	Depression ☐	Gall bladder problems ☐
Headaches ☐	Poor circulation ☐	Frequent urination at night ☐
Enlarged or painful breasts ☐	Fatigue ☐	Vaginal discharge, itching or pain ☐
Discharge from nipples ☐	Low energy ☐	Pelvic Pain ☐
Breast lumps ☐	Heart burn, indigestion ☐	Sexual problems ☐
Shortness of breath ☐	Gas, cramps, pains ☐	Excessive thirst ☐
Fast or irregular heartbeat ☐	Blood in stool or black stool ☐	Temperature intolerance ☐
Hot flashes ☐	Dark skin on neck, armpits ☐	Hair thinning or loss ☐
Excessive face or body hair ☐	Acne or pimples ☐	

Please describe any checked boxes: ________________________________

____

GENERAL MEDICAL HISTORY (Continued)

ALLERGIES:

Latex? ______ Yes ______ No If yes, specify reaction: ____________________

Iodine or seafood? ______ Yes ______ No If yes, specify reaction: ____________________

Medications? ______ Yes ______ No Which meds, specify reaction: ____________________

____

Please indicate which of the following applies to you now or in the past:

Breast disease	☐	Liver disease	☐	Psychiatric illness	☐
High blood pressure	☐	Hepatitis	☐	Endometriosis	☐
Heart disease	☐	Hernia	☐	Ovarian Tumor	☐
Heart murmur	☐	Bladder/kidney disease	☐	Cancer	☐
Mitral valve prolapse	☐	Thyroid problems	☐	Herpes (oral)	☐
Lung disease	☐	Elevated prolactin	☐	Tuberculosis	☐
Asthma	☐	Adrenal Hyperplasia	☐	Rubella (German Measles)	☐
Blood clots	☐	Diabetes	☐	Birth defects	☐
Blood transfusions	☐	Neurologic disease	☐	Past history of IV drug use	☐
Bleeding disorder	☐	Seizures	☐	Bulimia or anorexia	☐

Other disorder: ____

Please explain any positive responses:

____

____

____

SURGICAL HISTORY:

Please list any major surgeries or hospitalizations in the table below. Include abortions, ectopic pregnancy, tubal surgery or any other surgeries:

	Mo. / Year	Procedure	Reason
1			
2			
3			
4			

GENERAL MEDICAL HISTORY (Continued)

MEDICATIONS:

Please list all medications or treatments you are currently taking: (please include any over-the counter or herbal drug.

Medication	Dosage	Frequency	Reason

FAMILY HEALTH HISTORY

Are there any known genetic diseases or conditions that run in your family? _____Yes _____No

If yes, which one(s) and whom?______________________________

Have any of your blood relatives (siblings, children, aunts, uncles, etc.) had birth defects, [e.g, heart, mental retardation, neural tube defect (e.g., spina bifida)], or other? _____Yes _____No

Are you adopted? _____Yes _____No

Ethnic Background: ______________________________

Are any of your blood relatives of the following ethnic groups? **There is increased risk for:**

Caucasian	____ Yes	____ No	Cystic Fibrosis
English, Irish	____ Yes	____ No	Neural Tube Defects
Mediterranean (Greek, Italian)	____ Yes	____ No	Thalassemia
Ashkenazi Jewish	____ Yes	____ No	Tay Sachs, Canavan
French Canadian	____ Yes	____ No	Tay Sachs
Southeast Asian	____ Yes	____ No	Thalassemia
African descent	____ Yes	____ No	Sickle Cell Anemia, Thalassemia

FAMILY HEALTH HISTORY (Continued)

Please indicate whether any of your blood relatives have had any of the following conditions:

MEDICAL PROBLEM	PARENTS		SIBLINGS		MATERNAL		PATERNAL		YOUR	OTHER
	Mother	Father	Sisters	Brothers	GF	GM	GF	GM	Children	Relatives
Diabetes										
Cancer (specify)										
Heart Disease										
High Blood Pressure										
High Cholesterol										
Stroke										
Cystic Fibrosis (CF)										
Clotting or bleeding disorder										
Sickle cell anemia										
Thalassemia										
Other serious health issue										

Please explain any positive answers: ______________________

____

SOCIAL HISTORY

Current Occupation: ______________________

Prior Occupation(s): ______________________

Have you or do you use any of the following?

	Never	Not in the last 3 months	Yes	List amount, type and frequency (how often-per day / per week)
Tobacco	☐	☐	☐	
Alcohol	☐	☐	☐	
Social drugs	☐	☐	☐	
Exercise	☐	☐	☐	

EMOTIONAL STATUS:

On a scale of 1 to 10, (10 being the highest) what do you estimate your average level of stress to be? ________

Were there times during the past month when you experienced little interest in doing things? ____ Yes ____ No

In the past month, have there been times when you felt down, depressed, or hopeless? ____ Yes ____ No

Do you have any theories as to why you have been unable to conceive? ______________________

REPRODUCTIVE HEALTH HISTORY—MALE PARTNER

List all pregnancies you have fathered, specifying under outcome whether liveborn, stillborn, ectopic, miscarriage or abortion.

Pregnancy #	Preg. Ended (mo./yr.)	Preg. Length (weeks, months)	Outcome	MOTHER (check one)	
				Present partner	Previous partner

Have you previously conceived with another woman? _____ Yes _____ No

Have you ever been unable to conceive with anyone other than your current partner? _____ Yes _____ No

Have you ever had a serious exposure to radiation or toxins (e.g. pesticides, toxic chemicals, poisons, herbicides, plastics, organic chemicals, lead, cadmium, industrial by-products, etc.)? _____ Yes _____ No

Have you ever consulted a urologist or male infertility specialist? _____ Yes _____ No

If yes: Year: _______ Reason: ____________________

Findings / Recommendations: ____________________

PREVIOUS FERTILITY EVALUATION:
Have you had any of the following tests performed?

Fertility Test:	Yes	No	Date	Result normal? Yes	Result normal? No	If no, describe:
Semen Analysis	☐	☐	___/___/___	☐	☐	____________
Hamster Sperm Penetration Assay	☐	☐	___/___/___	☐	☐	____________
Antibody Testing	☐	☐	___/___/___	☐	☐	____________
Hormone Blood tests	☐	☐	___/___/___	☐	☐	____________

GENERAL MEDICAL HISTORY—MALE PARTNER

What is your current weight? ______ Height? ______ Usual weight? _______

Recent weight loss or gain? ____________________

GENERAL MEDICAL HISTORY—MALE PARTNER (Continued)

Place a check by any of the following that have been a problem for you during the last 6 months.

Eye problems	☐	Dizziness, fainting	☐	Constipation, diarrhea	☐
Stuffy nose, sinus trouble, hayfever	☐	Fevers, sweats, chills	☐	Hemorrhoids	☐
Frequent nosebleeds	☐	Depression	☐	Hernia	☐
Anemia	☐	Poor circulation	☐	Gall bladder problems	☐
Bleeding or bruising from minor injury	☐	Fatigue	☐	Frequent urination at night	☐
Headaches	☐	Low energy	☐	Sexual problems	☐
Shortness of breath	☐	Heart burn, indigestion	☐	Excessive thirst	☐
Fast or irregular heartbeat	☐	Gas, cramps, pains	☐	Temperature intolerance	☐
Anxiety	☐	Blood in stool or black stool	☐	Acne or pimples	☐
Shaking, tremor	☐	Nausea, vomiting	☐	Pains in joints, arthritis	☐

Please describe any positive answers:______________________________

____

Please indicate which of the following applies to you now or in the past:

High blood pressure	☐	Liver disease	☐	Seizures	☐
Lung disease	☐	Bladder/kidney disease	☐	Herpes (oral or genital)	☐
Heart disease	☐	Hepatitis	☐	Psychiatric illness	☐
Heart murmur	☐	Hernia	☐	Cancer	☐
Asthma	☐	Thyroid problems	☐	Tuberculosis	☐
Blood clots	☐	Elevated prolactin	☐	Birth defects	☐
Blood transfusions	☐	Congenital Adrenal Hyperplasia	☐	Neurological disease	☐
Bleeding disorder	☐	Diabetes	☐	Past history of IV drug use	☐
Genital or groin injuries	☐	Other	☐		

Please give detail and dates: ______________________________

____

GENERAL MEDICAL HISTORY—MALE PARTNER (Continued)

Please list any major surgeries or hospitalizations in the table below. Include vasectomy, vasectomy reversal, varicocele repair, or any other surgeries:

	Mo. / Year	Procedure	Reason
1			
2			
3			
4			

Please list all medications or treatments you are currently taking: (please include any over-the counter or herbal drugs)

Medication	Dosage	Frequency	Reason

ALLERGIES:

Latex? _____ Yes _____ No If yes, specify reaction: ____________________

Iodine or seafood? _____ Yes _____ No If yes, specify reaction: ____________________

Medications? _____ Yes _____ No Which meds, specify reaction:____________________

____

FAMILY HEALTH HISTORY—MALE PARTNER

Are there any known genetic diseases or conditions that run in your family? _____Yes _____No

If yes, which one(s) and whom?____________________

Have any of your blood relatives (siblings, children, aunts, uncles, etc.) had birth defects, [e.g, heart, mental retardation, neural tube defect (e.g., spina bifida)], or other? _____Yes _____No

Are you adopted? _____Yes _____No

Ethnic Background: ____________________

FAMILY HEALTH HISTORY—MALE PARTNER (Continued)

Are any of your blood relatives of the following ethnic groups?			Risk increased for:
Caucasian	____ Yes	____ No	Cystic Fibrosis
English, Irish	____ Yes	____ No	Neural Tube Defects
Mediterranean (Greek, Italian)	____ Yes	____ No	Thalassemia
Ashkenazi Jewish	____ Yes	____ No	Tay Sachs, Canavan
French Canadian	____ Yes	____ No	Tay Sachs
Southeast Asian	____ Yes	____ No	Thalassemia
African descent	____ Yes	____ No	Sickle Cell Anemia, Thalassemia

Please indicate whether any of your blood relatives have had any of the following conditions:

MEDICAL PROBLEM	PARENTS		SIBLINGS		GRANDPARENTS				YOUR	OTHER
					MATERNAL		PATERNAL			
	Mother	Father	Sisters	Brothers	GF	GM	GF	GM	Children	Relatives
Diabetes										
Cancer (specify)										
Heart Disease										
High Blood Pressure										
High Cholesterol										
Stroke										
Cystic Fibrosis (CF)										
Clotting or bleeding disorder										
Sickle Cell Anemia										
Thalassemia										

Please explain any positive answers: ____

____

____

SOCIAL HISTORY—MALE PARTNER

Current Occupation: ____

Prior Occupation(s): ____

SOCIAL HISTORY—MALE PARTNER (Continued)

Have you or do you use any of the following?

	Never	Not in the last 3 months	Yes	List amount, type and frequency (how often-per day / per week)
Tobacco	☐	☐	☐	
Alcohol	☐	☐	☐	
Social drugs	☐	☐	☐	
Exercise	☐	☐	☐	

EMOTIONAL STATUS:

On a scale of 1 to 10, (10 being the highest) what do you estimate your average level of stress to be? ______

Were there times during the past month when you experienced little interest in doing things? ____ Yes ____ No

In the past month, have there been times when you felt down, depressed, or hopeless? ____ Yes ____ No

Do you have any theories as to why you and your partner have been unable to conceive? ____ Yes ____ No

Please comment: ____

____

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Regional Access Network ART Screening Summary
(Standard Infectious Disease Testing)

Patient Name: ____________________ **Birth date:** ________ **Age:** _____
Partner's Name: ____________________ **Birth date:** ________ **Age:** _____

Past Medical and Gynecologic History:

G___ P___ Ect___ SAB___ TAB___ Living___ # Years Infertile___
Primary Infertility Diagnosis(s): ____________________

Previous Treatment: ☐ None CC#___ IUI#___ TDI#___ COH#___ IVF#___
Menses: ☐ Regular every ___ days
☐ Oligomenorrhea ☐Amenorrhea ☐ Menopausal
Allergies: ____________ Meds: ____________________

Other Medical Problems/Concerns: ____________________

PRE-ART Evaluation (within the past 1 year)

Physical Exam: Date: __________ Ht: ______ Wt: ______ BP: ______
☐ Normal ☐ Abnormal Findings: ____________________

* Please attach HX/PE

Uterine Evaluation:

HSG: Date: __________ ☐ Normal ☐ Abnormal (see attached report)
SHG: Date: __________ ☐ Normal ☐ Abnormal (see attached report)
Hysteroscopy: Date: __________ ☐ Normal ☐ Abnormal (see attached report)

Surgical Procedure (e.g., polypectomy, salpingectomy, myomectomy) ☐see attached report

Ovarian Reserve Testing (with 6 months if ≥38 or prior abnormal):

Day 3 FSH/E2: Date: ________ FSH______mIU/ml E2______pg/ml
Date: ________ FSH______mIU/ml E2______pg/ml

Antral Follicle Count: Date: ________ Total No. Antral Follicles 2-10mm: _____

Please do not send until completed. Screen will not be reviewed until all information is present.

Revised 9/10/08

Patient Name:___________________________

Preconception Screening Tests (within 1 year):

	Date (mm/dd/yy)	Result		Notes
RPR		☐ Pos	☐Neg	
Hepatitis B Surface Antigen		☐ Pos	☐Neg	
Hepatitis C Antibody		☐ Pos	☐Neg	
HIV 1		☐ Pos	☐Neg	

Blood Type/Rh				Any year
TSH				Within 1 year
Rubella		☐ Pos	☐Neg	Within 3 years
Hematocrit				Within 1 year
Varicella		☐ Pos	☐+Hx	**Clinical hx or positive titer within past 3 yrs**
Pap smear		☐ Pos	☐Neg	Within 1 year or if risk factors
Mammogram		☐ Pos	☐Neg	(if over 40 or risk factors)

Attach other pertinent test result (i.e., karyotype, thyroid testing, HgbA1C, etc)
Comments ____

Male Partner Info:

Semen Analysis (most recent within 1 year or 6 months for patients with concentration <10 mil/ml):
Date: _________ Conc_______$x10^6$/ml Motility______% Morph______% (strict/WHO)
☐ see attached report

Preconception Screening Tests (within 1 year):

	Date	Result		Notes
RPR		☐ Pos	☐Neg	
Hepatitis B Surface Antigen		☐ Pos	☐Neg	
Hepatitis C Antibody		☐ Pos	☐Neg	
HIV 1		☐ Pos	☐Neg	

Patient Name:________________________

Medications will be ordered for your patient thru IVP Care unless you specify otherwise.
Order meds: ☐ SRM (IVP Care) ☐ Regional Office

Referring Provider: ____

Optional Screening for Patients Considering Future Embryo Donation (please check one):

☐ Collect additional laboratory requirements at SRM
☐ Do not collect additional laboratory requirements at SRM

Protocol: ☐ Luteal Lupron ☐ Microdose Lupron ☐ Antagonist

Dose: FSH_______IU/daily hMG_______IU/daily

Sperm: ☐ Partner Fresh ☐ Partner Frozen ☐ ICSI
☐ Urology back-up ☐ Urology Collection ☐ Urology Back-up
☐ Donor Back-up ☐ Donor Sperm

Other requirements/recommendations:

Reviewing MD____________________________ Date______________

☐ Criniti ☐ Davis ☐ Dudley ☐ Klein ☐ Lin ☐ Soules ☐ Thyer