

# New patient history

## CONNECTICUT FERTILITY ASSOCIATES

Welcome to Connecticut Fertility Associates. Please take a moment to complete and return the following confidential information prior to your initial visit with us.

### 1. IDENTIFYING INFORMATION

Date:

Your Name:

Date of Birth:

Partner's Name:

Date of Birth:

How long have you been trying to conceive?

### 2. HISTORY OF PRIOR FERTILITY TESTING & THERAPY

Have you been tested for infertility before?

Yes  No

If yes, with whom, where and when?

What cause of infertility was diagnosed?

Which of the following TESTS have you had performed? Check all that apply and the results (if known):

	When:	Results:
<input type="checkbox"/> Genetic testing	_____	_____
<input type="checkbox"/> Ultrasound	_____	_____
<input type="checkbox"/> Hormonal Assays (FSH, LH, Prolactin, Estrogen, DHEAS, Testosterone, Progesterone)	_____	_____
<input type="checkbox"/> Hysteroscopy	_____	_____
<input type="checkbox"/> Hysterosalpingogram	_____	_____
<input type="checkbox"/> Sonohysterogram	_____	_____
<input type="checkbox"/> Endometrial Biopsy	_____	_____
<input type="checkbox"/> Laparoscopy	_____	_____
<input type="checkbox"/> Mycoplasma/Chlamydia cultures	_____	_____
<input type="checkbox"/> Thyroid tests	_____	_____
<input type="checkbox"/> Other, please specify:	_____	_____

Have you ever taken MEDICATIONS to enhance your fertility? Check all that apply and the results (if known):

Medication	Number of cycles:	When:	Where:	Results:
<input type="checkbox"/> Clomiphene citrate (Clomid)	_____	_____	_____	_____
<input type="checkbox"/> Injections - (Pergonal, Repronex)	_____	_____	_____	_____
<input type="checkbox"/> Injections - (Gonal F, Follistim, Bravelle)	_____	_____	_____	_____
<input type="checkbox"/> HCG	_____	_____	_____	_____
<input type="checkbox"/> Antibiotics	_____	_____	_____	_____
<input type="checkbox"/> Lupron	_____	_____	_____	_____
<input type="checkbox"/> Progesterone	_____	_____	_____	_____
<input type="checkbox"/> Bromocriptine (Parlodel)	_____	_____	_____	_____
<input type="checkbox"/> Other :	_____	_____	_____	_____
<input type="checkbox"/> None	_____	_____	_____	_____

Have you ever undergone Intrauterine Insemination (IUI)?  Yes  No  
*Number of cycles* *When* *Where* *Result*

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Have you undergone In Vitro Fertilization (IVF)?  Yes  No  
*Number of cycles* *When* *Where* *Result*

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Have you ever had fertility SURGERY for: (if so, when and where?)

	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>When</i>	<i>Where</i>
Myomectomy	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Endometriosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Lysis of Adhesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Ovarian Cysts	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Cervical Conization or Cautery	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Appendectomy	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
D and C	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Other		_____	_____

Is your partner seeing a doctor for evaluation of his fertility?  Yes  No  
*If yes, Physician Name:* *When:*

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What is the diagnosis; and how has he been treated?

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Has your partner ever achieved a pregnancy in the past with you or someone else?  Yes  No  
*If yes, when?*

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### 3. MENSTRUAL & PREGNANCY HISTORY

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#### *Menstrual History*

Age at first period? *When was your last period?*

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Are your periods regular?  Yes  No  
*If yes, what is the usual number of days between periods?*

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*If no, how many times per year do you menstruate?*

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What is the usual duration of your period?

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Are cramps present before, during, or after your period?  
*Are your cramps:*  mild  moderate  severe?

Do you have to take pain medication for cramps?  Yes  No  
*If yes, specify medication:*

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Do you bleed or spot between your periods?  Yes  No

# Pregnancy History

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How many times have you been pregnant?

1ST pregnancy:

When?  
End in abortion?  
End in miscarriage?  
Ectopic pregnancy?  
Infertility therapy required?  
How long to conceive?  
Baby born alive?  
Is current partner the father?

2nd pregnancy:

When?  
End in abortion?  
End in miscarriage?  
Ectopic pregnancy?  
Infertility therapy required?  
How long to conceive?  
Baby born alive?  
Is current partner the father?

3rd pregnancy:

When?  
End in abortion?  
End in miscarriage?  
Ectopic pregnancy?  
Infertility therapy required?  
How long to conceive?  
Baby born alive?  
Is current partner the father?

4th pregnancy:

When?  
End in abortion?  
End in miscarriage?  
Ectopic pregnancy?  
Infertility therapy required?  
How long to conceive?  
Baby born alive?  
Is current partner the father?

Other pregnancies:

When?  
End in abortion?  
End in miscarriage?  
Ectopic pregnancy?  
Infertility therapy required?  
How long to conceive?  
Baby born alive?  
Is current partner the father?

Were there any complications during or after your pregnancies?

Yes  No

If yes, explain:

Did your mother have any difficulty with conception or pregnancy?

Yes  No

If yes, explain:

Did your mother take diethylstilbestrol (DES) when she was pregnant with you?

Yes  No

## 4. CONTRACEPTIVE & SEXUAL HISTORY

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What form of contraception do you use or have you used in the past?

How many times per week do you and your partner have sexual intercourse?

How many times do you have intercourse around ovulation?

Is intercourse painful or difficult for you?  Yes  No

Do you use lubricants?  Yes  No

## 5. MEDICAL HISTORY

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Weight:

Height:

Blood type (if known):

Have you lost greater than 20 pounds of weight in the last year?

Yes  No

Do you follow a particular food diet or have any special dietary habits?

Yes  No

List the forms and frequency of regular vigorous exercise?

Do you have or have you ever had (check all that apply):

- Anemia
- Appendicitis
- Arthritis
- Blood Transfusions
- Breast Milky Discharge
- Breast Soreness
- Breast Tenderness
- Cancer? Specify:
- Chlamydia
- Chronic Bronchitis
- Chronic Headaches
- Colitis
- Color Blind
- Diabetes
- Dizziness
- Endometriosis

- Epilepsy
- Gallbladder Problems
- Gonorrhea
- Heart Disease
- Hepatitis
- Herpes
- Hirsutism (excess hair growth)
- High Blood Pressure
- Immunization(German measles)
- Kidney Infection
- Liver Problems
- Loss of balance
- Measles: German
- Measles: Regular
- Neurological Problems
- Nongonococcal Urethritis

- Ovarian Cysts
- Parasitic Infection
- Pelvic Infection
- Pneumonia
- Poor Sense of Smell
- Rheumatic Fever
- Scarlet Fever
- Seizures
- Syphilis
- Thyroid Problems
- Tuberculosis
- Ulcers
- Vaginitis (Trichomoniasis, yeast)  
# of episodes \_\_\_\_\_
- Visual Disturbances

Allergies?

please list:

Within the last year have you taken any prescription or over-the-counter medications?

please list:

Do you use or have you ever used (check all that apply):

- Alcohol
- Cigarettes
- Illicit or Recreational Drugs

How many glasses per week do you usually drink? \_\_\_\_\_

Number of packs per day \_\_\_\_\_

(Marijuana, Cocaine, etc.) \_\_\_\_\_

