N o v a I n V i t r o

F e r t i l i z a t i o n

**Fertility Preservation Intake Form**

Name: ____________________ DOB: _____________________

Date:______________________

Who referred you to our practice?

- ☐ Former Patient
- ☐ Friend
- ☐ SART Data
- ☐ Self-referral
- ☐ Yelp
- ☐ Physician - please list name:
- ☐ Internet Search- please specify what search terms:

Reason for consultation: _______________________________________________________________

What are your goals or expectations for your consultation? ____________________________________

_________________________________________________________________________________

**Demographic Information:**

Occupation: _________________________________________

Current weight _______ pounds Height____ feet _______ inches

Ethnicity:

- ☐ White
- ☐ Hispanic or Latino
- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific
- ☐ Asian
- ☐ Other:__________________
- ☐ Decline to answer

**Medical History:**

How old were you when your periods first started? _______ years

Did you develop regular monthly periods at that time? ☐ Yes ☐ No

Do you have monthly menstrual periods now? ☐ Yes ☐ No

If yes, what is the usual number of days *between* the start of one period to the start of the next period? _______ days

Dates of the 1st day of your last 2 menstrual periods: ___/___/___ ___/___/___

How many menstrual periods do you have per year? _________

Do you have severe cramping or pelvic pain with your menstrual periods? ☐ Yes ☐ No

Do you have pain with intercourse? ☐ Yes ☐ No

Have you been diagnosed with endometriosis? ☐ Yes ☐ No

Have you ever had a pelvic infection? ☐ Yes ☐ No

Have you ever had any of the following sexually transmitted diseases or pelvic infections?

☐ Chlamydia ☐ Gonorrhea ☐ Genital Warts/HPV
☐ Syphilis ☐ Herpes

When was your last pap smear (month/year)? ____ / ____ ☐ Normal ☐ Abnormal

When was your last abnormal pap smear? ____ / ____ ☐ Not applicable

Do you perform self breast exams? ☐ Yes ☐ No

Have you ever had a mammogram? ☐ Yes ☐ No

When was your last mammogram? _______ month ______ year ☐ Normal ☐ Abnormal

**Pregnancy History:**

| Pregnancy | 1st | 2nd | 3rd | 4th |
|---|---|---|---|---|
| Mo/Yr of conception | | | | |
| How long did it take to conceive? | | | | |
| Infertility treatment? (Y/N) | | | | |
| Did your current partner sire the pregnancy? | | | | |
| Outcome (vaginal delivery, cesarean, ectopic, miscarriage, termination | | | | |
| Live birth > 37 weeks? (Y/N) | | | | |
| Other pregnancy complications? | | | | |

**Prior Fertility Treatment:**

Have you been treated for infertility before?_______________________________________________

If yes, where did you receive care and who was your physician?_______________________________

What cause of infertility was diagnosed?__________________________________________________

*(If applicable):*

Number of prior Fresh IVF Cycles ___________

Number of prior Frozen IVF Cycles __________

Please complete the following table as accurately as possible, especially the "Physician/Clinic" column.

| Test | Date(s) | Physician/Clinic | Results/Findings |
|---|---|---|---|
| Thyroid Test (TSH) | | | |
| Day 3 blood test for FSH/Estrogen | | | |
| AMH | | | |
| Prolactin level | | | |
| Hysterosalpingogram (X-Ray of Tubes/HSG) | | | |
| Sonohysterography (water ultrasound) | | | |
| Hysteroscopy | | | |
| Genetic Testing | | | |

**Surgical History:**

Please list any surgeries you have had in chronological order:

| Year | Reason and Type of Surgery |
|---|---|
| | |
| | |
| | |
| | |

**Medications/Supplements:**

Are you allergic to any medications? ☐ No ☐ Yes:_______________________________________

Are you currently taking any medications or supplements? If yes please list below:

| Medication/Supplement | Start Date | Dose |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Social History:**

Are you currently in a relationship? ☐ Yes ☐ No

If yes, duration of relationship: _______ years and ____ months

Are you currently using a method to keep you from getting pregnant? ☐ Yes ☐ No

If yes, what method(s):_________________________________________

How many caffeinated beverages (coffee, soda, tea) do you drink per day? _____________

On average how much water are you consuming daily? _____________

Do you exercise regularly? ☐ Yes ☐ No
If yes, describe:______________________________________________________________

Any history of significant weight loss/gain in last 12 months? ☐ Yes ☐ No

Any history of eating disorders? ☐ Yes ☐ No

Do you smoke cigarettes or have you ever used tobacco products? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

Have you ever used illicit drugs? ☐ Yes ☐ No

Are you allergic to any foods? ☐ Yes ☐ No
If yes, describe:______________________________________________________________

Have you had significant weight change in the last year? ☐ Yes ☐ No

**Family History:**

Have any of these illnesses occurred in your family:

☐ High blood pressure ☐ Breast cancer ☐ Infertility
☐ Diabetes ☐ Ovarian cancer

**Immunization History:**

Chickenpox (Varicella): ☐ No ☐ Yes (dates: ) ☐ Don't Know

MMR- Measles, Mumps, Rubella (German Measles): ☐ No ☐ Yes (dates: ) ☐ Don't Know

Tetanus (Tdap): ☐ No ☐ Yes (dates: ) ☐ Don't Know

Hepatitis B: ☐ No ☐ Yes (dates: ) ☐ Don't Know

Polio: ☐ No ☐ Yes (dates: ) ☐ Don't Know

Influenza: ☐ No ☐ Yes (dates: ) ☐ Don't Know

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