Please complete as much of this form as possible before your appointment. It will help us maximize your time with Dr. Lane. Thank you.

LANE fertility institute

Medical Information Form

	First Name	Last Name	Date of Birth	Age
PATIENT				
PARTNER				

Referring Doctor: _____

Please describe your fertility issues: **Duration of Infertility:**_____

Menstrual/Contraceptive History:

Age of 1st Period _____ Last Period _____

Length of cycle _____ Days Cramps? YES / NO _____ Days prior to period Spotting? YES / NO _____ Days prior to period Period Pain? YES / NO

Vaginal Dryness? YES / NO Hot Flashes? YES / NO Other _____

Birth Control Pills? Yes / No Duration _____ Date Stopped _____ IUD? Yes / No Other _____

Last PAP _____ Abnormal ? ☐ Yes ☐ No Treatment:_____ Last Mammogram _____

Lab or Radiology Results:

Have you had any fertility related lab tests? YES / NO

Please list labs

Hysterosalpingogram (Dye test) : ☐ Yes ☐ No Date _____

If you have copies of any lab or surgical reports, please request a copy from your doctor and forward them to us before your appointment. Thank you.

General Medical History:

Drug Allergies?

Problems:

Current Medications:

Weight: **Height:** **Tobacco? YES / NO** **Alcohol? Units/wk**

Caffeinated drinks per day? **Exercise:**

Patient Surgical History:

Year	Surgery Type	Physician Name	Findings

Partner Surgical History:

Year	Surgery Type	Physician Name	Findings

Family History:

Patient Family History of:				Patient or Partner Family History of:			
Ovarian Cancer	YES ☐	NO ☐		Birth Defect/Genetic	NO ☐	PATIENT ☐	PARTNER ☐
Breast Cancer	YES ☐	NO ☐		Cystic Fibrosis	NO ☐	PATIENT ☐	PARTNER ☐
Colon Cancer	YES ☐	NO ☐		Sickle Cell	NO ☐	PATIENT ☐	PARTNER ☐
Thyroid Disease	YES ☐	NO ☐		Hemophilia	NO ☐	PATIENT ☐	PARTNER ☐
Autoimmune Disease	YES ☐	NO ☐		Down Syndrome	NO ☐	PATIENT ☐	PARTNER ☐
Blood Disorder	YES ☐	NO ☐		Tay Sachs	NO ☐	PATIENT ☐	PARTNER ☐
Diabetes	YES ☐	NO ☐		Thalassemia	NO ☐	PATIENT ☐	PARTNER ☐

Mother's Fertility History:

Age at last child? Age of Menopause: Sister's Fertility:

Please give any other relevant details regarding the fertility history in your family:

Male History

Male Partner? ☐ Yes ☐ No Initiation of past pregnancy? ☐ Yes ☐ No ☐ Unsure

Semen Analysis? ☐ Yes ☐ No When? _____ Surgical History? ☐ Yes ☐ No

What was the result? _____ (*Please bring a copy of the report with you)*

Other Surgical Issues:

Varicocoelectomy: ☐ Yes ☐ No
Vasectomy: ☐ Yes ☐ No
Vasectomy Reversal: ☐ Yes ☐ No
Testicular biopsy: ☐ Yes ☐ No

Current Medications: Allergies?

Tobacco? YES / NO Alcohol? Exercise?

Infertility Treatment and Testing

Have you had prior infertility treatment? Yes ☐ No ☐

If yes, it would be very helpful if you could arrange for us to have a copy of your treatment notes from your earlier infertility specialist.

Cycles with timed intercourse? Did you use an OPK?

Clomid

Injectable Cycles (COH) Type of Medication

Total number of IUI's

In Vitro Fertilization Cycles: ☐ Yes ☐ No If yes, number of prior fresh cycles

Prior Frozen IVF cycle: Clinic Name:

Do you have frozen embryos at a clinic? If yes, where?

Pregnancy Information

Pregnancy (year)	Outcome	Time to Conception/Treatment	Complications	Partner (Current/past)
1.				
2.				
3.				

FOR COMPLETION BY DOCTOR LANE

Physical Examination: **Current CD _____**

Uterus

Right Ovary Right AFC

Left Ovary Left AFC

Assessment/Plan:

Tests Ordered:

Day 2 / 3 FSH/Estradiol	ABO/Rh	Semen Analysis
FSH / LH	Rubella	Infectious Disease Female
Prolactin	Varicella	Infectious Disease Male
TSH	Cystic Fibrosis Female Male	Creatinine and AST
CBC	HSG	RPL

Pictures: