



N o v a I n V i t r o
F e r t i l i z a t i o n

Comprehensive Medical History Form

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? _____

Patient Demographic Information

	Patient	Partner
Name:		
Date of Birth:		
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

Fertility History:

Duration of relationship: _____ years and _____ months

Duration of unprotected intercourse: ____ years and ____ months

How long have you been actively attempting pregnancy? _____ years and _____ months

How frequently do you and your partner have intercourse? _____ per week / _____ per month

Have you ever used a method to keep you from getting pregnant? Yes No

If yes, what method(s)? _____

If known, what is the cause of your infertility? _____



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Pregnancy history (Patient):

Pregnancy	1 st	2 nd	3 rd	4 th
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?				

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 been diagnosed with any health problems? No Yes (explain)

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

- Hepatitis
- Chlamydia
- Syphilis
- Gonorrhea
- Herpes
- Genital Warts/HPV



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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			
Endometrial receptivity testing			

Health care maintenance:

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

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



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Surgical history:

Please list any surgeries you have had in chronological order:

Year	Reason and Type of Surgery

Social History:

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: _____

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

Emotional Status:

On a scale of 1-10 (10 being the worst), estimate the level of stress you feel due to infertility and other pressures: _____

Do you see a counselor? Yes No

List any anti-depressant/anti-anxiety medication you are currently taking: _____

Has your infertility produced marital or sexual dysfunction? Yes No

Family History:

Have any of these illnesses occurred in your family:

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



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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
- Covid-19: No Yes (dates:) Don't Know
 Moderna Pfizer Johnson & Johnson Other _____

Prior Infertility Treatment (please indicate which medication if applicable):

Treatment	# of Cycles	Dates: From (Mo/Yr) / To (Mo/Yr)	Outcome
<input type="checkbox"/> Clomid or Femara / Letrozole with timed intercourse			
<input type="checkbox"/> Clomid or Femara / Letrozole with insemination (IUI)			
<input type="checkbox"/> Injectable medications with insemination (IUI)			
<input type="checkbox"/> Intrauterine insemination (IUI) alone-natural cycle			

In Vitro Fertilization Treatment History

Treatment	Cycle 1	Cycle 2	Cycle 3	Cycle 4
Cycle date				
IVF center/physician				
Maximum gonadotropin dose (Follistim, Gonal-F, Menopur)				
# Eggs retrieved				
Was ICSI performed? (Y/N)				
# Eggs fertilized				
#Eggs/embryos frozen				
Was genetic testing performed on the embryos?				
Did an embryo transfer take place in a fresh or frozen cycle?				
How many embryos transferred?				
Embryo age (day 2, 3, 5)				
Outcome				



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Partner History:

Partner: pregnancies from previous marriage(s) or partner(s):

Pregnancy	1 st	2 nd	3 rd	4 th
Mo/Yr of conception				
How long did it take to conceive?				
Gender				
Outcome	<input type="checkbox"/> Living <input type="checkbox"/> Miscarriage <input type="checkbox"/> Ectopic <input type="checkbox"/> Abortion	<input type="checkbox"/> Living <input type="checkbox"/> Miscarriage <input type="checkbox"/> Ectopic <input type="checkbox"/> Abortion	<input type="checkbox"/> Living <input type="checkbox"/> Miscarriage <input type="checkbox"/> Ectopic <input type="checkbox"/> Abortion	<input type="checkbox"/> Living <input type="checkbox"/> Miscarriage <input type="checkbox"/> Ectopic <input type="checkbox"/> Abortion

Have you ever been evaluated by a urologist? Yes No

Do you have difficulty with erections? Yes No

Do you have retrograde ejaculation of sperm into the bladder? Yes No

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

- Chlamydia
- Syphilis
- Gonorrhea
- HIV/AIDS
- Herpes
- Hepatitis
- Genital Warts/HPV

Do you have a history of undescended testicles? Yes No

Do you have scrotal or testicular pain? Yes No

Have you had prior injury to your testicles requiring hospitalization? Yes No

Have you had a high fever in the last 3 months? Yes No

Have you had a vasectomy? Yes No

Have you had surgery for varicocele repair? Yes No

Have you had hernia surgery? Yes No

Did you undergo any bladder or penis surgery as a child? Yes No

Are you exposed to any radiation or harmful chemicals in the workplace? Yes No

Have you had chemotherapy for cancer? Yes No

Have you ever used testosterone, androGel or androgenic hormones? Yes No



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Have you been diagnosed with any health problems? No Yes (explain)

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Test	Date(s)	Physician/Clinic	Results
Semen Analysis			
Chromosomes (karyotype)			
Genetic Testing			

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