Nova

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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