THE FERTILITY INSTITUTE OF NEW ORLEANS
FEMALE HISTORY

Name_____ Date of birth___/___/___ Age___ Date_____
Partner's name_____ Date of birth___/___/___ Age_____
Patient's race_____ Partner's race_____
Duration of relationship ____yrs Duration of infertility ____yrs
Occupation_____ How long_____
Are you exposed to any work hazards?_____
Last pap_____ Wt Now_____lbs Wt 1yr ago_____lbs Wt at 18yrs_____lbs
Referring physician:_____
Please circle:

PREGNANCY

Y N 1. Pregnancy? If yes, fill out chart on back of page two.
Y N 2. Were there any complications during or after pregnancy?
If yes, please explain:_____
_____
Y N 3. Adopted a child?

MENSES

Y N 4. Are menses regular? If not, how often do they occur?_____
_____ How long?_____
Last menstrual period ____/____/____
Are cramps: ____mild ____moderate ____severe
Y N 5. Do you spot between periods?
Y N 6. Do you take pain medication for cramps?_____

SURGERY

Y N 7. Previous surgery? Female organs_____
Appendicitis or other?_____
_____

MEDICAL

Y N 8. Medical problems? Now_____
Prior_____
Y N 9. Medication? Now_____ Prior_____
Y N 10. Allergies? Drugs_____
Other_____
Y N 11. Injury or transfusions?_____
_____

FERTILITY HISTORY

12. Age of first menses:_____
13. Have you been told that you have:

Y N endometriosis
Y N thyroid disease
Y N trapped egg (luteinized unruptured follicle)
Y N anovulation (not ovulating)
Y N blocked tubes
Y N abnormal uterus
Y N scar tissue in uterus
Y N ovarian cysts
Y N luteal phase defect
Y N uterine bleeding
Y N mother took hormone while pregnant with you

Y N 14. Have you had an infertility work-up?

NORM	ABN	
____	____	hysterosalpingogram (dye in uterus & tubes)
____	____	basal body temperature
____	____	laparoscopy (belly button surgery)
____	____	hysteroscopy (look inside uterus)
____	____	D & C or endometrial biopsy (scrape uterus)
____	____	husband sperm count

____ ____ post coital test (check cervical mucus after intercourse)
____ ____ blood test for infertility

Y N 15. Have you ever been treated with Clomid, Parlodel, or Danocrine (fertility drugs)
Y N Clomiphene Citrate (Serophene, Clomid)
# of months_____ dosage_____
Y N Danocrine (duration _____days/months)
Y N Parlodel
Y N Pergonal (_____months)
Y N HCG shots
Y N Metrodin
Y N Progesterone
Y N Lupron

Y N 16. Do you have symptoms of premenstrual tension syndrome?
personality changes_____ anxiety_____ headaches_____ swollen feet_____

Y N 17. Are your periods regular? How long?_____
How many pads or tampons are soaked per day?_____
How long from the start of one period to the start of the next?_____
How old were you when you started your menses?_____yrs

Y N 18. Do you have cramps with your periods?

Y N 19. Are you confined to bed because of pain with periods?

Y N Miss work or school?

Y N 20. Have you ever had:
pelvic infection____ gonorrhea____ syphilis____ herpes____ chlamydia____ AIDS____

Y N 21. Do you have male type hair growth on your upper lip, chin, side burn area, or midline between your breast and upper abdomen?
If so, how often do you pluck, shave, tweeze, wax or laser?
_____

Y N 22. Do you have problems with oily skin or acne?

Y N 23. Have you had a chronic progressive weight gain?

Y N 24. Breast or nipple discharge?

Y N 25. Do you use any lubricants with intercourse? Type_____

Y N 26. Do you have pain with sex?

Y N 27. Do you douche after intercourse?

Y N 28. Has infertility caused problems in your marriage?
sex_____ orgasm_____ unhappiness_____

29. How often do you have intercourse per week?_____

Y N 30. Have you had any artificial inseminations? How many?_____

PERSONAL HISTORY

Y N 31. Smoke: _____ pkg/day, # of years_____

Y N 32. Alcohol: beers, cocktails, wine ____/week, # years_____

Y N 33. Coffee: ____cups/day, # of years_____, Caffeinated_____
Decaffeinated_____

Y N 34. Tea: ____glasses/day, # of years____

Y N 35. Soft Drinks: ____glasses/day, # of years____,
Caffeinated_____, Decaffeinated_____

Y N 36. Artificial sweeteners: ____ pkg/week, # of years_____
Y N 37. Adverse environmental conditions (cold or toxic chemicals)
Y N 38. Do you use hot tub, sauna, or steam bath?
Y N 39. Are you or your husband away from home frequently?
How many days are you separated per month?_____
Y N 40. Illicit or recreational drugs (marijuana, cocaine, etc)?
If you would not feel comfortable writing anything down, please discuss this with your physician.

_____

Y N 41. Have you ever used birth control:
Y N 41-A. IUD (If yes, have you had any of these problems?)
IUD name _____ Date_____
Y N infection
Y N lost IUD
Y N increased bleeding
Y N increased pain
Y N 41-B. Birth Control pills (if yes, any problems?)
Pill name_____ Date_____
Y N nausea & vomiting
Y N decreased menses
Y N increased menses
Y N clotting
Y N no menses
Y N break-through bleeding or spotting
Y N weight gain
Y N high blood pressure
Y N headaches
Y N milk in breast
other_____
Y N 41-C. Other birth control?_____ Date_____
Y N 41-D. Spermicide (with diaphragm, condom cervical sponge/cap)

FEMALE HISTORY

Y N 42. Infertility or miscarriages in mother or sister?
Y N 43. Did your mother use diethylstilbestrol (DES) when she was pregnant with you?
Y N 44. Birth defects in relatives? Type_____
Y N 45. Menstrual problems in mother or sisters?
Y N 46. Endometriosis in female relatives?
Y N 47. Other medical disorders?
Y N diabetes? who?_____
Y N hypertensin? who?_____
Y N thyroid disease? who?_____
Y N heart attack? who?_____
Y N cancer? who?_____ what kind?_____

	Age	General Health	Fertility Problem?
MOTHER	_____	_____	_____
MATERNAL RELATIVES	_____	_____	_____
FATHER	_____	_____	_____
PATERNAL RELATIVES	_____	_____	_____
SISTERS OR BROTHERS	_____	_____	_____

_____ _____ _____
_____ _____ _____

REVIEW OF SYSTEMS (If yes, please explain)

Y N 48. Any eye disease, injury, impaired sight?_____
Y N 49. Any ear disease, injury, impaired hearing?_____
Y N 50. Any nose, sinus, throat, or mouth trouble?_____
Y N 51. Loss of consciousness?_____
Y N 52. Convulsions?_____
Y N 53. Fainting spells?_____
Y N 54. Dizziness?_____
Y N 55. Paralysis?_____
Y N 56. Depression or anxiety?_____
Y N 57. Frequent or severe headaches?_____
Y N 58. Hallucinations?_____
Y N 59. Enlarged glands?_____
Y N 60. Thyroid disease?_____
Y N 61. Skin disease?_____
Y N 62. Chronic or frequent cough?_____
Y N 63. Shortness of breath?_____
Y N 64. Asthma?_____
Y N 65. Chronic bronchitis?_____
Y N 66. Spitting up blood?_____
Y N 67. Night sweats?_____
Y N 68. Tuberculosis?_____
Y N 69. Chest pain or angina?_____
Y N 70. Palpitation or heart fluttering?_____
Y N 71. Swelling of ankles, feet, or hands?_____
Y N 72. Extreme weakness or tiredness?_____
Y N 73. Varicose veins?_____
Y N 74. Kidney disease or stones?_____
Y N 75. Bladder disease?_____
Y N 76. Difficulty in urination?_____
Y N 77. Albumin, sugar, pus, etc. in urine?_____
Y N 78. High blood pressure?_____
Y N 79. Abnormal thirst?_____
Y N 80. Indigestion?_____
Y N 81. Stomach trouble or ulcers?_____
Y N 82. Appendicitis?_____
Y N 83. Colitis or other bowel disease?_____
Y N 84. Liver or gallbladder disease?_____
Y N 85. Abnormal diarrhea or constipation?_____
Y N 86. Hemorrhoids or rectal bleeding?_____
Y N 87. Psychosis_____
Y N 88. Valvular disease_____
Y N 89. Cancer_____
Y N 90. Any other medical problems?_____
_____
_____

GENETIC SCREENING

Y N 91. Do you or the baby's father have a birth defect or genetic condition? If so, explain_____

Y N 92. Does your family or the family of the baby's father have children with birth defects or a condition that has been diagnosed to be genetic or inherited?
If yes, explain_____

Y N 93. Are you or the baby's father from any of the ethnic backgrounds listed below:
___ Jewish ___ Black ___ Asian ___ Mediterranean

Y N 94. Have you or the baby's father ever been screened for any of the disorders listed below?
___ Tay-Sachs ___ Sickle Cell ___ Thalassemia
If yes, results_____

PREGNANCY CHART

	Year	Abortion? Spont or Induced		Ectop	Therapy Required?	Time to Conception	Baby Born Alive?
1st preg	_____	_____	_____	_____	_____	_____	_____
2nd preg	_____	_____	_____	_____	_____	_____	_____
3rd preg	_____	_____	_____	_____	_____	_____	_____
4th preg	_____	_____	_____	_____	_____	_____	_____
5th preg	_____	_____	_____	_____	_____	_____	_____

THE FERTILITY INSTITUTE OF NEW ORLEANS
MALE HISTORY

Name_____ Wife_____

Age____Date of Birth____/____/____ Duration of infertility_____yrs

Ht_____in. Wt: Now-_____lbs, 1yr ago-_____lbs, 18yrs-_____lbs

Occupation_____ How long_____yrs.

Referring Physician_____

CIRCLE

Y N 1. Have you fathered children before this marriage?

Y N 2. Have you had a semen analysis (sperm count)? (Normal___ or Abnormal___)

Y N 3. Have you seen a urologist?

Y N 3a. Have you been tested for a varicocele?

Y N 3b. Have you ever been diagnosed as having any abnormalities? Diagnosis_____

Y N 3c. Have you been treated medically? Drugs _____

Y N 3d. Have you been treated surgically? Procedure _____

Y N 4. Do any family members have fertility problems?

Y N 5. Do any family members have children with birth defects?

Y N 6. Did your mother take any medicines to prevent miscarriage?

Y N 7. Have any of your female relatives over age 18 never had a menstrual period?

Y N 8. Do you have any medical disorders?

Y N 9. Medical problems:_____

_____

Y N 10. Medicines:_____

_____

Y N 11. Surgeries:_____

_____

Y N 12. Allergies:_____

_____

Y N 13. Do you smoke? If so, how long, at what age did you start, how many per day. If you stopped, at what age?_____

_____

_____

_____

Y N 14. Alcohol? # beers ___/wk, # cocktails ___/wk, # wine___/wk

Y N 15. Do you use hot tubs, saunas, or steambaths?

Y N 16. Have you had mumps as an adult?

Y N 17. Have your testes every been sore?

Y N 18. Have you ever had trauma to your testes?

Y N 19. Do you work out, play a sport, or run regularly? How often? _____/wk

Y N 20. Have you ever had a sexually transmitted disease? Gonorrhea _____, Syphilis _____, Herpes _____, Other _____

Y N 21. Has infertility caused stress in your marriage?

Y N 22. Is infertility affecting other relationships or your lifestyle in general?

Y N 23. Do you use lubricants with intercourse?

Y N 24. Do you have any trouble ejaculating?

Y N 25. Do you have problems with premature ejaculation?

Y N 26. Many men occasionally have problems maintaining an erection. Do you frequently have this problem?

Y N 27. Have you come into contact with dusts, fumes, vapors, gases, chemicals, radiation, pressure, noise, vibration, or temperature extremes?

Y N 28. Have you noticed any adverse effects?

Y N 29. Has your employer supplied you with Material Safety Data Sheets?

Y N 30. Does anyone in the family work in a trade where hazardous materials (solvents, mercury, lead, formaldehyde, vinyl chloride, etc.) could have been brought home?

Y N 31. Have you ever lived near a plant, shipyard, mine, or other facility that could have released hazardous materials? If yes, where and when?_____

Y N 32. Any hobbies or leisure activities involving adverse exposures? If yes, when, time span, and which ones?
_____

33. Please list your last five jobs. Include the years worked, a description of your duties, and any exposures.

_____

_____

_____

_____

_____

Date_____ Marital Status M____S____D____W____

Name_____
Last First M initial

Address_____Apt #:_____

City_____State_____Zip_____

Age_____Date of Birth_____SS number_____

Home phone_____work phone_____cell phone_____

Employer:_____Occupation_____

Address:_____
City/State/Zip

Husband/Partner/Parent_____
Circle one Name social security number

Date of birth_____Employer_____

Emergency contact_____relationship_____

Phone numbers_____
Home work cell

Email address_____

Insurance company (Wife)_____Please provide card

Insurance company (Husband)_____Please provide card

Are you covered on your husband's insurance policy? Yes_____No_____

Referred by:_____(if physician please provide address)

I,_____authorize the release of any medical information necessary to process medical claims submitted to my insurance company.

I,_____authorize payment of medical benefits to the physician or supplier of the medical service.

I,_____understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any services rendered. The filing of insurance claims is a courtesy extended to our patients. I understand that it is my responsibility to determine my financial liability as it pertains to "in" or "out" of network and to secure referrals and/or authorizations, if needed, prior to any services being rendered.

I,_____authorize the Fertility Institute of New Orleans to discuss my medical treatment with my family/friend(s) listed below.

Name Relationship Name Relationship

**********office use only**********

Dickey_____Taylor_____Rye_____Lu_____Sartor_____

Dunaway_____Hayes_____Montz_____Farrell_____

Patients come to us from a large surrounding area. In our efforts to make sure we let infertile couples or gynecological patients know where we are, we are most interested in how you found us. Please help us by indicating on the following choices how you found out about us. Some patients will have multiple answers EXAMPLE: 1) Visualized our ad on NOLA.com and then 2) asked their OB/GYN for a referral. Please number your choices as is in the example.

Thank you very much……this will be a great help.

_____ Ad in Louisiana Life Magazine

_____ Ad in Mississippi Magazine

_____ Ad on NOLA.com

_____ Searching the web arriving at our website, fertilityinstitute.com

_____Referred by a patient

_____ Referred by a physician

_____Referred by a friend who had heard about us.

_____ Found us in the phone book/yellow pages.

_____ Other, please list_____

_____