BEVERLY HILLS
FERTILITY

Comprehensive History Form

Date Completed _____
What is the primary reason for your consultation? _____
_____
Who referred you to our practice?

_____ Former patient
_____ Friend
_____ Lecture series
_____ Insurer (name)
_____ Internet
_____ Media article
_____ Medical literature
_____ Physician (name)
_____ Self referral
_____ Yellow pages
_____ Other

Comments _____
Religious issues concerning conception or infertility treatment: _____
_____

Male Patient

_____
(name)

_____
(date of birth) (age)

Occupation_____

Preferred Pharmacy _____
Tel. #._____

Phone (day) _____
(eve) _____
(cellular) _____
(e-mail) _____
(voicemail) _____
(pager) _____

Primary Care Physician
_____
(name)

Address_____
City_____
State, Zip_____
Phone _____
Medical specialty_____
Would you like a summary letter sent? _____

Female Patient

_____
(name)

_____
(date of birth) (age)

Occupation _____

Preferred Pharmacy _____
Tel. #. _____

Phone (day) _____
(eve) _____
(cellular) _____
(e-mail) _____
(voicemail) _____
(pager) _____

Primary Care Physician
_____
(name)

Address _____
City _____
State, Zip _____
Phone _____
Medical specialty _____
Would you like a summary letter sent? _____

Comprehensive History Form

Duration of relationship _____

Duration of unprotected intercourse _____

How long have you been actively attempting pregnancy?_____

Contraceptive practices

	(yes)	(no)	(dates)
Intrauterine device (IUD)	_____	_____	_____
Oral contraceptives	_____	_____	_____
Other	_____	_____	_____

	(yes)	(no)
Use of lubricants	_____	_____
Douche after intercourse	_____	_____
Painful intercourse	_____	_____
Bleeding/spotting after intercourse	_____	_____

Pregnancies (female):

Pregnancy (include all pregnancies)	When? (Year)	How long to conceive	Gender	Is current Partner the Father (Y/N)	Outcome (spontaneous miscarriage, abortion, or terminations, ectopic pregnancy, vaginal delivery, cesarean section, fetal demise or stillbirth) and list complications, if any.
First					
Second					
Third					
Fourth					
Fifth					

Male: Pregnancies from previous marriage(s) or partner(s), if any:

Pregnancy (include all pregnancies)	When? (Year)	How long to conceive	Gender	Outcome (spontaneous miscarriage, abortion, or terminations, ectopic pregnancy, vaginal delivery, cesarean section, fetal demise or stillbirth) and list complications, if any
First				
Second				
Third				
Fourth				

Comprehensive History Form

Female History

Menstrual History

Age at first menstrual period_____ last menstrual period _____
How often do menses occur?_____ duration of menstrual flow _____
Amount/severity of menstrual flow _____
Medication taken for cramps_____ amount_____frequency _____

Midcycle: spotting _____ pelvic pain_____increase mucus _____

When was your last pap smear? _____ When was your last mammogram? _____
Any abnormal pap smears: _____
Do you have or have you ever had (Place a "Check Mark" by any that apply):

Infectious Problems		**Gynecologic Problems**		**Medical Problems**			
Chicken Pox (varicella)		Chlamydia		Anemia		Kidney disease	
Chicken Pox vaccine		Gonorrhea		Bleeding disorders		Kidney infection	
Hepatitis A, B, or C		Syphilis		Blood clots		Liver problems	
German measles-rubella		Pelvic infection (PID)		Blood transfusion		Lost > 15 pounds last year	
Rubella immunization		Mycoplasma/Ureaplasma		Diabetes		Lung disease	
Rheumatic fever		Condyloma-venereal warts		Cancer		Asthma	
Chronic bronchitis		Herpes: genital		Appendicitis		Recurrent urinary infections	
		Abnormal mammogram		Heart disease		Thyroid problems	
Neurological Problems		Abnormal pap smear		High blood pressure		Arthritis	
Migraine headaches		Blocked fallopian tubes		Mitral valve prolapse			
Seizures (epilepsy)		Pelvic adhesions		Excess hair growth		Other Problems:	
		Endometriosis		Hot flashes or night sweats			
		Uterine anomalies		Rh sensitized			
		Cervical Stenosis		Breast discharge			
		DES exposure					

Comments_____

Toxicant Exposure:	(yes)	(no)	(date)	
Alcohol				
none	____	____	_____	
weekend	____	____	_____	
daily	____	____	_____	
Smoking	____	____	_____	
Pesticides	____	____	_____	
Radiation	____	____	_____	
Coffee/caffeine	____	____	_____	(amount)
Other chemicals	____	____	_____	

Comprehensive History Form

Female History

List all medication you take now (prescription, vitamin, over-the-counter, alternative therapies):

(drug)	(date)	(dose)
(drug)	(date)	(dose)

Are you taking prenatal vitamins? _____

Complete information about allergies you have had: No known allergies (circle N/A)

Drug or Allergen	Reaction	Sensitivity (mild/moderate/severe)

List all surgeries you have had (cervix, uterus, ovarian cysts, tubes, endometriosis, appendix, etc.):

(type of surgery)	(date)
(type of surgery)	(date)
(type of surgery)	(date)

List all other serious illnesses for which you have been under the care of a physician:

(illness)	(date)
(illness)	(date)

Weight _____ Height _____

Special dietary habits: _____

How much do you exercise? _____

Comprehensive History Form

Family History of Female

Country of origin: Mother_____ Father _____

Ethnic background (circle): African/American Asian Asian-Indian Caucasian
Hispanic Jewish American/Indian Mediterranean Middle Eastern Other: _____

Ethnic group (Circle all that apply)	Have you been tested for:	Yes	No	Date	Result
African, African/American	Sickle cell trait				
Asian, Mediterranean or Hispanic	Thalassemia				
Caucasian, Jewish	Cystic fibrosis				
Jewish	Tay Sachs				
Jewish	Gaucher				

Are you related to your current partner (consanguinity)? _____

Is there anyone in the family who has had any of the following illnesses:

	Yes	Who		Yes	Who
Endometriosis			Infertility		
Excess body hair			Mental retardation		
Genital abnormalities			Early menopause < 40 yrs old		
Breast cancer			Miscarriages (2 or more)		
Chromosomal disorders			Ovarian cancer		
Delayed development					
Early puberty			Hormone disorders		
Birth defects			Metabolic disorders		
Bleeding disorders			Genetic (inherited) disorders		

Comments _____

Comprehensive History Form

Male History

Growth and development:	(yes)	(no)
Undescended testicles	_____	_____
Delayed puberty	_____	_____
Breast enlargement	_____	_____

Testicular injury:	(yes)	(no)	(date)
Varicocele	_____	_____	_____
Torsion (twisted)	_____	_____	_____
Painful swelling	_____	_____	_____
Severe trauma	_____	_____	_____

Toxicant exposure:	(yes)	(no)	(date)
Alcohol	_____	_____	_____
none	_____	_____	_____
weekend	_____	_____	_____
daily	_____	_____	_____
Smoking	_____	_____	_____
Pesticides	_____	_____	_____
Radiation	_____	_____	_____
Other chemicals	_____	_____	_____

Sexually transmitted diseases:

Chlamydia	_____	_____	_____
Genital warts (HPV)	_____	_____	_____
Gonorrhea	_____	_____	_____
Herpes	_____	_____	_____
Syphilis	_____	_____	_____
Other	_____	_____	_____

Urinary tract:

Bladder/kidney infection	_____	_____	_____
Prostatitis	_____	_____	_____
Other	_____	_____	_____

Frequency of hot tub use: _____ _____ _____

Comprehensive History Form

Male History

List all medication you take now (prescription, vitamin, over-the-counter, alternative therapies):

(drug)	(date)	(dose)
(drug)	(date)	(dose)

Complete information about allergies you have had: No known allergies (circle N/A)

Drug or Allergen	Reaction	Sensitivity (mild/moderate/severe)

List all surgeries or blood transfusions you have had:

(type of surgery)	(date)
(type of surgery)	(date)

List all other serious illnesses for which you have been under the care of a physician:

(illness)	(date)
(illness)	(date)

	(yes)	(no)
Difficulty with sexual function (male): (please explain)		

Comprehensive History Form

Male Family History

Country of origin: Mother_____ Father _____

Ethnic background (circle): African/American Asian Asian-Indian Caucasian
Hispanic Jewish American Indian Mediterranean Middle Eastern Other: _____

Ethnic group (Circle all that apply)	Have you been tested for:	Yes	No	Date	Result
African, African/American	Sickle cell trait				
Asian, Mediterranean or Hispanic	Thalassemia				
Caucasian, Jewish	Cystic fibrosis				
Jewish	Tay Sachs				
Jewish	Gaucher				

Are you related to your current partner (consanguinity)?_____

Is there anyone in the family who has had any of the following illnesses:

	Yes	Who		Yes	Who
Infertility			Learning problems		
Genital abnormalities			Mental retardation		
Birth defects			Metabolic disorders		
Chromosomal disorders			Miscarriages (2 or more)		
Delayed development			Short stature		
Early puberty			Testicular cancer		
Hormone disorders			Undescended testicles		
Pituitary tumor			Abnormal breasts		
Lack of sense of smell			Genetic (inherited) disorders		

Comments _____

Comprehensive History Form

Previous Female Infertility Tests:	(result)	(date)
Ovulation predictor kits		
Endometrial biopsy		
HSG		
Chromosome studies		
Hysteroscopy		
Laparoscopy		
Pelvic ultrasound		
Other		

Previous Male Infertility Tests:	(result)	(date)
Semen analyses		
Chromosomes		
Other (SCSA, EFT, etc.)		

Previous Hormonal Tests:	Female		Male	
	Result	Date	Result	Date
Testosterone				
Prolactin				
TSH				
FSH (random)				
FSH (day 3)				
Estradiol (day 3)				
DHEA-S				
Progesterone				

Comprehensive History Form

Previous Treatments:

	Yes/No	# cycles	Comments (dose, # days/cycle)
Inseminations (IUIs, without medication)			
Clomiphene (Clomid, Serophene) (with intercourse only)			
Clomiphene with inseminations (IUI)			
FSH * with intercourse only			
FSH * with inseminations (IUI)			
Progesterone supplements			
Dexamethasone, prednisone			
Aspirin			
Heparin			
IVIG			
Other			

Comments _____

_____

_____

Prior in-vitro fertilization (IVF), GIFT, or intracytoplasmic sperm injection (ICSI) results, if applicable

Date of procedure	Procedure	Protocol	# of eggs obtained	# of eggs mature	# of eggs fertilized	# embryos transferred	# embryos frozen	Pregnancy outcome

Comments

_____

_____

_____

_____

_____

*FSH - Pergonal, Humegon, Repronex, Metrodin, Fertinex, HMG, Gonal-F and/or Follistim