GENETICS & IVF Institute

Patient History Form

Today's Date: _____

Please complete all applicable sections of this questionnaire to the best of your ability.
Your confidential answers will be reviewed by a physician and will help to give you the best possible care.

PATIENT INFORMATION

Patient Legal Name: _____ Preferred Name: _____

Sex assigned at birth: ■ Male ☐ Female Personal Pronouns: _____ Height: _____ Weight: _____

Date of Birth: ____/___/_____ Age: _____ Start Date of last menstrual period: _____

Partner/Spouse Legal Name *(if applicable)*: _____ Preferred Name: _____

Sex assigned at birth: ☐ Male ☐ Female Personal Pronouns: _____ Height: _____ Weight: _____

Partner Date of Birth: ____/___/_____ Partner Age: _____ *(Male Partner Medical History Continues on Pg 7)*

Who is your OB/GYN? Name/Practice: _____ Phone/Fax: _____

Address: _____

☐ Check here if you would like a summary of your consult sent to your Ob/Gyn and/or your referring clinician

Any other clinician you regularly see to manage your health? **(cardiologist, hematologist, urologist, endocrinologist, PCP, etc.)**

Name/Practice: _____ Phone/Fax: _____

Address: _____

What is the Primary Reason for your Visit? What are your goals/expectations for the consultation?
Please be as specific as possible, including if you are specifically interested in one or more of the following: Egg Freezing, Infertility Evaluation, Donor Egg or Donor Sperm, Genetic Testing, Recurrent Pregnancy Loss, Family Balancing, Second Opinion

_____

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How many months have you been actively trying to conceive? _____ ☐ N/A

How many months have you been having vaginal intercourse without using any form of birth control? _____ ☐ N/A

How many times do you have vaginal intercourse per **week**? _____times per week ☐ None/Not Applicable

Have you used over-the-counter ovulation predictor kits to time intercourse? ☐ Yes ☐ No

PATIENT MEDICAL HISTORY & HEALTH INFORMATION

SEXUAL & CONTRACEPTION HISTORY:

Do you use lubricants (K-Y Jelly®, etc.) during intercourse? ☐ Yes: *what types?* _____ ☐ No ☐ N/A

Do you currently or have you had any of the following sexually transmitted diseases or pelvic infections? ☐ N/A

☐ Chlamydia – date: _____ ☐ Gonorrhea – date: _____ ☐ Herpes – date: _____ ☐ Hepatitis – date: _____

☐ Genital warts/HPV – date: _____ ☐ Syphilis – date: _____ ☐ HIV/AIDS – date: _____

☐ Trichomoniasis – date: _____ ☐ Pelvic Inflammatory Disease – date: _____ ☐ Other _____ date: _____

Check all forms of contraception ever used, note approx. dates of use, and any complications. ☐ N/A – None Used

Contraception Method	Dates of use	Complications?
☐ Barrier Method (Condoms/Diaphragm)		
☐ Oral Birth Control Pills		
☐ Skin Patch		
☐ Depo-Provera or other injection		
☐ Nexplanon or other implant		
☐ IUD – hormonal / ☐ IUD – Copper		
☐ Tubal Sterilization (tubes tied)	Procedure date: _____	
☐ Other: _____		
☐		

Notes: _____

_____

PREGNANCY HISTORY*:*

Total Number of ALL Pregnancies: _____ Number of Miscarriages: _____

Number of Ectopic/Tubal Pregnancies: _____ Number of Elective Terminations (Abortions): _____

Number of Full-Term Deliveries: _____ *Of these:* How many were live births? _____ How many were stillborn? _____

Number of Premature Deliveries (less than 37 weeks): _____ *Of these:* How many were live births? ____ How many were stillborn? _____

Year Pregnancy Ended or Delivered	**Months to Conception** (how long did it take to get pregnant)	**Treatments to Conceive** *if any*	**Delivery Type** *if applicable* Vaginal or C-Section	**Baby Sex & Weight** at birth	**Outcomes/Complications** (full-term, miscarriage, termination, ectopic, preterm delivery, etc.)	**Conceived with Current Partner?**
1. _____			■vaginal ■c-section			☐ Yes ☐ No
2. _____			☐vaginal ☐c-section			☐ Yes ☐ No
3. _____			☐vaginal ☐c-section			☐ Yes ☐ No
4. _____			☐vaginal ☐c-section			☐ Yes ☐ No
5. _____			☐vaginal ☐c-section			☐ Yes ☐ No

Additional Comments: _____

_____

MENSTRUAL & GYN HISTORY:

Age at first menstrual period: _____ How many days of bleeding do you usually have? _____ days

Menstrual cycle pattern (check all that apply): ☐ Regular periods ☐ Irregular periods ☐ No Periods ☐ Midcycle spotting ☐ Light periods ☐ Moderate periods ☐ Heavy periods

Number of days between the start of one period to the start of the next period: _____ days

If irregular: what's the shortest and longest number of days? _____ - _____ days

Have you ever gone longer than 3 months without a menstrual period? ☐ YES ☐ NO

Severity of cramping or pelvic pain with your periods: ☐ Mild ☐ Moderate ☐ Severe

Do you experience midcycle cramping? ☐ YES ☐ NO

Do you experience pain with vaginal intercourse? ☐ YES ■ NO

Month/Year of your last Pap smear? _____ Result: ☐ Normal ☐ Abnormal

Have you had an abnormal Pap smear in the past? ☐ Yes: date of most recent abnormal Pap: _____ ☐ No

Have you undergone any procedures as a result of an abnormal pap smear? ☐ Yes (check all that apply) ☐ No

☐ Colposcopy ☐ Cryosurgery (Freezing) ☐ Laser treatment ☐ Conization ☐ LEEP procedure

Month/Year of your most recent Mammogram? _____ Result: ☐ Normal ☐ Abnormal

Any prior history of abnormal mammograms? _____

PRIOR FERTILITY TESTS & TREATMENTS *(Please provide medical records if possible):*

Have you had prior infertility testing or treatment elsewhere? ☐ No ☐ Yes – where/when: _____

Prior Testing & Results, if known *(check all that apply and provide as much information as known):*

☐ Hormonal blood tests (FSH/AMH/TSH) – date: _____ results: _____

☐ Pelvic Ultrasound – date: _____ results: _____

☐ Hysterosonogram or Saline Sonogram - date: _____ results: _____

☐ Hysterosalpingogram (HSG) – date: ____ results: _____

☐ Endometrial Biopsy – date: _____ results: _____

☐ Infectious disease screening (HIV/Hep C/Hep B/Syphilis) – date: _____ results: _____

Prior Fertility Treatments (check all that apply):

Treatment	Outcome	Date(s) of Treatment
☐ Intrauterine insemination (IUI) – ☐ medicated ☐ un-medicated/natural		
☑ In-Vitro fertilization		
☐ Frozen Embryo Transfer (FET)		
☐ Donor Egg		
☐ Other: _____		

Additional Information: _____

_____

GENERAL MEDICAL HISTORY:

Are you experiencing or have you been diagnosed with any of the following? *(check all that apply & provide details in the comments):*

General:
- ☐ Recent unintentional weight gain or loss of greater than 15 pounds
- ☐ Anorexia/Bulimia
- ☐ Lack of energy
- ☐ Fever/Chills
- ☐ Chronic Pain
- ☐ Other _____

Cardiovascular:
- ☐ Palpitations/Skipped beats
- ☐ Chest pain
- ☐ Heart attack
- ☐ Stroke
- ☐ Murmurs
- ☐ High blood pressure
- ☐ Rheumatic fever
- ☐ Mitral Valve prolapse
- ☐ Other _____

Pelvic (Genito-Urinary):
- ☐ Bladder infections/recurrent UTIs
- ☐ Kidney infections
- ☐ Vaginal infections
- ☐ Frequent urination
- ☐ Leaking urine
- ☐ Blood in the urine
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Polycystic Ovarian Syndrome (PCOS)
- ☐ Other _____

Hematologic:
- ☐ Blood clotting disorder/Blood clots
- ☐ Sickle cell Anemia
- ☐ Easy bruising
- ☐ Swollen glands/lymph nodes
- ☐ Blood transfusions (list dates/reasons)
- ☐ Other_____

Mental Health Conditions:
- ☐ Depression
- ☐ Anxiety disorder
- ☐ Schizophrenia
- ☐ Other _____

Head, Eyes, Ears, Nose, and Throat:
- ☐ Dizziness
- ☐ Loss/poor sense of smell
- ☐ Blurred vision
- ☐ Ringing ears
- ☐ Hearing loss/deafness
- ☐ Sinus problems/hay fever/allergic rhinitis
- ☐ Other _____

Breasts:
- ☐ Discharge:
  ☐ clear ☐ bloody ☐ milky ☐ Lumpy
- ☐ Significant or Regular Pain
- ☐ Cancer
- ☐ Other _____

Skin:
- ☐ Unexplained rash/inflammation
- ☐ Acne
- ☐ Skin cancer
- ☐ Moles changing in appearance
- ☐ Excess hair growth
- ☐ Other _____

Neurological Problems:
- ☐ Weakness/Loss of balance
- ☐ Seizures/Epilepsy
- ☐ Severe Headaches or Migraines
- ☐ Numbness
- ☐ Memory loss
- ☐ Other_____

Respiratory:
- ☐ Shortness of breath
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Bloody cough
- ☐ Other _____

Gastrointestinal:
- ☐ Nausea/Vomiting
- ☐ Ulcers
- ☐ Hepatitis
- ☐ Diarrhea
- ☐ Blood in your stools
- ☐ Constipation
- ☐ Irritable Bowel Syndrome
- ☐ Change in bowel habits
- ☐ Colitis (ulcerative or Crohn's)
- ☐ GERD/heartburn
- ☐ Other _____

Endocrine/Hormonal:
- ☐ Diabetes
- ☐ Hair loss
- ☐ Thyroid gland problems
- ☐ Excessive hunger/thirst
- ☐ Temperature intolerance (hot flashes or feeling cold)
- ☐ Other _____

Musculoskeletal:
- ☐ Unusual muscle weakness
- ☐ Rheumatoid arthritis
- ☐ Lupus Erythematosus
- ☐ Myasthenia gravis
- ☐ Other_____

List any other chronic conditions/serious illnesses or Comments:

_____

_____

_____

_____

_____

GENERAL MEDICAL HISTORY, *Continued:*

Allergies: **Are you allergic to any medications**? ☐ No ☐ Yes (please list and describe reactions)

_____

_____

Are you allergic to any foods? (e.g., peanuts, eggs, etc.) ☐ No ☐ Yes (please list and describe reactions)

_____

_____

List any medications you are taking, including over-the-counter medicines, vitamins, herbals, and supplements:

Medication/Supplement	Dose & Frequency

List all prior surgeries (including on cervix, uterus, ovarian cysts, tubes, endometriosis, appendix, etc.) ☐ Not Applicable

Year	Reason & Type of Surgery

Did you have any anesthesia problems? ☐ No ☐ Yes (describe) _____

Have you had any of these illnesses/diseases/conditions? At what age? ☐ Cancer – age: ____ ☐ Covid-19 – age: ___

☐Congenital Heart Defect – age: ____ ☐Chicken pox/Shingles – age: ____ ☐ German Measles (rubella) – age: ____

☐ Other diseases: _____ ☐ N/A – None

Additional information: _____

Vaccination History:

Chickenpox (Varicella):	☐ Yes (date: _____) ☐ No	MMR (Measles, Mumps & Rubella):	☐ Yes (date: _____) ☐ No
BCG (Tuberculosis):	☐ Yes (date: _____) ☐ No	Polio:	☐ Yes (date: _____) ☐ No
Hepatitis A:	☐ Yes (date: _____) ☐ No	Hepatitis B:	☐ Yes (date: _____) ☐ No
Tetanus:	☐ Yes (date: _____) ☐ No	Influenza:	☐ Yes (date: _____) ☐ No
Covid19:	☐ Yes (date: _____) ☐ No		

SOCIAL HISTORY:

How many caffeinated beverages (coffee, tea, energy drinks, soda) do you drink per day? _____ ☐ None

Do you smoke cigarettes? ☐ No ☐ Yes - how many/day? _____ How many years? _____ ☐ Quit - when? _____

Do you drink alcohol? ☐ No ☐ Yes: # per week_____

Do you use marijuana, cocaine, or any other recreational drug? ☐ No ☐ Yes - frequency: _____

Do you exercise? ☐ No ☐ Yes – describe: _____

Do you follow a particular food diet or have any special dietary habits? ☐ No ☐ Yes – describe: _____

_____

Are you aware of any radiation exposures other than X-rays? ☐ No ☐ Yes – describe: _____

Do you have any concerns with abuse, past or present? _____

PATIENT FAMILY HISTORY:

Ethnic Background/Ancestry (if known): ☐ African American ☐ East Asian ☐ Southeast Asian ☐ Caucasian ☐ Hispanic ☐ Jewish ☐ Native American ☐ Mediterranean ☐ Middle Eastern ☐ Other _____

Have you had any genetic carrier screening (e.g. cystic fibrosis, spinal muscular atrophy, fragile X, Tay-Sachs, etc.):

_____

Are you related to your current partner? ☐ No ☐ Yes – describe: _____

Did your mother take DES during pregnancy to prevent miscarriage? ☐ No ☐ Yes ☐ Don't know

Is there anyone in the family who has had any of the following disorders?

Condition	Yes	Relationship to you	Condition	Yes	Relationship to you
Breast cancer	☐		Endometriosis	☐	
Ovarian cancer	☐		Infertility	☐	
Colon cancer	☐		Menopause before age 40	☐	
Other cancer or tumors	☐		Two (2) or more miscarriages	☐	
Diabetes	☐		Polycystic ovarian syndrome (PCOS)	☐	
Thyroid problems	☐		Birth defects	☐	
Heart disease	☐		Malignant Hyperthermia	☐	
Hypertension/stroke	☐		Inherited diseases	☐	
Blood clots/blood disorders	☐				
Congenital deafness/blindness	☐				
Developmental delay	☐				
Learning delay or disorder	☐				
Tuberculosis	☐				

Other Relevant Family History/Comments: _____

_____

_____

Male Partner history, if applicable, continues on the next page

MALE PARTNER HISTORY *(if applicable)*

Name: _____

Ethnic Background/Ancestry (if known): ☐ African American ☐ East Asian ☐ Southeast Asian
☐ Caucasian ☐ Hispanic ☐ Jewish ☐ Native American ☐ Mediterranean ☐ Middle Eastern
☐ Other _____

Medical & Health History:

Have you been evaluated by a urologist? ☐ No ☐ Yes – MD name & date of evaluation: _____

Have you previously conceived with another partner? ☐ No ☐ Yes - How many times? _____ How many live births? _____

Have you had a semen analysis? ☐ No ☐ Yes – results: _____

Do you have difficulty with erections? ☐ No ☐ Yes

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

Do you currently or have you had any of the following sexually transmitted diseases or pelvic infections? ☐ N/A

☐ Chlamydia – date: _____ ☐ Gonorrhea – date: _____ ☐ Herpes – date: _____ ☐ Hepatitis – date: _____

☐ Genital warts/HPV – date: _____ ☐ Syphilis – date: _____ ☐ HIV/AIDS – date: _____

☐ Other _____ date: _____

Have you had a history of undescended testicles? ☐ No ☐ Yes ____One side ___ Both

Do you have scrotal or testicular pain? ☐ No ☐ Yes

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

Have you had any fever in the last 3 months? ☐ No ☐ Yes

Have you had a vasectomy? ☐ No ☐ Yes – date: _____ Have you had a vasectomy reversal? ☐ No ☐ Yes - date: ____

Have you had surgery for varicocele repair? ☐ No ☐ Yes – date: _____

Have you had hernia surgery? ☐ No ☐ Yes – date: _____

Did you undergo any bladder or penis surgery as a child? ☐ No ☐ Yes – describe: _____

Have you had any other surgeries? ☐ No ☐ Yes – list year, type: _____

_____

Did you have any anesthesia problems? ☐ No ☐ Yes – describe: _____

Are you exposed to any radiation, harmful chemicals, or prolonged heat, in the workplace? ☐ No ☐ Yes

Have you had chemotherapy for cancer? ☐ No ☐ Yes

For any question you answered yes to, please provide additional relevant details such as dates, frequency, etc.:

_____

_____

_____

_____

Male Partner Medical & Health History, *continued:*

List any current chronic illness or medical problem: _____

_____

_____

_____

List any medications you are taking, including over-the-counter pills, creams, vitamins, herbals, and supplements:

Medication/Supplement	Dose & Frequency

Are you allergic to any medication, food, or other toxicant? ☐ No ☐ Yes (please list and describe reactions)

_____

_____

Have you had any genetic carrier screening? (e.g., cystic fibrosis, fragile X, Tay-Sachs, etc.): ☐ No ☐ Yes – describe:

_____

List any family history of infertility, cancer, or serious illness:

_____

_____

_____

_____

_____

Social History:

How many caffeinated beverages (coffee, tea, energy drinks, soda) do you drink per day? _____ ☐ None

Do you smoke cigarettes? ☐ No ☐ Yes - how many/day? _____ How many years? _____ ☐ Quit - when? _____

Do you drink alcohol? ☐ No ☐ Yes: # per week_____

Do you use marijuana, cocaine, or any other recreational drug? ☐ No ☐ Yes - frequency: _____

Do you exercise? ☐ No ☐ Yes – describe: _____

Do you use hot tubs regularly? ☐ No ☐ Yes - frequency: _____

Are you aware of any radiation exposures other than X-rays? ☐ No ☐ Yes – describe: _____

_____