AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE
Infertility History Form

IMPORTANT:
Please complete this form and bring it with you to your scheduled visit.

This form was developed by the American Society for Reproductive Medicine to assist physicians and patients in obtaining a complete infertility history. It consists of three parts:
Part I: Contact Information
Part II: Your medical history
Part III: Your male partner’s medical history (if applicable)

PART I: CONTACT INFORMATION

First Name ___________________________ Middle Initial ___ Last Name ___________________________ Age ______

Date of Birth (MM/DD/YY) ________/_____/______ Occupation __________________________

Home Street Address _____________________________________________________________

City __________________ State____ Zip/Postal Code__________ Country _______________

Indicate which number to call or leave messages.
☐ Home Telephone ( )__________________ ☐ Work Telephone ( )__________________ ☐ Cell Phone ( )________

Do you have a male partner? ☐ Yes ☐ No

Male Partner’s First Name ___________________________ Middle Initial ___ Last Name ___________________________ Age ______

☐ Not Applicable

Date of Birth (MM/DD/YY) ________/_____/______ Occupation __________________________

Home Street Address _____________________________________________________________

City __________________ State____ Zip/Postal Code__________ Country _______________

Indicate which number to call or leave messages.
☐ Home Telephone ( )__________________ ☐ Work Telephone ( )__________________ ☐ Cell Phone ( )________

By whom were you referred?
☐ Physician
Name ___________________________ Phone ( )__________________
Address _____________________________________________________________

☐ Former Patient/Friend

☐ Web Site

☐ Insurance (Name of Insurance) ___________________________

Who is your Ob/Gyn?
Name ___________________________ Phone ( )__________________
Address _____________________________________________________________

Who is your Primary Care Physician?
Name ___________________________ Phone ( )__________________
Address _____________________________________________________________

Physician Notes
(for office use only)

Page 1
PART II: FEMALE MEDICAL HISTORY AND INFORMATION

Reason for Visit: □ Infertility Evaluation □ Sperm Insemination □ Other

How many months have you been trying to conceive (unprotected intercourse or inseminations)?

Pregnancy Summary
• Total Number of ALL Pregnancies:_____
• Number of Full Term Deliveries:_____ Of these, how many were live births? __ How many were stillborn? __
• Number of Premature (less than 37 weeks) Deliveries:____ Of these, how many were live births? ____ How many were stillborn? ___
• Number of Miscarriages (less than 20 weeks):_____
• Number of Ectopic/Tubal Pregnancies:_____
• Number of Elective Terminations (Abortions):_____
• Any Pregnancies with Birth Defects? □ No □ Yes - explain

<table>
<thead>
<tr>
<th>Date Pregnancy Ended or Delivered</th>
<th>Months to Conception</th>
<th>Treatments to Conceive</th>
<th>Delivery Type/D&amp;C/Complications</th>
<th>Current Partner?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
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<td>□ Y □ N</td>
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<td>2.</td>
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<td>5.</td>
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<td>□ Y □ N</td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td></td>
<td></td>
<td>□ Y □ N</td>
</tr>
</tbody>
</table>

Menstrual History
• Menstrual cycle pattern (check all that apply): □ Regular periods □ Irregular periods □ Spotting before periods □ No periods
□ Heavy periods □ Light periods □ Bleeding between periods
• Number of days between the start of one period to the start of the next period:_____ days
• How many days of bleeding do you have? _____ days
• Dates of the 1st day of your last 2 menstrual periods:_____ / _____ ; _____ / _____
• Age when you had your first period:_____ years old
• Age when you first noticed Breast development:_____ years old Pubic hair:_____ years old Underarm hair:_____ years old
• How many periods do you have per year? _____
• Do you need medication to bring on a period? □ Yes - what type? ____________________ □ No
• If you do not have periods, at what age did you stop having them? _____ years old
• Do you have severe cramping or pelvic pain with your periods? □ Yes: Always ___ Sometimes ___ Recently ___ In the past ___ □ No

Contraceptive History
□ None □ Condoms - dates of use _________ □ Diaphragm - dates of use _________ □ IUD - dates of use _________
□ Birth control pills - dates of use _________ - complications? _________ □ Never used birth control pills
□ Injectable contraception (Depo-Provera®, Lanette™, etc.) - dates of use _________ - complications?
□ Skin patch - dates of use _________ - complications? _________ □ Foam or Jelly
□ Tubal sterilization procedure (tubes tied) - date (month/year) _________ / _________ □ Tubes untied - date (month/year) _________ / _________

Did your mother take DES when she was pregnant with you? □ Yes □ No □ Don’t know

Sexual History
• How many times do you have intercourse per week? _____ times per week □ None □ Not applicable
• Have you used over-the-counter ovulation kits to time intercourse? □ Yes □ No
• Do you have pain with intercourse? □ Yes □ No
• Do you use lubricants (K-Y Jelly®, etc.) during intercourse? □ Yes - what types? _________ □ No

Any prior exposure to sexually transmitted diseases or pelvic infections?
□ Yes (check all that apply) □ No
□ Chlamydia - date _________ □ Gonorrhea - date _________ □ Herpes - date _________ Genital warts/HPV - date _________
□ Syphilis - date _________ □ HIV/AIDS - date _________ □ Hepatitis - date _________

Physician Notes (for office use only)
Pap Smear History
• When was your last pap smear (month and year)? _____/_____ □ Normal □ Abnormal
• When was your last abnormal pap smear? _____ □ Not applicable

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

Breast Screening History
Have you ever had a mammogram? □ No □ Yes - date _____ Result: □ normal □ abnormal - explain
Do you perform self breast exams? □ Yes □ No

Medical History
• Are you allergic to any medications? □ No □ Yes (Please list and describe reactions)

• Are you allergic to any foods (peanuts, eggs, etc.)? □ No □ Yes (Please list and describe reactions)

• List any medications you are currently taking, including over the counter medicines.

• Do you take any herbal medicines/vitamins or health food store supplements? □ No □ Yes (Please list)

• Do you have any medical problem(s)? □ No □ Yes (Please list type, dates, and treatments.)
  (1)
  (2)
  (3)
  (4)
  (5)

• Did you have either of these childhood illnesses? □ Chickenpox (Varicella) □ German Measles (Rubella) □ Don’t know
Other childhood diseases:

Vaccinations
• Chickenpox (Varicella): □ No □ Yes (dates_____ ) □ Don’t know
• MMR - Measles, Mumps, and Rubella (German Measles): □ No □ Yes (dates_____ ) □ Don’t know
• BCG (Tuberculosis): □ No □ Yes (dates_____ ) □ Don’t know
• Hepatitis B: □ No □ Yes (dates_____ ) □ Don’t know
• Polio: □ No □ Yes (dates_____ ) □ Don’t know
• Hepatitis A: □ No □ Yes (dates_____ ) □ Don’t know
• Tetanus: □ No □ Yes (dates_____ ) □ Don’t know
• Influenza: □ No □ Yes (dates_____ ) □ Don’t know

Social History
• How many caffeinated beverages (coffee, tea, 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
  □ Beer - # per week _____ □ Wine - # per week _____ □ Liquor - # per week _____
• Do you use any marijuana, cocaine, or any other similar drug? □ No □ Yes (describe _____)
• Do you exercise? □ No □ Yes (describe _____)
• Are you aware of any radiation exposures other than X-rays? □ No □ Yes (describe _____)

Physician Notes (for office use only)
## Surgical History
- Have you had any surgeries?  □ No  □ Yes (List all surgeries in chronologic order.)

<table>
<thead>
<tr>
<th>Year</th>
<th>Reason and Type of Surgery</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

- Did you have any anesthesia problems?  □ No  □ Yes (describe__________ )

## Physical Symptoms

**General:**
- Recent weight gain or loss
- Anorexia/Bulimia
- Lack of energy
- Fever/Chills
- Other______________________________________
- None

**Endocrine/Hormonal:**
- Diabetes
- Hair loss
- Thyroid gland problems
- Rapid weight gain or loss
- Excessive hunger/thirst
- Temperature intolerance—hot flashes or feeling cold
- Other______________________________________
- None

**Gastrointestinal:**
- Nausea/Vomiting
- Ulcers
- Hepatitis
- Diarrhea
- Blood in your stools
- Constipation
- Irritable Bowel Syndrome
- Change in bowel habits
- Colitis (ulcerative or Crohn’s)
- Other______________________________________
- None

**Musculoskeletal:**
- Unusual muscle weakness
- Decreased energy/sitamina
- Rheumatoid arthritis
- Lupus Erythematosus
- Myasthenia gravis
- Other______________________________________
- None

**Mental Health Problems:**
- Depression
- Anxiety disorder
- Schizophrenia
- Other______________________________________
- None

**Head, Eyes, Ears, Nose and Throat:**
- Dizziness
- Loss of sense of smell
- Headaches
- Chronic nasal congestion
- Blurred vision
- Ringing ears
- Hearing loss/deafness
- Other______________________________________
- None

**Breasts:**
- Discharge (clear?__ bloody?__ milky?__)
- Lumps
- Pain
- Cancer
- Abnormal mammogram
- Reduction
- Augmentation/Breast implants (saline?__ silicone?__)
- Other______________________________________
- None

**Genito-Urinary:**
- Bladder infections
- Kidney infections
- Vaginal infections
- Frequent urination
- Leaking urine
- Herpes
- Blood in the urine
- Other______________________________________
- None

**Hematologic:**
- Blood clotting disorder/Blood clot
- Sickle cell Anemia
- Thrombophlebitis
- Easy bruising
- Swollen glands/lymph nodes
- Blood transfusions (dates/reasons______)
- Other______________________________________
- None

**Respiratory:**
- Shortness of breath
- Asthma
- Bronchitis
- Pneumonia
- Tuberculosis
- Bloody cough
- Other______________________________________
- None

**Neurological Problems:**
- Weakness/Loss of balance
- Seizures/Epilepsy
- Headaches
- Migraine headaches
- Numbness
- Memory loss
- Other______________________________________
- None

**Skin/Extremities:**
- Unexplained rash/inflammation
- Acne
- Skin cancer
- Burn injury
- Moles changing in appearance
- Excess hair growth
- Other______________________________________
- None

**Cardiovascular:**
- Palpitations/Skipped beats
- Chest pain
- Heart attack
- Stroke
- Murmurs
- High blood pressure
- Rheumatic fever
- Mitral valve prolapse (Need antibiotics before dental procedures? Yes____ No____)
- Other______________________________________
- None

**Physician Notes (for office use only)**

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Page 4
## Family History

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<thead>
<tr>
<th>Relation to You</th>
<th>Living</th>
<th>Cause of Death/Age at Death</th>
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</tr>
<tr>
<td>Father</td>
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<td>Brother(s)</td>
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<td>Sister(s)</td>
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## Disorders in Your Family

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<td>Heart disease</td>
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<td>Niemann-Pick disease</td>
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<td>Bone/Skeletal Defects</td>
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<td>Hemophilia</td>
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<td>Sickle Cell Anemia</td>
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<td>Thalassemia</td>
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<td>Galactosemia</td>
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<td>Don't Know</td>
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<td>Deafness/Blindness</td>
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<td>Color Blindness</td>
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<td>Hemochromatosis</td>
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</table>

None of the above: Yes
Other (Specify): No

Page 5
PRIOR INFERTILITY TESTING AND TREATMENT

- Have you had prior infertility testing or treatment elsewhere?  □ Yes  □ No

Prior Tests (check all that apply):
- Basal body temperature chart (date_/results_)
- Thyroid test (date_/results_)
- Ovulation test kit (date_/results_)
- Day 3 blood test for FSH level (date_/results_)
- Hysterosalpingogram (HSG) (date_/results_)
- Laparoscopy surgery (date_/results_)
- Hysteroscopy surgery (date_/results_)
- Progesterone blood test (date_/results_)
- Prolactin blood test (date_/results_)

Prior Treatment (check all that apply):

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<thead>
<tr>
<th></th>
<th># of cycles</th>
<th>Dates (mo/year) (mo/year)</th>
<th>Pregnant</th>
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<tr>
<td>Intrauterine insemination:</td>
<td>_____</td>
<td>From__/____ to__/____</td>
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<td>Clomiphene citrate with timed intercourse: maximum # tablets per day? _____</td>
<td>_____</td>
<td>From__/____ to__/____</td>
<td>Yes____  No____</td>
</tr>
<tr>
<td>Clomiphene citrate with insemination: maximum # tablets per day? _____</td>
<td>_____</td>
<td>From__/____ to__/____</td>
<td>Yes____  No____</td>
</tr>
<tr>
<td>Daily fertility drug injections with insemination: maximum # vials per day? _____</td>
<td>_____</td>
<td>From__/____ to__/____</td>
<td>Yes____  No____</td>
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<tr>
<td>Completed in vitro fertilization cycle(s): 1. # eggs____ #embryos transferred____ #frozen____</td>
<td>_____</td>
<td>/____</td>
<td>Yes____  No____</td>
</tr>
<tr>
<td>2. # eggs____ #embryos transferred____ #frozen____</td>
<td>/____</td>
<td>/____</td>
<td>Yes____  No____</td>
</tr>
<tr>
<td>3. # eggs____ #embryos transferred____ #frozen____</td>
<td>/____</td>
<td>/____</td>
<td>Yes____  No____</td>
</tr>
<tr>
<td>4. # eggs____ #embryos transferred____ #frozen____</td>
<td>/____</td>
<td>/____</td>
<td>Yes____  No____</td>
</tr>
<tr>
<td>Frozen embryo transfers: 1. # embryos transferred _____</td>
<td>_____</td>
<td>/____</td>
<td>Yes____  No____</td>
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<tr>
<td>2. # embryos transferred _____</td>
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<td>/____</td>
<td>Yes____  No____</td>
</tr>
<tr>
<td>3. # embryos transferred _____</td>
<td>/____</td>
<td>/____</td>
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</tr>
<tr>
<td>4. # embryos transferred _____</td>
<td>/____</td>
<td>/____</td>
<td>Yes____  No____</td>
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</tbody>
</table>

Canceled in vitro fertilization attempt(s) _____

- Additional Information/Complications

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
- Describe any emotional, marital, or sexual problems caused by your infertility.

__________________________

__________________________

PATIENT'S SIGNATURE

DATE

__________________________

I confirm that I have reviewed the information above.

__________________________

PHYSICIAN'S SIGNATURE

DATE
PART III: MALE PARTNER MEDICAL HISTORY AND INFORMATION

Complete with your male partner if applicable.

- Have you been evaluated by a urologist? □ Yes □ No
- Have you previously conceived with another woman? □ Yes: How many times? □ No: Birth control used? Yes □ No
- Have you had a semen analysis? □ Yes □ No
- Do you have difficulty with erections? □ Yes □ No
- Do you have retrograde ejaculation of sperm into the bladder? □ Yes □ No
- Any prior exposure to sexually transmitted diseases or infections?
  □ Yes (check all that apply) □ No
    □ Chlamydia - date □ Gonorrhea - date □ Herpes - date □ Genital warts/HPV - date
    □ Syphilis - date □ HIV/AIDS - date □ Hepatitis - date
- Have you had a history of undescended testicles? □ Yes - One side □ Both □ No
- Do you have scrotal or testicular pain? □ Yes □ No
- Did you have the mumps after puberty? □ Yes □ No
- Have you had prior injury to your testicles requiring hospitalization? □ Yes □ No

- Have you been diagnosed with any of the following diseases?
  □ Diabetes Mellitus - Yes □ No □ Cancer - Yes □ No
  □ Multiple Sclerosis - Yes □ No □ Other neurologic problems - Yes □ No
  □ Prostatic infections - Yes □ No □ Urinary infections - Yes □ No
  □ High Blood Pressure - Yes □ No □ If yes, any medications?

- Have you had any fever in the last 3 months? □ Yes □ No
- Have you had a vasectomy? □ Yes (date ) □ No
  If yes, have you had a vasectomy reversal? □ Yes (date ) □ 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 prolonged heat in the workplace? □ Yes □ No
- Are you exposed to any radiation or harmful chemicals in the workplace? □ Yes □ No
- Have you had chemotherapy for cancer? □ Yes □ No
- Are you allergic to any medications? □ No □ Yes (Please list and describe reactions)

List your current medications:

List any current medical problem(s):

- How many caffeinated beverages 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
  □ Beer - # per week □ Wine - # per week □ Liquor - # per week
- Do you use any marijuana, cocaine, or any other similar drug? □ No □ Yes (describe )
- Do you use herbal medicines/vitamins or health food store supplements? □ No □ Yes (describe )
- Are you aware of any radiation/toxic materials exposure? □ No □ Yes

- Do you use hot tubs regularly? □ Yes □ No
- Did your mother take DES during pregnancy to prevent miscarriage? □ Yes □ No □ Don’t know
- Have any of your immediate family members had difficulty conceiving a child? □ Yes □ No
  If yes, please describe

Physician Notes (for office use only)
Disorders in Your Family

- Cystic Fibrosis  □ Yes □ No □ Don't Know
- Tay-Sachs disease □ Yes □ No □ Don't Know
- Canavan disease □ Yes □ No □ Don't Know
- Bloom syndrome □ Yes □ No □ Don't Know
- Gaucher disease □ Yes □ No □ Don't Know
- Niemann-Pick disease □ Yes □ No □ Don't Know
- Fanconi Anemia □ Yes □ No □ Don't Know
- Familial Dysautonnia □ Yes □ No □ Don't Know
- Muscular Dystrophy □ Yes □ No □ Don't Know
- Neurologic (brain/spine) □ Yes □ No □ Don't Know
- Neural Tube Defects □ Yes □ No □ Don't Know
- Bone/Skeletal Defects □ Yes □ No □ Don't Know
- Dwarfism □ Yes □ No □ Don't Know
- Developmental delay □ Yes □ No □ Don't Know
- Learning problems □ Yes □ No □ Don't Know
- Polycystic kidney disease □ Yes □ No □ Don't Know
- Heart defect from birth □ Yes □ No □ Don't Know
- Down syndrome □ Yes □ No □ Don't Know
- Other chromosome defects □ Yes □ No □ Don't Know
- Marfan syndrome □ Yes □ No □ Don't Know
- Hemophilia □ Yes □ No □ Don't Know
- Sickle Cell Anemia □ Yes □ No □ Don't Know
- Thalassemia □ Yes □ No □ Don't Know
- Galactosemia □ Yes □ No □ Don't Know
- Deafness/Blindness □ Yes □ No □ Don't Know
- Color Blindness □ Yes □ No □ Don't Know
- Hemochromatosis □ Yes □ No □ Don't Know

□ None of the above   □ Other (Specify)

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MALE PARTNER'S SIGNATURE ___________________________ DATE _____________

I confirm that I have reviewed the information above.

PHYSICIAN'S SIGNATURE ___________________________ DATE _____________

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Physician Notes (for office use only)

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