

Do you use or have you ever used (check all that apply):

- Alcohol - How many glasses per week do you usually drink? Wine _____ Beer _____ Cocktails _____
- Cigarettes - Number of packs per day _____
- Illicit or Recreational Drugs (Marijuana, Cocaine, etc.) If you would feel more comfortable not writing anything down, please discuss this directly with your physician. Specify: _____

III. MENSTRUAL AND PREGNANCY HISTORY

YES NO

Age at first period? ____ When was your last period? _____

Are your periods regular?..... YES NO

If yes, what is the usual number of days between periods? _____

If no, how many times per year do you menstruate? _____

What is the usual duration of your period? _____ Use: Tampons? Pads?

Are cramps present before, during, or after your period? _____

Are cramps: Mild Moderate Severe

Do you have to take pain medication for cramps?..... YES NO

If yes, specify medication: _____

Do you bleed or spot between periods?..... YES NO

How many pregnancies (including abortions) have you had? _____

	When? (year)	End in Abortion?	End in Marriage?	Ectopic Pregnancy?	Infertility therapy required to conceive?	How Long to conceive?	Baby born alive?	Is Current partner the father
1st Pregnancy								
2nd Pregnancy								
3rd Pregnancy								
4th Pregnancy								
5th Pregnancy								

Were there any complications during or after your pregnancies?..... YES NO

If yes, explain: _____

Did your mother have any difficulty with conception or pregnancy?..... YES NO

If yes, explain: _____

How long have you now been trying to get pregnant? _____

Did your mother take diethylstilbestrol (DES) when she was pregnant with you?..... YES NO

IV. CONTRACEPTIVE/SEXUAL HISTORY

YES NO

What form of contraception do you use now or have you used in the past? Check all that apply:

- Pills Name: _____ IUD Name: _____ Diaphragm Withdrawal Foams/Jellies
- Condom Rhythm None Other: _____

For each contraceptive method used, specify length of use and reason for discontinuation:

Method	Length of Use	Reason for Discontinuation
_____	_____	_____
_____	_____	_____
_____	_____	_____

If you've ever been on oral contraceptives (pills), were your periods regular after stopping the pills?..... YES NO

How many times per week do you and your partner have sexual intercourse? _____

How many times do you have intercourse around ovulation? _____

Is intercourse painful or difficult for you?..... YES NO

YES **NO**

Do you use lubricants for intercourse?.....

If yes, which one? _____

Do you douche before or after intercourse?.....

V. FAMILY HISTORY

YES **NO**

Is there a family history of infertility?.....

If yes, who (list all members and relationship to you): _____

Is there a history of hormonal disorders in your family?.....

If yes, list who (relationship to you) and what type: _____

VI. HISTORY OF FERTILITY THERAPY

YES **NO**

Have you been treated for infertility before?.....

If yes, who was your physician? _____

What cause of infertility was diagnosed? _____

What drugs have you taken for infertility? Check all that apply:

<input type="checkbox"/> clomiphene citrate (Serophene®, Clomid®)	<input type="checkbox"/> hCG (Profasi®, A.P.L.®)
<input type="checkbox"/> hMG (Pergonal®)	<input type="checkbox"/> bromocriptine (Parlodel®)
<input type="checkbox"/> estrogens	<input type="checkbox"/> danazol (Danocrine®)
<input type="checkbox"/> progesterone	<input type="checkbox"/> urofollitropin or FSH (Metrodin®)
<input type="checkbox"/> prednisone (or cortisone-like drugs)	<input type="checkbox"/> Other - Specify _____
<input type="checkbox"/> antibiotics	<input type="checkbox"/> None
<input type="checkbox"/> GnRH or LHRH (Factrel®)	

Which of the following tests have you had performed? Check all that apply and the results if known:

<input type="checkbox"/> BBT	When? _____ Results: _____
<input type="checkbox"/> Postcoital Test	When? _____ Results: _____
<input type="checkbox"/> Hormonal Assays (FSH, LH, prolactin, estrogen DHEA-S, testosterone, progesterone)	When? _____ Results: _____
<input type="checkbox"/> Endometrial Biopsy	When? _____ Results: _____
<input type="checkbox"/> Hysterosalpingogram	When? _____ Results: _____
<input type="checkbox"/> Ultrasound	When? _____ Results: _____
<input type="checkbox"/> Antibodies	When? _____ Results: _____
<input type="checkbox"/> Laparoscopy, Hysteroscopy	When? _____ Results: _____
<input type="checkbox"/> Mycoplasma/Klamydia Cultures	When? _____ Results: _____
<input type="checkbox"/> Thyroid Tests	When? _____ Results: _____
<input type="checkbox"/> Other - Specify _____	When? _____ Results: _____

Have you ever had surgery for tubal reversal?.....

If yes, specify dates: _____

Have you ever had surgery for lysis of adhesions?.....

Have you ever had cervical conization or cauterization?.....

Have you ever had any other surgery (D&C, ovarian, appendectomy, thyroid)? .0 0

If yes, please specify: _____

Have you ever undergone artificial insemination or in vitro fertilization?.....

If yes, using partner or donor sperm? _____

Is your partner seeing a doctor for evaluation of infertility?.....

If yes, specify physician name and location: _____

Does the doctor feel that your partner has an infertility problem?.....

If yes, what is the diagnosis and how is he being treated? _____

Has he ever fathered a child with another woman?.....

If yes, when? _____