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Initial Consult History

Name: _____ Date: _____
Date of Birth: _____ Age: _____
Marital Status: Single Married Divorced Separated Widow Domestic partner
Referred by: _____
Primary Care Physician: _____
Gynecologist: _____

Reason for visit: _____

Length of time attempting to conceive: _____ years, or _____ months

Partner's name: _____ □ not applicable
Partner's Date of Birth: _____ Age: _____
Children: □No □Yes, number fathered_____
Prior semen analysis: □No □Yes, date:_____findings:_____
Smoker?: □No □Yes,____ packs per day ____ years of smoking
Medication allergies:_____
Other significant medical history: _____
Primary care physician: _____
Urologist: _____

Previous Infertility Evaluation(s): □ none
Hysterosalpingogram (HSG) dye test: □ normal □ abnormal Date/Findings _____
Hysterosonogram: □normal □abnormal Date/Findings: _____
Laparoscopic or pelvic surgery: □normal □abnormal Date/Findings: _____
_____

Previous Infertility Treatment(s): Dates / Number Cycles □none
Clomid cycle(s): _____ Gonadotropin cycle(s): _____
Insemination cycle(s): _____ IVF cycle(s): _____

Previous laboratory testing: Dates / Results □ none
Bloodtype: _____ Cystic fibrosis screening: _____ Rubella titer: _____
Thyroid (TSH): _____ Prolactin: _____ Chicken Pox (VZV) titer: _____
Syphilis (VDRL): _____ HIV: _____ Hepatitis B titer: _____
Baseline (day3) FSH/Estradiol: _____
Other infertility evaluations, treatments or tests? _____
_____

Name: _____ Date:_____

Pregnancy history: □ have never been pregnant
Date: _____ Outcome: _____ Current or Previous partner? _____
Date: _____ Outcome: _____ Current or Previous partner? _____
Date: _____ Outcome: _____ Current or Previous partner? _____
Date: _____ Outcome: _____ Current or Previous partner? _____

Gynecological history:
Date of last menstrual period: _____ Age when periods began: _____
Cycle length (days between one cycle and the next): _____
Cycle duration (days of bleeding):_____
Periods are □regular □irregular _____
Intermenstrual spotting or bleeding? □No □Yes, duration: _____
Date of last pap smear: _____ □Normal □Abnormal
History of abnormal pap: □No □Yes, Date: _____
Mammogram: □Never □Normal □Abnormal Date: _____
Contraception used in the past: _____
History of pelvic infection(s): □No □Yes, type_____
History of endometriosis: □No □Yes

Medical History:
Medication allergies: □none/denies _____
_____
_____
Current medications/dosage: □ none _____
_____
_____

Height: ____ft. ____in. Weight: _____ lbs.

Past medical history: (Please check and comment on all that apply) □ none/denies
□ Anemia _____ □ High Cholesterol _____
□ Anxiety/depression _____ □ Hypertension _____
□ Arthritis _____ □ Kidney disease _____
□ Asthma _____ □ Liver disease_____
□ Bleeding/clotting disorder _____ □ Lung disease _____
□ Bleeding tendencies _____ □ Musculoskeletal disorder _____
□ Blood transfusions _____ □ Neurological disorder _____
□ Cancer _____ □ Seizure/epilepsy _____
□ Chest pain _____ □ Shortness of breath _____
□ Diabetes _____ □Stomach/GI disorder _____
□ Dizziness/fainting _____ □ Stroke _____
□ Endometriosis _____ □ Urinary tract infections _____
□ Fevers _____ □Weight gain _____
□ Headaches/migraines _____□ Weight loss_____
□ Heart attack _____ □ Other: _____
□ Hepatitis _____

Name: _____ Date:_____

Past Surgeries and/or Hospitalizations: List dates, procedure and findings. □none/denies
_____
_____
_____
_____

Social History:
Tobacco use: □No □Yes, number of packs and years of use: _____
Alcohol use: □No □Yes, glasses per day / week: _____
Drug use: □No □Yes, _____
Intravenous drug use: □No □Yes, _____
Multiple sexual partners currently: □No □Yes, _____
Do you exercise regularly? □No □Yes, how often / how much? _____

Family History:
Mother's age:_____ Medical history: _____
Father's age: _____ Medical history: _____

Please check any that apply and indicate which family member has/had the disease.
□ Birth defect/genetic disorder _____ □ Hepatitis/liver disease_____
□ Blood clots/bleeding disorder _____ □ Kidney disease _____
□ Breast disease _____ □ Seizures/neurological disorder _____
□ Cancer _____ □ Stroke _____
□ Complications with anesthesia _____ □ Tuberculosis _____
□ Diabetes _____ □ Other: _____
□ Heart disease _____

Other information: _____
_____
_____
_____