AFMC
American Fertility
Medical Center

AMERICAN FERTILITY MEDICAL CENTER

2 Hughes, Suite 175, Irvine, CA 92618

History and Physical

A. Identifying Data

Date this form when completed___________

Your Name ______________________ Partner's Name ______________________

Age _________ Birth Date _________ Height _________ Weight _________

Length of marriage (or relationship) ___________________________________

How long have you been trying unsuccessfully to get pregnant? ___________________________________

Have you previously been pregnant? ___________________________________

Have you previously tried to get pregnant? ___________________________________

Reason for your visit today?

____

B. Pregnancy History

Times pregnant__________ Term births_________ Premature births _________

Miscarriages _________ Elective abortion ________ Adopted children________

	Date	Miscarriage	Elective abortions	Ectopic	Months to conceive	Infertility treatment	Weight & Sex	C-section	Complication	Is current partner the father
1										
2										
3										
4										
5										

C. Contraceptive Use

	Type	From when to when	Reason discontinued
1			
2			
3			

D. Operations and Hospitalizations

	Date	Diagnosis	Operation	Where performed	Physician
1					
2					
3					
4					
5					
6					

E. Medications: List all prescriptions and over the counter drugs used in the past year.

	Date	Dosage and frequency	From when to when	Reason for taking
1				
2				
3				
4				
5				
6				

F. Allergies

	To what (drug or substance)	When	What type of reaction?
1			
2			
3			
4			
5			

G. Menstrual (hormonal) history

Date your last menstrual period began________________________________

Your age at your first period____

Are your periods regular? ____

How many days from onset to onset? _________________________________

How many days do your period last? _________________________________

Do you bleed between periods? _______________________________________

Do you always have premenstrual symptoms___always___rarely___never?

Vigorous exercise: Type _________________________hours/week________

If you have a hormonal disorder, please specify type and treatment:

____

Pelvic pain/cramps: ___none___during your period___before your period ___after your period

___at mid cycle ___during intercourse ___with urination ___ with bowel movements ___cause you

to miss usual activities ___cause you to miss work

Pelvic pain/cramps are ___mild ___moderate ___severe ___getting worse ___ improving ___not

changing ___ on the right side ___ on the left side ___ in the middle

What medications do you take for pain/cramps? _______________________

Do you have or have you had:

	Yes	No		Yes	No
Hot flashes	_____	_____	Increased facial or body hair	_____	_____
Breast discharges	_____	_____	Increased acne	_____	_____
Vision problems	_____	_____	Weight gain (>10 lb.)	_____	_____
Poor sense of smell	_____	_____	Weight loss (>10 lb.)	_____	_____
Chronic headache	_____	_____	Special dietary habits	_____	_____
Head injury	_____	_____	Vomiting	_____	_____
Seizures	_____	_____	Diabetes	_____	_____
Thyroid disorder	_____	_____	Autoimmune disease	_____	_____
Excessive stress	_____	_____	Psychiatric treatment	_____	_____

If you answered yes to any question, please explain

____

____

H. Physical Conditions/Infections

Do you have, or have you had:

	Yes	No		Yes	No
Pelvic infection	_____	_____	Appendicitis	_____	_____
Chlamydia	_____	_____	Colitis or enteritis	_____	_____
Anti-chlamydia antibodies	_____	_____	Endometriosis	_____	_____
Gonorrhea	_____	_____	Pelvic Adhensions	_____	_____
Syphilis	_____	_____	Uterine fibroids or myoma	_____	_____
Mycoplasma	_____	_____	Abnormal uterus (shape, etc.)	_____	_____
Urea plasma	_____	_____	Ovarian cysts	_____	_____

tuberculosis	_____	_____	Toxoplasmosis	_____	_____
			Cytomegalovirus	_____	_____

I. Combined

Do you have or have you had:

	Yes	No		Yes	No
Cervitis	_____	_____	Recurring vaginitis	_____	_____
Genital Herpes	_____	_____	Abnormal pap smears	_____	_____
Genital warts/ condyloma	_____	_____	Cryo (freezing) or surgery of the cervix	_____	_____
Trichomonas	_____	_____			

How many times a week do you have sexual intercourse? ____________________

How many times do you have intercourse around ovulation? _________________

Do you use lubricants for intercourse? ___________________________________

Do you douche before or after intercourse? _______________________________

Have you ever had unwanted sexual experiences? __________________________

Do you have any sexual problems at this time? _____________________________

J. Other medical history

Your occupation____

Years of formal education____

Cigarettes--packs smoked/day____

Alcohol--type and number of drinks/week_________________________________

Marijuana--amount____

Other drugs--type and amount____

Ever used intravenous drugs? ____

Caffeine drinks per day____

Radiation exposure____

Toxic Exposure____

Video display terminal--hours/day____

Electric blanket use____

Hot tub or sauna use____

List all serious or chronic illnesses or injuries not already described

____

____

Do you or you family members have: ___infertility hormonal disorder___other inherited disorders?

If yes, please explain

____

____

K. Partner's Medical History

Your partner's age____ Occupation____

List all serious or chronic illnesses or injuries __________________________________

Medications____

____

Cigarettes--packs smoked/day____

Alcohol--type and number of drinks/week___________________________________

Marijuana--amount____

Other drugs--type and amount____

Ever used intravenous drugs? ____

Caffeine drinks per day____

Radiation exposure____

Toxic exposure____

Video display terminal--hours/day_______________________________________

Electric blanket use____

Hot tub or sauna use____

Any problems with erection or ejaculation_________________________________

Has semen analysis ever been abnormal___________________________________

Has your partner seen a doctor for infertility evaluation? ____________________

Doctor____

Diagnosis____

Treatment____

Has your partner ever fathered a pregnancy with another woman? ____________

Any inherited diseases in your partners' family? ____________________________

Does your partner have or has he had:

	Yes	No		Yes	No
Chlamydia	_____	_____	Vasectomy	_____	_____
Anti-chlamydia antibodies	_____	_____	Vasectomy reversal	_____	_____
Gonorrhea	_____	_____	Varicocele	_____	_____
Syphilis	_____	_____	Varicocele surgery	_____	_____
Genital Herpes	_____	_____	Biopsy of testicles	_____	_____
Genital warts/ condyloma	_____	_____	Hernia surgery	_____	_____
Mycoplasm	_____	_____	Abnorminal surgery	_____	_____
Urea plasma	_____	_____	Cancer	_____	_____
Urethritis/ epididymitis	_____	_____	High blood pressure	_____	_____
Prostatitis	_____	_____	Diabetes	_____	_____
Penile discharge or pain	_____	_____	Colitis	_____	_____
Un-descended testicle	_____	_____	Seizures	_____	_____

Injury to the testicle(s)	_____	_____	Psychiatric treatment	_____	_____
Mumps with injury to the testicles	_____	_____	Excessive stress	_____	_____
Physical abnormality	_____	_____	Strenuous exercise	_____	_____
DES exposure in womb	_____	_____	Tight underwear	_____	_____

L. Previous Evaluation

Have you've had:

	Not done	Result		Approx. Date	Values (if known)
		Normal	Abnormal		
Basal body temperature (BBT)	_____	_____	_____	_____	_____
Urine LH surge	_____	_____	_____	_____	_____
Endometrial biopsy	_____	_____	_____	_____	_____
Blood tests:					
FSH	_____	_____	_____	_____	_____
LH	_____	_____	_____	_____	_____
Prolactin	_____	_____	_____	_____	_____
Throid tests (TSH, T4)	_____	_____	_____	_____	_____
DHEAS	_____	_____	_____	_____	_____
Testosterone	_____	_____	_____	_____	_____
Estradiol	_____	_____	_____	_____	_____
Progesterone	_____	_____	_____	_____	_____
Postcoital test	_____	_____	_____	_____	_____
Cervical Mucus penetration test	_____	_____	_____	_____	_____
Mycoplasma culture	_____	_____	_____	_____	_____

Chlamydia culture	_____	_____	_____	_____	_____
Anti-chlamydia antibodies	_____	_____	_____	_____	_____
Female anti-sperm antibodies	_____	_____	_____	_____	_____
Hysterosalpingogram (HSG)	_____	_____	_____	_____	_____
Ultrasound	_____	_____	_____	_____	_____
IVP (kidney x-ray)	_____	_____	_____	_____	_____
Laparoscopy	_____	_____	_____	_____	_____
Hysteroscopy	_____	_____	_____	_____	_____
Karyotype	_____	_____	_____	_____	_____
Anticardiolipin antibodies (ANA)	_____	_____	_____	_____	_____
Coagulation screen	_____	_____	_____	_____	_____
Biochemistry/ hematology panel	_____	_____	_____	_____	_____
Blood type	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____

Has your partner ever had:

Semen analysis	_____	_____	_____	_____	_____
Hamster egg penetration assay	_____	_____	_____	_____	_____
Semen anti-sperm antibodies	_____	_____	_____	_____	_____

List all causes of infertility previously diagnosed

____

____

M. Previous Treatment

	How many months?	Dose (if known)	Approx. dates taken
Antibiotics	_____	_____	_____
Clomiphene(Clomid, Serophene)	_____	_____	_____
hMG (Repronex)	_____	_____	_____
FSH (Gonal-F, Follistim)	_____	_____	_____
HCG (Profasi, Novarel)	_____	_____	_____
Progesterone	_____	_____	_____
Dexamethasone	_____	_____	_____
GnRH agonis/ Anatgonist (Ganirelix, Lupron)	_____	_____	_____
Danazol	_____	_____	_____
Intrauterine insemination	_____	_____	_____
Insemination with donor sperm	_____	_____	_____
IVF (in vitro fertilization)	_____	_____	_____
GIFT	_____	_____	_____
other	_____	_____	_____

Please use the remainder of this page to explain any additional information you feel we may need.