Fertility Patient Intake Form

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Name: _____ Date _____

Your Reproductive Endocrinologist or OB/GYN's Name:

Dr. _____

Hospital _____

You are preparing for:

Natural Cycle (unassisted) ☐
IUI/ Date (month): ☐
IVF/ Date (month) ☐
IVF Donor Egg Cycle (month) ☐
FET/Frozen Embryo Transfer (month) ☐

How many times have you had each/any of these procedures?

_____IUI _____ IVF

Physician's Fertility Diagnosis: _____

Schedule of FERTILITY drugs to be used in current or projected cycles:

Vitamin supplements, prescriptions, and over-the-counter drugs currently being used unrelated to fertility treatment:

Are you a smoker? yes ☐ no ☐

Drink alcohol? yes ☐ no ☐ how many X per week? _____

Has there been a sperm analysis? yes ☐ no ☐

Is there, or was there any indication of MALE factor infertility?
yes ☐ no ☐

Have you ever conceived naturally in the past? ☐ yes ☐_no
with this partner? yes ☐ no ☐

Live births? _____ age(s) of children if any _____ please indicate which, if any were born via IVF/IUI

Your age _____

History of:

☐ Fibroids
☐ Endometriosis
☐ PID (pelvic inflammatory disease)
☐ POF (PREmature ovarian failure)
☐ PCOS (policystic ovarian disease)
☐ oral contraceptive use
If yes, how many years? _____
How long ago did you stop? __
☐ "poor responder" to fertility drugs? If so, which ones were used and when?
_____
☐ thin uterine lining
Progesterone level in normal range? yes ☐ no ☐
HSG/test for blocked tubes?
yes ☐ no ☐
If yes to previous question, are tubes open? yes ☐ no ☐

☐ ovarian hyperstimulation
☐ ovarian cysts
☐ miscarriage, if yes, how many times? _____
At what week? _____
☐ abortion(s)
☐ tubal pregnancy
☐ fetal genetic abnormalities
☐ thyroid
☐ uterine anatomical abnormalities
☐ pelvic adhesions
☐ antiphospholipid antibodies

Have you had a midcycle vaginal ultrasound? yes☐ no ☐ results:
Post-coital vaginal ultrasound?
yes ☐ no ☐
☐ Diagnosed with hostile cervical mucous?