



Seattle Reproductive Medicine®

AN INTEGRATED AFFILIATE

MEDICAL AND REPRODUCTIVE HISTORY—INFERTILITY

Today's date: ___/___/___ Date of appointment: ___/___/___

FEMALE PATIENT:

Last name: _____ First name: _____ Middle Initial: _____

Age: _____ Date of Birth: ___/___/___ Soc. Security #: _____ - _____ - _____

Marital Status: ___ single ___ married ___ divorced ___ widowed Length of Relationship: _____ years

PARTNER:

Last name: _____ First name: _____ Middle Initial: _____

Age: _____ Date of Birth: ___/___/___ Soc. Security #: _____ - _____ - _____

Day phone: () _____ - _____ (of partner)

MAILING ADDRESS:

Street: _____ City: _____

State/Province: _____ Zip/ Postal code: _____ Country: _____

OK to leave message? Best # to reach you:

Home Phone Number: () _____ - _____ Yes No

Work Phone Number: () _____ - _____ Yes No

Cell Phone Number: () _____ - _____ Yes No

Email Address: _____

REFERRING PHYSICIAN or HEALTH CARE PROVIDER:

Last name: _____ First name: _____

Address: _____

Phone: () _____ - _____ FAX: () _____ - _____

Do you wish for SRM to send copies of your medical notes to your referring provider? ___ Yes ___ No

Why are you coming to see us? _____

REPRODUCTIVE HEALTH HISTORY—FEMALE PATIENT

MENSTRUAL HISTORY:

Age when you had your first menstrual period: _____ years old

The first day of your last menstrual period: _____ / _____ / _____

Menstrual cycle pattern (check all that apply):

- Regular periods Irregular periods No periods
 Spotting between periods Heavy periods Light periods

How many days of bleeding do you usually have? _____ days

How many days from the first day of one period to the first day of the next? _____ days

Do you need medication to bring on a period? _____ If yes, what type? _____

Do you have cramping or pelvic pain with your periods? (check one)

- Always Sometimes Recently In the past No

Degree of pain (1 to 10, with 10 being most severe): _____

Over the past few years, is the pain: getting better getting worse staying the same

If you do not have periods, at what age did you stop having them? _____ years old

PREGNANCY HISTORY: List all pregnancies, specifying under outcome whether liveborn, stillborn, ectopic, miscarriage or abortion.

Pregnancy #	Preg. Ended (mo./yr.)	Preg. Length (weeks, months)	Outcome	FATHER (check one)	
				Present partner	Previous partner

When was your last Pap smear? _____ / _____ / _____ Was it normal? Yes No

Have you ever had an abnormal Pap smear? _____ Yes _____ No If "Yes," date and treatment: _____

Did your mother take DES while pregnant with you? _____ Yes _____ No _____ Don't know

Have you ever had a mammogram? _____ Yes _____ No If yes, when was the last one? _____ / _____ / _____

REPRODUCTIVE HEALTH HISTORY—FEMALE PATIENT (continued)

CONTRACEPTIVE METHOD HISTORY:

Type	Years Used
<input type="checkbox"/> Birth Control Pill / Patch	
<input type="checkbox"/> Depo-Provera, Lunelle	
<input type="checkbox"/> Norplant	
<input type="checkbox"/> Diaphragm	
<input type="checkbox"/> IUD	
<input type="checkbox"/> Condoms	
<input type="checkbox"/> Tubal Sterilization	
<input type="checkbox"/> Vasectomy	
<input type="checkbox"/> Rhythm (natural method)	
<input type="checkbox"/> Other	

SEXUAL HISTORY:

How often do you have intercourse (number of times per week)?

Usually _____ Mid-cycle _____

Any pain with intercourse? _____

Do you use a lubricant with intercourse? _____

Have you ever had any sexually transmitted diseases? (please check all that apply)

- | | | | |
|------------------------------------|--|--------------------------------------|--------------------------------|
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Herpes | <input type="checkbox"/> Other |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Genital Warts | <input type="checkbox"/> Trichomonas | _____ |
| <input type="checkbox"/> HIV | <input type="checkbox"/> HPV | <input type="checkbox"/> Hepatitis | |

Have you ever had pelvic inflammatory disease? ____ Yes ____ No

If yes, when? _____ Were you hospitalized? _____

FERTILITY HISTORY

Please complete this section if you are being seen for fertility:

- How long have you been trying to conceive? _____
- Time since contraception last used? _____
- If you previously have been pregnant, how long has it been since the most recent pregnancy? _____
- Have you experienced any difficulty conceiving for a year or more with any man other than your current partner? ____ Yes ____ No

FERTILITY HISTORY (continued)

PREVIOUS FERTILITY EVALUATION:

Have you had any of the following tests performed?

Fertility Test:	Yes No		Date	Result normal?		If no, describe:
	Yes	No		Yes	No	
Day 3 FSH level	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	_____
Post Coital Test	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	_____
Progesterone level(s)	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hysterosalpingogram (HSG)	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sonohysterogram (SHG)	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hysteroscopy	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid blood test	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prolactin blood test	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fasting blood glucose	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endometrial biopsy	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	_____
Testosterone level	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	_____

PRIOR TREATMENTS: (check all that apply)

Treatment	# of cycles	Dates: (mo./year) to (mo./year)	Outcome (baby, miscarriage, etc.)
Intrauterine insemination:	___	from: ___/___ to: ___/___	
Clomiphene citrate with timed intercourse: maximum # tablets per day?	___	from: ___/___ to: ___/___	
Clomiphene citrate with insemination: maximum # tablets per day?	___	from: ___/___ to: ___/___	
Gonadotropins (injections) with insemination?	___	from: ___/___ to: ___/___	
Complete in vitro fertilization (IVF) cycle(s):			
1. # eggs _____ # fertilized _____ # transferred _____ # frozen _____	___	___/___	
2. # eggs _____ # fertilized _____ # transferred _____ # frozen _____	___	___/___	
3. # eggs _____ # fertilized _____ # transferred _____ # frozen _____	___	___/___	

FERTILITY HISTORY (continued)

Treatment	# of cycles	Dates: (mo./year) to (mo./year)	Outcome (baby, miscarriage, etc.)
Frozen embryo transfers:			
1. #embryos transferred _____	_____	____/____	
2. #embryos transferred _____		____/____	
3. #embryos transferred _____		____/____	
Canceled in vitro fertilization attempt(s)	_____	from: ____/____ to: ____/____	

GENERAL MEDICAL HISTORY

What is your current weight? _____ Height? _____ Usual weight? _____

Recent weight loss or gain? _____

Approximately how much did you weigh at age 18? _____ 25? _____ 30? _____ 35? _____ 40? _____

Check any of the following that have been a problem for you during the past 6 months:

- | | | |
|--|--|---|
| Eye problems <input type="checkbox"/> | Anxiety <input type="checkbox"/> | Nausea, vomiting <input type="checkbox"/> |
| Stuffy nose, hay fever <input type="checkbox"/> | Shaking, tremor <input type="checkbox"/> | Constipation, diarrhea <input type="checkbox"/> |
| Frequent nosebleeds <input type="checkbox"/> | Dizziness, fainting <input type="checkbox"/> | Hemorrhoids <input type="checkbox"/> |
| Anemia <input type="checkbox"/> | Fevers, sweats, chills <input type="checkbox"/> | Hernia <input type="checkbox"/> |
| Easy bleeding or bruising <input type="checkbox"/> | Depression <input type="checkbox"/> | Gall bladder problems <input type="checkbox"/> |
| Headaches <input type="checkbox"/> | Poor circulation <input type="checkbox"/> | Frequent urination at night <input type="checkbox"/> |
| Enlarged or painful breasts <input type="checkbox"/> | Fatigue <input type="checkbox"/> | Vaginal discharge, itching or pain <input type="checkbox"/> |
| Discharge from nipples <input type="checkbox"/> | Low energy <input type="checkbox"/> | Pelvic Pain <input type="checkbox"/> |
| Breast lumps <input type="checkbox"/> | Heart burn, indigestion <input type="checkbox"/> | Sexual problems <input type="checkbox"/> |
| Shortness of breath <input type="checkbox"/> | Gas, cramps, pains <input type="checkbox"/> | Excessive thirst <input type="checkbox"/> |
| Fast or irregular heartbeat <input type="checkbox"/> | Blood in stool or black stool <input type="checkbox"/> | Temperature intolerance <input type="checkbox"/> |
| Hot flashes <input type="checkbox"/> | Dark skin on neck, armpits <input type="checkbox"/> | Hair thinning or loss <input type="checkbox"/> |
| Excessive face or body hair <input type="checkbox"/> | Acne or pimples <input type="checkbox"/> | |

Please describe any checked boxes: _____

GENERAL MEDICAL HISTORY (Continued)

ALLERGIES:

Latex? _____ Yes _____ No If yes, specify reaction: _____

Iodine or seafood? _____ Yes _____ No If yes, specify reaction: _____

Medications? _____ Yes _____ No Which meds, specify reaction: _____

Please indicate which of the following applies to you now or in the past:

Breast disease	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	Psychiatric illness	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Endometriosis	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	Ovarian Tumor	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	Bladder/kidney disease	<input type="checkbox"/>	Cancer	<input type="checkbox"/>
Mitral valve prolapse	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	Herpes (oral)	<input type="checkbox"/>
Lung disease	<input type="checkbox"/>	Elevated prolactin	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Adrenal Hyperplasia	<input type="checkbox"/>	Rubella (German Measles)	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Birth defects	<input type="checkbox"/>
Blood transfusions	<input type="checkbox"/>	Neurologic disease	<input type="checkbox"/>	Past history of IV drug use	<input type="checkbox"/>
Bleeding disorder	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	Bulimia or anorexia	<input type="checkbox"/>

Other disorder: _____

Please explain any positive responses:

SURGICAL HISTORY:

Please list any major surgeries or hospitalizations in the table below. Include abortions, ectopic pregnancy, tubal surgery or any other surgeries:

	Mo. / Year	Procedure	Reason
1			
2			
3			
4			

GENERAL MEDICAL HISTORY (Continued)

MEDICATIONS:

Please list all medications or treatments you are currently taking: (please include any over-the counter or herbal drug.

Medication	Dosage	Frequency	Reason

FAMILY HEALTH HISTORY

Are there any known genetic diseases or conditions that run in your family? Yes No

If yes, which one(s) and whom? _____

Have any of your blood relatives (siblings, children, aunts, uncles, etc.) had birth defects, [e.g. heart, mental retardation, neural tube defect (e.g., spina bifida)], or other? Yes No

Are you adopted? Yes No

Ethnic Background: _____

Are any of your blood relatives of the following ethnic groups?

There is increased risk for:

- | | | | |
|--------------------------------|------------------------------|-----------------------------|---------------------------------|
| Caucasian | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cystic Fibrosis |
| English, Irish | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Neural Tube Defects |
| Mediterranean (Greek, Italian) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Thalassemia |
| Ashkenazi Jewish | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tay Sachs, Canavan |
| French Canadian | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tay Sachs |
| Southeast Asian | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Thalassemia |
| African descent | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sickle Cell Anemia, Thalassemia |

FAMILY HEALTH HISTORY (Continued)

Please indicate whether any of your blood relatives have had any of the following conditions:

MEDICAL PROBLEM	PARENTS		SIBLINGS		MATERNAL		PATERNAL		YOUR Children	OTHER Relatives
	Mother	Father	Sisters	Brothers	GF	GM	GF	GM		
Diabetes										
Cancer (specify)										
Heart Disease										
High Blood Pressure										
High Cholesterol										
Stroke										
Cystic Fibrosis (CF)										
Clotting or bleeding disorder										
Sickle cell anemia										
Thalassemia										
Other serious health issue										

Please explain any positive answers: _____

SOCIAL HISTORY

Current Occupation: _____

Prior Occupation(s): _____

Have you or do you use any of the following?

	Never	Not in the last 3 months	Yes	List amount, type and frequency (how often-per day / per week)
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Social drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

EMOTIONAL STATUS:

On a scale of 1 to 10, (10 being the highest) what do you estimate your average level of stress to be? _____

Were there times during the past month when you experienced little interest in doing things? ___ Yes ___ No

In the past month, have there been times when you felt down, depressed, or hopeless? ___ Yes ___ No

Do you have any theories as to why you have been unable to conceive? _____

REPRODUCTIVE HEALTH HISTORY—MALE PARTNER

List all pregnancies you have fathered, specifying under outcome whether liveborn, stillborn, ectopic, miscarriage or abortion.

Pregnancy #	Preg. Ended (mo./yr.)	Preg. Length (weeks, months)	Outcome	MOTHER (check one)	
				Present partner	Previous partner

Have you previously conceived with another woman? ___ Yes ___ No

Have you ever been unable to conceive with anyone other than your current partner? ___ Yes ___ No

Have you ever had a serious exposure to radiation or toxins (e.g. pesticides, toxic chemicals, poisons, herbicides, plastics, organic chemicals, lead, cadmium, industrial by-products, etc.)? ___ Yes ___ No

Have you ever consulted a urologist or male infertility specialist? ___ Yes ___ No

If yes: Year: _____ Reason: _____

Findings / Recommendations: _____

PREVIOUS FERTILITY EVALUATION:

Have you had any of the following tests performed?

Fertility Test:	Yes		No		Date	Result normal?		If no, describe:
	Yes	No	Yes	No		Yes	No	
Semen Analysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hamster Sperm Penetration Assay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	_____
Antibody Testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hormone Blood tests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	_____

GENERAL MEDICAL HISTORY—MALE PARTNER

What is your current weight? _____ Height? _____ Usual weight? _____

Recent weight loss or gain? _____

GENERAL MEDICAL HISTORY—MALE PARTNER (Continued)

Place a check by any of the following that have been a problem for you during the last 6 months.

Eye problems <input type="checkbox"/>	Dizziness, fainting <input type="checkbox"/>	Constipation, diarrhea <input type="checkbox"/>
Stuffy nose, sinus trouble, hayfever <input type="checkbox"/>	Fevers, sweats, chills <input type="checkbox"/>	Hemorrhoids <input type="checkbox"/>
Frequent nosebleeds <input type="checkbox"/>	Depression <input type="checkbox"/>	Hernia <input type="checkbox"/>
Anemia <input type="checkbox"/>	Poor circulation <input type="checkbox"/>	Gall bladder problems <input type="checkbox"/>
Bleeding or bruising from minor injury <input type="checkbox"/>	Fatigue <input type="checkbox"/>	Frequent urination at night <input type="checkbox"/>
Headaches <input type="checkbox"/>	Low energy <input type="checkbox"/>	Sexual problems <input type="checkbox"/>
Shortness of breath <input type="checkbox"/>	Heart burn, indigestion <input type="checkbox"/>	Excessive thirst <input type="checkbox"/>
Fast or irregular heartbeat <input type="checkbox"/>	Gas, cramps, pains <input type="checkbox"/>	Temperature intolerance <input type="checkbox"/>
Anxiety <input type="checkbox"/>	Blood in stool or black stool <input type="checkbox"/>	Acne or pimples <input type="checkbox"/>
Shaking, tremor <input type="checkbox"/>	Nausea, vomiting <input type="checkbox"/>	Pains in joints, arthritis <input type="checkbox"/>

Please describe any positive answers: _____

Please indicate which of the following applies to you now or in the past:

High blood pressure <input type="checkbox"/>	Liver disease <input type="checkbox"/>	Seizures <input type="checkbox"/>
Lung disease <input type="checkbox"/>	Bladder/kidney disease <input type="checkbox"/>	Herpes (oral or genital) <input type="checkbox"/>
Heart disease <input type="checkbox"/>	Hepatitis <input type="checkbox"/>	Psychiatric illness <input type="checkbox"/>
Heart murmur <input type="checkbox"/>	Hernia <input type="checkbox"/>	Cancer <input type="checkbox"/>
Asthma <input type="checkbox"/>	Thyroid problems <input type="checkbox"/>	Tuberculosis <input type="checkbox"/>
Blood clots <input type="checkbox"/>	Elevated prolactin <input type="checkbox"/>	Birth defects <input type="checkbox"/>
Blood transfusions <input type="checkbox"/>	Congenital Adrenal Hyperplasia <input type="checkbox"/>	Neurological disease <input type="checkbox"/>
Bleeding disorder <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Past history of IV drug use <input type="checkbox"/>
Genital or groin injuries <input type="checkbox"/>	Other <input type="checkbox"/>	

Please give detail and dates: _____

GENERAL MEDICAL HISTORY—MALE PARTNER (Continued)

Please list any major surgeries or hospitalizations in the table below. Include vasectomy, vasectomy reversal, varicocele repair, or any other surgeries:

	Mo. / Year	Procedure	Reason
1			
2			
3			
4			

Please list all medications or treatments you are currently taking: (please include any over-the-counter or herbal drugs)

Medication	Dosage	Frequency	Reason

ALLERGIES:

Latex? Yes No If yes, specify reaction: _____

Iodine or seafood? Yes No If yes, specify reaction: _____

Medications? Yes No Which meds, specify reaction: _____

FAMILY HEALTH HISTORY—MALE PARTNER

Are there any known genetic diseases or conditions that run in your family? Yes No

If yes, which one(s) and whom? _____

Have any of your blood relatives (siblings, children, aunts, uncles, etc.) had birth defects, [e.g. heart, mental retardation, neural tube defect (e.g., spina bifida)], or other? Yes No

Are you adopted? Yes No

Ethnic Background: _____

FAMILY HEALTH HISTORY—MALE PARTNER (Continued)

Are any of your blood relatives of the following ethnic groups?

Risk increased for:

- | | | | |
|--------------------------------|---------|--------|---------------------------------|
| Caucasian | ___ Yes | ___ No | Cystic Fibrosis |
| English, Irish | ___ Yes | ___ No | Neural Tube Defects |
| Mediterranean (Greek, Italian) | ___ Yes | ___ No | Thalassemia |
| Ashkenazi Jewish | ___ Yes | ___ No | Tay Sachs, Canavan |
| French Canadian | ___ Yes | ___ No | Tay Sachs |
| Southeast Asian | ___ Yes | ___ No | Thalassemia |
| African descent | ___ Yes | ___ No | Sickle Cell Anemia, Thalassemia |

Please indicate whether any of your blood relatives have had any of the following conditions:

MEDICAL PROBLEM	PARENTS		SIBLINGS		GRANDPARENTS				YOUR Children	OTHER Relatives
	Mother	Father	Sisters	Brothers	MATERNAL		PATERNAL			
					GF	GM	GF	GM		
Diabetes										
Cancer (specify)										
Heart Disease										
High Blood Pressure										
High Cholesterol										
Stroke										
Cystic Fibrosis (CF)										
Clotting or bleeding disorder										
Sickle Cell Anemia										
Thalassemia										

Please explain any positive answers:

SOCIAL HISTORY—MALE PARTNER

Current Occupation: _____

Prior Occupation(s): _____

SOCIAL HISTORY—MALE PARTNER (Continued)

Have you or do you use any of the following?

	Never	Not in the last 3 months	Yes	List amount, type and frequency (how often-per day / per week)
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Social drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

EMOTIONAL STATUS:

On a scale of 1 to 10, (10 being the highest) what do you estimate your average level of stress to be? _____

Were there times during the past month when you experienced little interest in doing things? ___ Yes ___ No

In the past month, have there been times when you felt down, depressed, or hopeless? ___ Yes ___ No

Do you have any theories as to why you and your partner have been unable to conceive? ___ Yes ___ No

Please comment: _____



Seattle Reproductive Medicine®

A N I N T E G R A M E D® A F F I L I A T E

1505 Westlake Avenue North, Suite 400 ♦ Seattle, WA 98109

Phone (877) 777-6002 ♦ Fax (877) 888-6053

Regional Access Network ART Screening Summary (Standard Infectious Disease Testing)

Patient Name: _____ Birth date: _____ Age: _____

Partner's Name: _____ Birth date: _____ Age: _____

Past Medical and Gynecologic History:

G ___ P ___ Ect ___ SAB ___ TAB ___ Living ___ # Years Infertile ___

Primary Infertility Diagnosis(s): _____

Previous Treatment: None CC# ___ IUI# ___ TDI# ___ COH# ___ IVF# ___

Menses: Regular every ___ days

Oligomenorrhea Amenorrhea Menopausal

Allergies: _____ Meds: _____

Other Medical Problems/Concerns: _____

PRE-ART Evaluation (within the past 1 year)

Physical Exam: Date: _____ Ht: _____ Wt: _____ BP: _____

Normal Abnormal Findings: _____

* Please attach HX/PE

Uterine Evaluation:

HSG: Date: _____ Normal Abnormal (see attached report)

SHG: Date: _____ Normal Abnormal (see attached report)

Hysteroscopy: Date: _____ Normal Abnormal (see attached report)

Surgical Procedure (e.g., polypectomy, salpingectomy, myomectomy) see attached report

Ovarian Reserve Testing (with 6 months if ≥ 38 or prior abnormal):

Day 3 FSH/E2: Date: _____ FSH _____ mIU/ml E2 _____ pg/ml

Date: _____ FSH _____ mIU/ml E2 _____ pg/ml

Antral Follicle Count: Date: _____ Total No. Antral Follicles 2-10mm: _____

Please do not send until completed. Screen will not be reviewed until all information is present.

Patient Name: _____

Preconception Screening Tests (within 1 year):

	Date (mm/dd/yy)	Result		Notes
RPR		<input type="checkbox"/> Pos <input type="checkbox"/> Neg		
Hepatitis B Surface Antigen		<input type="checkbox"/> Pos <input type="checkbox"/> Neg		
Hepatitis C Antibody		<input type="checkbox"/> Pos <input type="checkbox"/> Neg		
HIV 1		<input type="checkbox"/> Pos <input type="checkbox"/> Neg		

Blood Type/Rh				Any year
TSH				Within 1 year
Rubella		<input type="checkbox"/> Pos <input type="checkbox"/> Neg		Within 3 years
Hematocrit				Within 1 year
Varicella		<input type="checkbox"/> Pos <input type="checkbox"/> +Hx		Clinical hx or positive titer within past 3 yrs
Pap smear		<input type="checkbox"/> Pos <input type="checkbox"/> Neg		Within 1 year or if risk factors
Mammogram		<input type="checkbox"/> Pos <input type="checkbox"/> Neg		(if over 40 or risk factors)

Attach other pertinent test result (i.e., karyotype, thyroid testing, HgbA1C, etc)
 Comments _____

Male Partner Info:

Semen Analysis (most recent within 1 year or 6 months for patients with concentration <10 mil/ml):

Date: _____ Conc _____ x10⁶/ml Motility _____ % Morph _____ % (strict/WHO) see attached report**Preconception Screening Tests (within 1 year):**

	Date	Result		Notes
RPR		<input type="checkbox"/> Pos <input type="checkbox"/> Neg		
Hepatitis B Surface Antigen		<input type="checkbox"/> Pos <input type="checkbox"/> Neg		
Hepatitis C Antibody		<input type="checkbox"/> Pos <input type="checkbox"/> Neg		
HIV 1		<input type="checkbox"/> Pos <input type="checkbox"/> Neg		

Patient Name: _____

Medications will be ordered for your patient thru IVP Care unless you specify otherwise.

Order meds: SRM (IVP Care) Regional Office

Referring Provider: _____

Optional Screening for Patients Considering Future Embryo Donation (please check one):

- Collect additional laboratory requirements at SRM
- Do not collect additional laboratory requirements at SRM

Protocol: <input type="checkbox"/> Luteal Lupron <input type="checkbox"/> Microdose Lupron <input type="checkbox"/> Antagonist
Dose: FSH _____ IU/daily hMG _____ IU/daily
Sperm: <input type="checkbox"/> Partner Fresh <input type="checkbox"/> Partner Frozen <input type="checkbox"/> ICSI <input type="checkbox"/> Urology back-up <input type="checkbox"/> Urology Collection <input type="checkbox"/> Urology Back-up <input type="checkbox"/> Donor Back-up <input type="checkbox"/> Donor Sperm
Other requirements/recommendations: _____ _____ _____ _____ _____ _____
Reviewing MD _____ Date _____
<input type="checkbox"/> Criniti <input type="checkbox"/> Davis <input type="checkbox"/> Dudley <input type="checkbox"/> Klein <input type="checkbox"/> Lin <input type="checkbox"/> Soules <input type="checkbox"/> Thyer