



# AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE

## Infertility History Form



### A BELLA BABY OBGYN

#### IMPORTANT:

**Please complete this form and  
bring it with you to your scheduled visit.**

This form was developed by the American Society for Reproductive Medicine to assist physicians and patients in obtaining a complete infertility history. It consists of three parts:

- Part I: Contact information
- Part II: Your medical history
- Part III: Your male partner's medical history (if applicable)

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 Woodridge, IL 60517  
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 630-810-1077 (fax)  
 www.abellababyobgyn@outlook.com

#### PART I: CONTACT INFORMATION

First Name \_\_\_\_\_ Middle Initial \_\_\_\_ Last Name \_\_\_\_\_ Age

Date of Birth (MM/DD/YY) \_\_\_\_/\_\_\_\_/\_\_\_\_ Occupation \_\_\_\_\_

Home Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip/Postal Code \_\_\_\_\_ Country \_\_\_\_\_

Indicate which number to call or leave messages.

Home Telephone ( ) \_\_\_\_\_  Work Telephone ( ) \_\_\_\_\_  Cell Phone ( ) \_\_\_\_\_

Do you have a male partner?  Yes  No

Male Partner's First Name \_\_\_\_\_ Middle Initial \_\_\_\_ Last Name \_\_\_\_\_ Age

Not Applicable

Date of Birth (MM/DD/YY) \_\_\_\_/\_\_\_\_/\_\_\_\_ Occupation \_\_\_\_\_

Home Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip/Postal Code \_\_\_\_\_ Country \_\_\_\_\_

Indicate which number to call or leave messages.

Home Telephone ( ) \_\_\_\_\_  Work Telephone ( ) \_\_\_\_\_  Cell Phone ( ) \_\_\_\_\_

#### By whom were you referred?

Physician

Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Address \_\_\_\_\_

Former Patient/Friend \_\_\_\_\_

Web Site \_\_\_\_\_

Insurance (Name of Insurance) \_\_\_\_\_

#### Who is your Ob/Gyn?

Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Address \_\_\_\_\_

#### Who is your Primary Care Physician?

Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Address \_\_\_\_\_

Physician Notes (for office use only)

**PART II: FEMALE MEDICAL HISTORY AND INFORMATION**

**Reason for Visit:**  Other \_\_\_\_\_

**How many months** have you been trying to conceive (unprotected intercourse or inseminations)? \_\_\_\_\_

**Pregnancy Summary**

- Total Number of ALL Pregnancies: \_\_\_\_\_
- Number of Full Term Deliveries: \_\_\_\_\_ Of these, how many were live births? \_\_\_\_ How many were stillborn? \_\_\_\_
- Number of Premature (less than 37 weeks) Deliveries: \_\_\_\_\_ Of these, how many were live births? \_\_\_\_ How many were stillborn? \_\_\_\_
- Number of Miscarriages (less than 20 weeks): \_\_\_\_\_
- Number of Ectopic/Tubal Pregnancies: \_\_\_\_\_
- Number of Elective Terminations (Abortions): \_\_\_\_\_
- Any Pregnancies with Birth Defects?  No  Yes - explain \_\_\_\_\_

Date Pregnancy Ended or Delivered	Months to Conception	Treatments to Conceive	Delivery Type/D&C/Complications	Current Partner?
1. _____	_____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
2. _____	_____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
3. _____	_____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
4. _____	_____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
5. _____	_____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
6. _____	_____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N

**Menstrual History**

- Menstrual cycle pattern (check all that apply):  Regular periods  Irregular periods  Spotting before periods  No periods  
 Heavy periods  Light periods  Bleeding between periods
- Number of days between the start of one period to the start of the next period: \_\_\_\_\_ days
- How many days of bleeding do you have? \_\_\_\_\_ days
- Dates of the 1st day of your last 2 menstrual periods: \_\_\_\_/\_\_\_\_/\_\_\_\_; \_\_\_\_/\_\_\_\_/\_\_\_\_
- Age when you had your first period: \_\_\_\_\_ years old
- Age when you first noticed: Breast development: \_\_\_\_ years old Pubic hair: \_\_\_\_ years old Underarm hair: \_\_\_\_ years old
- How many periods do you have per year? \_\_\_\_\_
- Do you need medication to bring on a period?  Yes - what type? \_\_\_\_\_  No
- If you do not have periods, at what age did you stop having them? \_\_\_\_\_ years old
- Do you have severe cramping or pelvic pain with your periods?  Yes: Always\_\_ Sometimes\_\_ Recently\_\_ In the past\_\_  No

**Contraceptive History**

- None  Condoms - dates of use \_\_\_\_\_  Diaphragm - dates of use \_\_\_\_\_  IUD - dates of use \_\_\_\_\_
- Birth control pills - dates of use \_\_\_\_\_ - complications? \_\_\_\_\_  Never used birth control pills
- Injectable contraception (Depo-Provera®, Lunelle™, etc.) - dates of use \_\_\_\_\_ - complications? \_\_\_\_\_
- Skin patch - dates of use \_\_\_\_\_ - complications? \_\_\_\_\_  Foam or Jelly
- Tubal sterilization procedure (tubes tied) - date (month/year) \_\_\_\_/\_\_\_\_  Tubes untied - date (month/year) \_\_\_\_/\_\_\_\_

Did your mother take DES when she was pregnant with you?  Yes  No  Don't know

**Sexual History**

- How many times do you have intercourse per week? \_\_\_\_\_ times per week  None  Not applicable
- Have you used over-the-counter ovulation kits to time intercourse?  Yes  No
- Do you have pain with intercourse?  Yes  No
- Do you use lubricants (K-Y Jelly®, etc.) during intercourse?  Yes - what types? \_\_\_\_\_  No

Any prior exposure to sexually transmitted diseases or pelvic infections?

- Yes (check all that apply)  No
- Chlamydia - date \_\_\_\_\_  Gonorrhea - date \_\_\_\_\_  Herpes - date \_\_\_\_\_ Genital warts/HPV - date \_\_\_\_\_
- Syphilis - date \_\_\_\_\_  HIV/AIDS - date \_\_\_\_\_  Hepatitis - date \_\_\_\_\_

**Physician Notes (for office use only)** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Pap Smear History**

- When was your last pap smear (month and year)? \_\_\_\_/\_\_\_\_/\_\_\_\_  Normal  Abnormal
- When was your last abnormal pap smear? \_\_\_\_  Not applicable

Have you undergone any procedures as a result of an abnormal pap smear?

- Yes (check all that apply)  No
- Colposcopy  Cryosurgery (Freezing)  Laser treatment  Conization  LEEP procedure

**Breast Screening History**

- Have you ever had a mammogram?  No  Yes - date \_\_\_\_ Result:  normal  abnormal - explain \_\_\_\_\_
- Do you perform self breast exams?  Yes  No

**Medical History**

- Are you allergic to any medications?  No  Yes (Please list and describe reactions) \_\_\_\_\_
- Are you allergic to any foods (peanuts, eggs, etc.)?  No  Yes (Please list and describe reactions) \_\_\_\_\_
- List any medications you are currently taking, including over the counter medicines. \_\_\_\_\_
- Do you take any herbal medicines/vitamins or health food store supplements?  No  Yes (Please list) \_\_\_\_\_
- Do you have any medical problem(s)?  No  Yes (Please list type, dates, and treatments.)
  - (1) \_\_\_\_\_
  - (2) \_\_\_\_\_
  - (3) \_\_\_\_\_
  - (4) \_\_\_\_\_
  - (5) \_\_\_\_\_
- Did you have either of these childhood illnesses?  Chickenpox (Varicella)  German Measles (Rubella)  Don't know  
Other childhood diseases: \_\_\_\_\_

**Vaccinations**

- Chickenpox (Varicella):  No  Yes (dates \_\_\_\_\_)  Don't know
- MMR - Measles, Mumps, and Rubella (German Measles):  No  Yes (dates \_\_\_\_\_)  Don't know
- BCG (Tuberculosis):  No  Yes (dates \_\_\_\_\_)  Don't know
- Hepatitis B:  No  Yes (dates \_\_\_\_\_)  Don't know
- Polio:  No  Yes (dates \_\_\_\_\_)  Don't know
- Hepatitis A:  No  Yes (dates \_\_\_\_\_)  Don't know
- Tetanus:  No  Yes (dates \_\_\_\_\_)  Don't know
- Influenza:  No  Yes (dates \_\_\_\_\_)  Don't know

**Social History**

- How many caffeinated beverages (coffee, tea, soda) do you drink per day? \_\_\_\_  None
- Do you smoke cigarettes?  No  Yes How many/day? \_\_\_\_ How many years? \_\_\_\_  Quit - when? \_\_\_\_\_
- Do you drink alcohol?  No  Yes
  - Beer - # per week \_\_\_\_  Wine- # per week \_\_\_\_  Liquor - # per week \_\_\_\_
- Do you use any marijuana, cocaine, or any other similar drug?  No  Yes (describe \_\_\_\_\_)
- Do you exercise?  No  Yes (describe \_\_\_\_\_)
- Are you aware of any radiation exposures other than X-rays?  No  Yes (describe \_\_\_\_\_)

**Physician Notes (for office use only)** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Surgical History**

• Have you had any surgeries?  No  Yes (List all surgeries in chronologic order.)

Year	Reason and Type of Surgery
_____	(1) _____
_____	(2) _____
_____	(3) _____
_____	(4) _____
_____	(5) _____
_____	(6) _____
_____	(7) _____

• Did you have any anesthesia problems?  No  Yes (describe \_\_\_\_\_)

**Physical Symptoms**

**General:**

- Recent weight gain or loss
- Anorexia/Bulimia
- Lack of energy
- Fever/Chills
- Other \_\_\_\_\_
- None

**Head, Eyes, Ears, Nose and Throat:**

- Dizziness  Loss of sense of smell
- Headaches  Chronic nasal congestion
- Blurred vision  Ringing ears
- Hearing loss/deafness
- Other \_\_\_\_\_
- None

**Respiratory:**

- Shortness of breath
- Asthma  Bronchitis
- Pneumonia  Tuberculosis
- Bloody cough
- Other \_\_\_\_\_
- None

**Endocrine/Hormonal:**

- Diabetes  Hair loss
- Thyroid gland problems
- Rapid weight gain or loss
- Excessive hunger/thirst
- Temperature intolerance—hot flashes or feeling cold
- Other \_\_\_\_\_
- None

**Breasts:**

- Discharge (clear?\_\_\_ bloody?\_\_\_ milky?\_\_\_)
- Lumps  Pain  Cancer
- Abnormal mammogram
- Reduction
- Augmentation/Breast implants (saline?\_\_\_ silicone?\_\_\_)
- Other \_\_\_\_\_
- None

**Neurological Problems:**

- Weakness/Loss of balance
- Seizures/Epilepsy
- Headaches
- Migraine headaches
- Numbness
- Memory loss
- Other \_\_\_\_\_
- None

**Gastrointestinal:**

- Nausea/Vomiting  Ulcers
- Hepatitis  Diarrhea
- Blood in your stools  Constipation
- Irritable Bowel Syndrome
- Change in bowel habits
- Colitis (ulcerative or Crohn's)
- Other \_\_\_\_\_
- None

**Genito-Urinary:**

- Bladder infections
- Kidney infections
- Vaginal infections
- Frequent urination  Leaking urine
- Herpes
- Blood in the urine
- Other \_\_\_\_\_
- None

**Skin/Extremities:**

- Unexplained rash/inflammation
- Acne
- Skin cancer
- Burn injury
- Moles changing in appearance
- Excess hair growth
- Other \_\_\_\_\_
- None

**Musculoskeletal:**

- Unusual muscle weakness
- Decreased energy/stamina
- Rheumatoid arthritis
- Lupus Erythematosus
- Myasthenia gravis
- Other \_\_\_\_\_
- None

**Hematologic:**

- Blood clotting disorder/Blood clot
- Sickle cell Anemia  Thrombophlebitis
- Easy bruising
- Swollen glands/lymph nodes
- Blood transfusions (dates/reasons\_\_\_\_\_)
- Other \_\_\_\_\_
- None

**Cardiovascular:**

- Palpitations/Skipped beats
- Chest pain  Heart attack
- Stroke  Murmurs
- High blood pressure
- Rheumatic fever
- Mitral valve prolapse (Need antibiotics before dental procedures? Yes\_\_\_ No\_\_\_)
- Other \_\_\_\_\_
- None

**Mental Health Problems:**

- Depression  Anxiety disorder
- Schizophrenia
- Other \_\_\_\_\_
- None

<p><b>Physician Notes (for office use only)</b> _____</p> <p>_____</p> <p>_____</p>
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**Family History**

	<u>Living</u>		<u>Cause of Death/Age at Death</u>
• Mother	<input type="checkbox"/> Yes - age ___	<input type="checkbox"/> No	_____
• Father	<input type="checkbox"/> Yes - age ___	<input type="checkbox"/> No	_____
• Brother(s)	<input type="checkbox"/> Yes - age ___	<input type="checkbox"/> No	_____
	<input type="checkbox"/> Yes - age ___	<input type="checkbox"/> No	_____
• Sister(s)	<input type="checkbox"/> Yes - age ___	<input type="checkbox"/> No	_____
	<input type="checkbox"/> Yes - age ___	<input type="checkbox"/> No	_____
• Maternal Grandmother	<input type="checkbox"/> Yes - age ___	<input type="checkbox"/> No	_____
• Maternal Grandfather	<input type="checkbox"/> Yes - age ___	<input type="checkbox"/> No	_____
• Paternal Grandmother	<input type="checkbox"/> Yes - age ___	<input type="checkbox"/> No	_____
• Paternal Grandfather	<input type="checkbox"/> Yes - age ___	<input type="checkbox"/> No	_____

<b>What is your Ancestry?</b>
<input type="checkbox"/> African-American
<input type="checkbox"/> American Indian/Native American
<input type="checkbox"/> Ashkenazi Jewish
<input type="checkbox"/> Asian-American
<input type="checkbox"/> Cajun/French Canadian
<input type="checkbox"/> Caucasian
<input type="checkbox"/> Eastern European
<input type="checkbox"/> Hispanic/Caribbean
<input type="checkbox"/> Northern European
<input type="checkbox"/> Southern European
<input type="checkbox"/> Other (specify _____)

**Disorders in Your Family**

	<u>Relationship to You</u>		
• Breast cancer	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
• Ovarian cancer	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
• Colon cancer	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
• Other cancer _____	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
• Diabetes	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
• Thyroid problems	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
• Heart disease	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
• Blood clots	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
• Obesity	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
• Psychiatric problems	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
• Tuberculosis	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
• Endometriosis	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
• Infertility	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
• Menopause before age 40	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
• Birth defects	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
• Cystic Fibrosis	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
• Tay-Sachs disease	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
• Canavan disease	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
• Bloom syndrome	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
• Gaucher disease	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
• Niemann-Pick disease	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
• Fanconi Anemia	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
• Familial Dysautonia	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
• Muscular Dystrophy	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
• Neurologic (brain/spine)	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
• Neural Tube Defects	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
• Bone/Skeletal Defects	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
• Dwarfism	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
• Developmental delay	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
• Learning problems	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
• Polycystic kidney disease	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
• Heart defect from birth	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
• Down syndrome	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
• Other chromosome defects	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
• Marfan syndrome	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
• Hemophilia	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
• Sickle Cell Anemia	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
• Thalassemia	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
• Galactosemia	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
• Deafness/Blindness	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
• Color Blindness	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
• Hemochromatosis	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No <input type="checkbox"/> Don't Know
<input type="checkbox"/> None of the above	<input type="checkbox"/> Other (Specify _____)	_____	

**PRIOR INFERTILITY TESTING AND TREATMENT**

• Have you had prior infertility testing or treatment elsewhere?  Yes  No

**Prior Tests** (check all that apply):  Basal body temperature chart (date\_\_\_\_/results\_\_\_\_)  
 Thyroid test (date\_\_\_\_/results\_\_\_\_)  Ovulation test kit (date\_\_\_\_/results\_\_\_\_)  
 Day 3 blood test for FSH level (date\_\_\_\_results\_\_\_\_)  Hysterosalpingogram (HSG) (date\_\_\_\_results\_\_\_\_)  
 Laparoscopy surgery (date\_\_\_\_results\_\_\_\_)  Hysteroscopy surgery (date\_\_\_\_results\_\_\_\_)  
 Progesterone blood test (date\_\_\_\_results\_\_\_\_)  Prolactin blood test (date\_\_\_\_results\_\_\_\_)

**Prior Treatment** (check all that apply):

	# of cycles	Dates (mo/year) (mo/year)	Pregnant
<input type="checkbox"/> <u>Intrauterine insemination:</u>	_____	From_____/_____ to_____/_____	Yes___ No___
<input type="checkbox"/> <u>Clomiphene citrate with timed intercourse:</u> maximum # tablets per day?_____	_____	From_____/_____ to_____/_____	Yes___ No___
<input type="checkbox"/> <u>Clomiphene citrate with insemination:</u> maximum # tablets per day?_____	_____	From_____/_____ to_____/_____	Yes___ No___
<input type="checkbox"/> <u>Daily fertility drug injections with insemination:</u> maximum # vials per day?_____	_____	From_____/_____ to_____/_____	Yes___ No___
<input type="checkbox"/> <u>Completed in vitro fertilization cycle(s):</u> 1. # eggs___ #embryos transferred___ #frozen___ 2. # eggs___ #embryos transferred___ #frozen___ 3. # eggs___ #embryos transferred___ #frozen___ 4. # eggs___ #embryos transferred___ #frozen___	_____	_____/_____ _____/_____ _____/_____ _____/_____	Yes___ No___ Yes___ No___ Yes___ No___ Yes___ No___
<input type="checkbox"/> <u>Frozen embryo transfers:</u> 1. # embryos transferred___ 2. # embryos transferred___ 3. # embryos transferred___ 4. # embryos transferred___	_____	_____/_____ _____/_____ _____/_____ _____/_____	Yes___ No___ Yes___ No___ Yes___ No___ Yes___ No___
Canceled in vitro fertilization attempt(s)	_____		

• Additional Information/Complications \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**EMOTIONAL STATUS**

• On a scale of 1-10 (10 being the worst ), estimate the level of stress you feel due to infertility and other pressures. \_\_\_\_\_  
 • Do you see a counselor?  Yes  No  
 • Describe any emotional, marital, or sexual problems caused by your infertility. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

PATIENT'S SIGNATURE _____	DATE _____
<b>I confirm that I have reviewed the information above.</b>	
PHYSICIAN'S SIGNATURE _____	DATE _____

## Submitting Your Questionnaire to A Bella Baby OBGYN

Once you have completed the form fields above there are two ways to send your completed information:

- 1) **Email.** Save this PDF to your computer with a unique name. i.e. "Jane Doe's Questionnaire.pdf". Then email this completed form as an email attachment to [abellababyobgyn@outlook.com](mailto:abellababyobgyn@outlook.com)
- 2) Fax: 630-810-1077