

Fertility Intake Form

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Name: _____ Date _____

Age: _____ General health: _____

Your Reproductive Endocrinologist or OB/GYN's Name:

Dr. _____

Hospital/Center _____

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 _____ FET

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 with this partner? yes no

Live births? _____ Age(s) of children if any _____

Please indicate which, if any were born via IVF/IUI _____

History of:

___ Fibroids

___ Endometriosis

___ Ovarian cysts

___ Abortion(s) (*how many?*) _____

___ Tubal pregnancy

___ Pelvic adhesions

___ PID (pelvic inflammatory disease)

___ POF (premature ovarian failure)

___ PCOS (polycystic ovarian disease)

___ Thin uterine lining

___ Ovarian hyperstimulation

___ "Hostile" cervical mucous diagnosis?

___ Uterine anatomical abnormalities

___ Fetal genetic abnormalities

___ Antiphospholipid antibodies

___ Thyroid condition

___ 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? _____

___ Miscarriage(s); if yes, how many times? _____

At what week? _____

Progesterone level in normal range? yes no

HSG/test for blocked tubes? yes no If yes, are tubes open? yes no

Have you had a midcycle vaginal ultrasound? yes no Results: _____

Post-coital vaginal ultrasound? yes no Results: _____