Prepare your first visit to Sakthi Fertility

Infertility History Form

CONTACT INFORMATION

FEMALE:

First Name_____Middle Initial_____Last Name_____

Date of birth (MM/DD/YY)_____/_____/_____ Occupation _____

Health card number_____Version_____ Your age ☐

Home street address _____

City_____State/Province_____Zip/Postal code _____

Indicate which number is best to call or leave messages:

□ home ( )_____ □ cell ( ) _____

□ work ( )_____ □ email _____

Are you married or have a partner? □ Yes (please complete partner section below) □ No
□ Divorced □ Other _____

SPOUSE/PARTNER:

First Name_____Middle Initial_____Last Name_____

Date of birth (MM/DD/YY)_____/_____/_____ Occupation _____

Health card number_____Version_____Your age ☐

Home street address _____

City_____State/Province_____Zip/Postal code _____

Indicate which number is best to call or leave messages:

□ home ( )_____ □ cell ( ) _____

□ work ( )_____ □ email _____

GENERAL INFORMATION:

Referring Doctor Name:_____Phone number: _____

Reason for referral: _____

Do you have a drug plan that covers fertility medications: □ YES □ NO □ NOT SURE

GENERAL HISTORY:

How long have you been having regular unprotected intercourse? _____

How long have you been trying to actively get pregnant? _____

How long have you been trying to get pregnant with a Doctor's help? _____

Was the Doctor a: □ General Gynecologist □ Reproductive Endocrinology & Infertility Specialist

Approximately how many times a week do you have intercourse on average? _____

Do either you or your partner smoke?_____How much (cig/day)? _____

Do either you or your partner drink alcohol?_____How much? _____

FEMALE HISTORY:

Height_____Weight_____Blood group _____

Skin color_____Ethnic background _____

Do you have allergies?_____If so, please list below and include allergies to medications if applicable:

_____

Menstrual periods occur every_____days. Are they regular? □ YES □ NO Duration of bleeding_____(days)

Amount of bleeding_____Are your periods painful? □ YES □ NO Age when started ____

Do you have endometriosis? □ YES □ NO Do you have any medical problems? □ YES □ NO If yes, explain:

_____

Do you take prescribed medications? □ YES □ NO If so please list names and dose below:

_____

Have you ever been diagnosed with pelvic inflammatory disease (PID)? □ YES □ NO

Have you had pelvic or abdominal surgeries and if so what were the findings? □ YES □ NO

_____

Number of pregnancies with current partner:_____with previous partner (if applicable): _____

Number of miscarriages:_____abortions:_____tubal pregnancies:_____which tube? _____

Number of live births:_____Vaginal birth:_____Cesarean sections: _____

TREATMENT HISTORY

Have you had any of the following?

TEST/PROCEDURE	**YES or NO**	**RESULT**
Hysterosalpingogram OR sonohysteroscopy		
Laparoscopy		
Hysteroscopy		

Previos ART treatment	**YES or NO**	**How many cycles?**	**Any success?**
Clomiphene stimulation with intercourse			
Clomiphene stimulation with insemination			
Injectable FSHstimulation (Puregon/GonalF etc.) with intercourse			
Injectable FSHstimulation (Puregon/GonalF etc.) with insemination			
Insemination without any stimulation			
In vitro fertilization (IVF)			
In vitro fertilization with ICSI (IVF+ICSI)			

OTHER

What other information should we know about your case? _____

Any pertinent test results, procedures or problems identified? _____

Is there a family history of infertility? □ YES □ NO _____

Give details of IVF results, if applicable:

Stimulation protocol:_____ Number of follicles: _____

Number of eggs retrieved:_____ Number of embryos transferred: _____

Number of embryos frozen: _____ Outcome: _____

MALE HISTORY (if applicable):

Height_____ Weight_____ Blood group _____

Skin color_____ Ethnic background _____

Do you have allergies?_____ If so, please list below and include allergies to medications if applicable:

_____

Have you been previously married? □ YES □ NO Number of pregnancies with previous partner: _____

Do you have problems with erection or ejaculation? □ YES □ NO _____

Do you take prescribed medications? □ YES □ NO If so, please list names and dose below:

_____

Do you have any medical problems? □ YES □ NO If so, please explain:

_____

Have you had hormonal blood testing done? □ YES □ NO

Have you had previous surgeries? □ YES □ NO If so, please list:

_____

Is there a family history of infertility? □ YES □ NO _____

Have you had a semen analysis done: □ YES □ NO Date of test: _____

Result of test:_____ Where was test done: _____

Have you ever been diagnosed with azoospermia (no sperms)? □ YES □ NO

Have you ever had a testicular biopsy? □ YES □ NO When was it done: _____

Where was it done:_____ Result: _____

QUESTIONS:

Are there any specific questions you would like to address with the Doctor?