UNC Fertility

New Infertility Patient Profile

Last Name ___ First Name ____ DOB _____

Occupation ____

Medical History

Height ____ Weight ____

How long have you been trying to conceive (in months)____

In your opinion, why are you having difficulty conceiving?

What are you hoping to learn about at your visit?

Have you had any prior fertility testing or treatments? ◯ Yes ◯ No

If yes, please mark all that apply:

- ☐ AMH (results:____)
- ☐ HSG (X-Ray Test)
- ☐ Clomid (# of cycles) ____
- ☐ Letrozole/Femara (# of cycles ____)
- ☐ Injectables/Shots (such as Follistem, Gonal F, Bravelle) # of cycles ____
- ☐ Intrauterine Insemination (IUI)
- ☐ In-Vitro Fertilization (IVF)
- ☐ Other: ____

Are your menstrual cycles regular? ◯ Yes ◯ No

How many days are there from Day 1 of your period to the Day 1 of your next period?____

When was the first day of your most recent period? (Day-Month) ____

Do you have pain with your menstrual cycles? ◯ Yes ◯ No

If yes, how severe? --

Do you take medication for menstrual pain? ◯ Yes ◯ No

If yes, what medication do you take and how much? ____

Have you used ovulation predictor kits? ◯ Yes ◯ No

Have you ever been diagnosed with any of the following? Check ALL that apply.

- ☐ Depression
- ☐ Anxiety
- ☐ Heart Problems
- ☐ Lung problems
- ☐ High blood pressure
- ☐ Kidney problems
- ☐ Diabetes
- ☐ Asthma
- ☐ Sleep apnea (or do you snore loudly)
- ☐ Thyroid Problems
- ☐ Other: _____

Do you use any of the following?

- ☐ Tobacco
- ☐ Alcohol
- ☐ Recreational Drugs

Have you ever had chicken pox? ◯ Yes ◯ No

What is your blood type?

Please list any surgical procedures you have had

1.	Date	5.	Date
2.	Date	6.	Date
3.	Date	7.	Date
4.	Date	8.	Date

History of Gynecologic problems

	Yes	No
STD's	☐	☐
Abnormal pap smears	☐	☐
Uterine fibroids	☐	☐

When was your last pap smear? ___

Please list any allergies:

Current Medications with doses. (please include non-prescription medications and dietary herbal supplements in your list)

Have you ever been pregnant? ◯ Yes ◯ No

If yes,

Number of spontaneous miscarriages __

Number of abortions __

Ectopic pregnancies __

Preterm Births less than 37 weeks ___

Term births greater than 37 weeks __

Marital Status: --

Ancestry for you and your partner (if applicable) **Check all that apply.**

	You	Your Partner
African American	☐	☐
Ashkenazi Jewish	☐	☐
Cajun	☐	☐
East/Southeast Asian	☐	☐
Caucasian (German, Scandinavian, French, Polish etc.)	☐	☐
French Canadian	☐	☐
Mediterranean (Greece, Portugal, Cyprus or Southern Spain etc.)	☐	☐
Other (please specify) : ____	☐	☐

In you or your partner's family, is there history of:		
Down's Syndrome	☐	☐
Mental retardation	☐	☐
Open neural tube defects (e.g. spna bifida)	☐	☐
Birth defects	☐	☐
Tay sachs, cystic fibrosis, sickle cell anemia	☐	☐
Other genetic, congenital or inborn disorders	☐	☐

We recommend avoiding travel to Zika-risk locations. Please let us know of any travel that you (or your partner) have taken within the last 6 months.

___

Partner Profile (if applicable)

Last Name _____ First Name ____ DOB _____

Occupation ____

Does your partner have any children or ever achieved a pregnancy? ◯ Yes ◯ No

Has your partner ever been diagnosed with any of the following? Check ALL that apply.

- ☐ Depression
- ☐ Anxiety
- ☐ Heart Problems
- ☐ Lung problems
- ☐ High blood pressure
- ☐ Kidney problems
- ☐ Diabetes
- ☐ Asthma
- ☐ Sleep apnea (or do you snore loudly)
- ☐ Thyroid Problems
- ☐ Other: _____
- ☐ Urinary or Prostate problems *(male partners)*

Please list any surgical procedures your partner has had:

1. _____ Date __
2. _____ Date __
3. _____ Date __
4. _____ Date __
5. _____ Date __

Current Medications with doses: (please include non-prescription medications and dietary herbal supplements in your list)

____

Please list any allergies (partner)

Does your partner use any of the following?

- ☐ Tobacco
- ☐ Alcohol
- ☐ Recreational Drugs

For male partners (if applicable):

Has your partner ever had a semen analysis? ◯ Yes ◯ No

Has your partner ever had problems with erections or ejaculation? ◯ Yes ◯ No

Struggling with infertility can impact all areas of your life. Please complete these questions so that we can best meet your needs.

How long have you been trying to conceive? --

Who can you count on to talk to when you are feeling upset about fertility? --

Have you experienced any pregnancy loss?	☐ Yes	☐ No
Has infertility affected your relationship or feelings about your partner or spouse?	☐ Yes	☐ No
Has infertility affected your relationship or feelings about your family?	☐ Yes	☐ No
Has infertility affected your relationship with your friends?	☐ Yes	☐ No
	☐ yes	☐ No

What areas of your life are at times impacted by your fertility struggles? (please indicate severity)

	Not affected --				Strongly affected
Confidence	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Sleeping	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Weight	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Finances	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Isolation	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Faith	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4

Mood changes?

	Not affected --				Strongly affected
Anxious feelings	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Anger	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Irritability	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Sadness	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
Guilt	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4
hopeless	◯ 0	◯ 1	◯ 2	◯ 3	◯ 4