UNC Fertility

NEW INFERTILITY PATIENT PROFILE

Last name _____ First Name _____

Date of birth _____ Current age _____

Referring Physician_____

MEDICAL HISTORY

Height_____Weight_____

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

Have you had prior fertility testing or treatments?
☐ Yes ☐ No

If yes, _____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); # of cycles _____

_____In vitro Fertilization (IVF); # of cycles _____

_____Other: _____

Are your menstrual cycles regular? ☐ Yes ☐ No

How many days from day 1 of your period to day 1 of the next period?_____

When was the first day of your last period (day/month)?_____

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

If yes, how severe is your pain?

Mild				Moderate					Severe
1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

If yes, what 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:

☐ Yes ☐ No Depression

☐ Yes ☐ No Anxiety

☐ Yes ☐ No Heart problems

☐ Yes ☐ No Lung problems

☐ Yes ☐ No High blood pressure

☐ Yes ☐ No Kidney problems

☐ Yes ☐ No Diabetes

☐ Yes ☐ No Asthma

☐ Yes ☐ No Sleep apnea (or do you snore loudly)

☐ Yes ☐ No Thyroid problems

☐ Yes ☐ No Other_____

Have you ever had Chicken Pox? ☐ Yes ☐ No

What is your blood type? ☐ A+ ☐ B+
☐ A- ☐ B-
☐ O+ ☐ AB+
☐ O- ☐ AB-

SURGERIES *(please list)*

Procedure #1_____Date_____

Procedure #2_____Date_____

Procedure #3_____Date_____

HISTORY OF GYNECOLOGIC PROBLEMS

☐ Yes ☐ No Sexually transmitted diseases

☐ Yes ☐ No Abnormal pap smears

☐ Yes ☐ No Uterine fibroids

When was your last pap smear? _____

ALLERGIES *(please list)* _____

CURRENT MEDICATIONS *Please include non-prescription medications and dietary or herbal supplements. Please include doses.*

_____

_____

Have you ever been pregnant?
☐ Yes ☐ No

If yes, _____Number of spontaneous miscarriages

_____Number of elective abortions

_____Ectopic pregnancies

_____Preterm births less than 37 weeks

_____Term births greater than 37 weeks

What is your occupation? _____

Do you use any of the following?

☐ Yes ☐ No Tobacco

☐ Yes ☐ No Alcohol

☐ Yes ☐ No Recreational drugs

MARITAL STATUS: ☐ Single ☐ Separated ☐ Widowed ☐ Married ☐ Divorced ☐ Partnered

ANCESTRY for you and your partner (if applicable) (check all that apply):

You	Your Partner	
☐	☐	African/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 your family (or your partner's family), is there history of:

☐ Yes ☐ No Downs syndrome

☐ Yes ☐ No Mental retardation

☐ Yes ☐ No Open neural tube defects (e.g. spina bifida)

☐ Yes ☐ No Birth defects

☐ Yes ☐ No Tay Sachs, cystic fibrosis, sickle cell anemia

☐ Yes ☐ No 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 in the past 6 months.

_____

_____

PARTNER'S PROFILE (if applicable)

Partner's Last Name_____First Name_____

Age_____DOB_____

What is your partner's occupation? _____

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

PARTNER'S MEDICAL PROBLEMS

☐ Yes ☐ No Anxiety
☐ Yes ☐ No Depression
☐ Yes ☐ No Heart problems
☐ Yes ☐ No Lung problems
☐ Yes ☐ No High blood pressure
☐ Yes ☐ No Kidney problems
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Asthma
☐ Yes ☐ No Thyroid problems
☐ Yes ☐ No Urinary or prostate problems
☐ Yes ☐ No Sleep apnea (or snores loudly)
☐ Yes ☐ No Other_____

PARTNER SURGERIES *(please list)*

Procedure #1_____Date_____

Procedure #2_____Date_____

Procedure #3_____Date_____

PARTNER ALLERGIES *(please list)*

_____

PARTNER MEDICATIONS Does your partner currently take medications? *Please include non-prescription medications and dietary or herbal supplements. Please include doses.*

_____

_____

Does your partner use any of the following?

☐ Yes ☐ No Tobacco

☐ Yes ☐ No Alcohol

☐ Yes ☐ No 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

In your opinion, why are you having difficulty conceiving?

_____

_____

What are you hoping to learn about at today's visit?

_____

_____