FERTILITY CLINIC – INTAKE FORM

1. Demographic information

Name: _____

Date of Birth: _____

2. Health history

2.1 General information

Weight (lbs) _____

Height (ft/inches) _____ BMI* _____ *Your clinic care team can help you determine your BMI.

Did you experience a dramatic (e.g., 20 lbs) weight gain or weight loss in the past year?
◯Yes ◯No

Are you taking any prescription medication(s) at this time?
◯Yes ◯No

Do you take over-the-counter medications or nutritional supplements including folic acid on a regular basis?
◯Yes ◯No

Do you have any allergies to medications?
◯Yes ◯No

Do you have any other allergies (e.g., food, environmental)?
◯Yes ◯No

Do you smoke tobacco?
◯Yes ◯No

Do you drink alcohol?
◯Yes ◯No

Do you use illicit or recreational drugs (e.g., marijuana, cocaine)?
◯Yes ◯No

2.2 Medical information

Have you ever had a pelvic infection?
○ Yes ○ No

Have you suffered (or are you currently suffering from) any chronic illness?
○ Yes ○ No

Please check all applicable:
☐ Anemia
☐ Autoimmune diseases, e.g., lupus
☐ Blood pressure problems (Low/High)
☐ Blood clots
☐ Breast milky discharge
☐ Cancer
☐ Colitis/Crohn's disease
☐ Cystic fibrosis
☐ Depression/Anxiety
☐ Diabetes
☐ Endometriosis
☐ Epilepsy (or seizures)
☐ Heart disease
☐ Hepatitis
☐ Hirsutism (excess hair growth)
☐ Kidney infection/problems
☐ Liver problems
☐ Measles – German
☐ Measles – regular
☐ Neurological problems
☐ Nongonococcal urethritis
☐ Ovarian cysts
☐ Parasitic infection
☐ Pelvic infection
☐ Respiratory diseases (pneumonia, lung diseases, tuberculosis, etc.)
☐ Stroke
☐ Sexually transmitted disease – please specify: _____
☐ Thyroid problems
☐ Uterine fibroids
☐ Vaginitis (trichomoniasis yeast)
☐ Vaginal discharge
☐ Other – please specify: _____

Have you ever been treated for cancer?
If yes, please specify type of cancer and type of therapy:

_____

2.3 Surgical history

Have you ever had surgery in your abdomen, womb or testicles?
◯Yes ◯No

If so, please specify: _____

2.4 Family history

Are there any diseases or conditions that are common in your close relatives?
◯Yes ◯No

If so, please specify: _____

Are there any known inherited conditions which have occurred in your family?
◯Yes ◯No

If so, please specify: _____

Is there a history of infertility in your family?
◯Yes ◯No

2.5 Sexual health history

At what age did you begin menstruation?

Please specify: _____

Do you have a regular menstrual cycle?
◯Yes ◯No

Do you bleed or spot between periods?
◯Yes ◯No

Are there any recent changes to your periods?
◯Yes ◯No

Have you used any form of contraception in the past?
◯Yes ◯No

If so, please specify by checking all that apply:
☐ Oral birth control pill
☐ Condom
☐ Diaphragm
☐ Intrauterine device (IUD)
☐ Rings
☐ Other

Have you had previous pregnancies?
◯Yes ◯No

If yes, please specify:

1st pregnancy

When? _____

Outcome? _____

Is your current partner the father?
◯Yes ◯No

Did you have other pregnancies?
◯Yes ◯No

2nd pregnancy

When? _____

Outcome? _____

Is your current partner the father?
◯Yes ◯No

Did you have other pregnancies?
◯Yes ◯No

3rd pregnancy

When? _____

Outcome? _____

Is your current partner the father?
◯Yes ◯No

Did you have other pregnancies?
◯Yes ◯No

If you have any children, are there any congenital problems or birth defects
(e.g., congenital malformations, genetic issues, etc.)?
◯Yes ◯No

How long (in months) have you been trying to get pregnant? Please specify: _____

On average, how many times per month do you have intercourse? Please specify: _____

Do you use a method to determine the time of ovulation?
◯Yes ◯No

If so, how many times do you have intercourse around the time of ovulation? _____

Do you use lubricants for intercourse?
◯ Yes ◯ No

If yes, which brand? _____

Have you ever received fertility treatment before?
◯ Yes ◯ No

If yes, in what year? _____

Where did you receive the treatment and what was the name of your fertility doctor?

_____

What was/were diagnosed as the cause(s) of infertility?
☐ Female factors
☐ Male factors
☐ Combined male/female factors
☐ Unexplained

Which of the following fertility treatment(s) did you undergo?
☐ Cycle monitoring
☐ Ovarian induction or superovulation
☐ Artificial insemination (or intrauterine insemination)
☐ In vitro fertilization
☐ Intracytoplasmic sperm injection
☐ Donor gametes (eggs, sperms)
☐ Donor embryos
☐ Surrogacy
☐ Other – please specify: _____

Were you prescribed any of the following medications?

Please check all that apply:
☐ Ovulation stimulant – oral tablet
Please specify how many courses were taken _____
☐ Injectable hormones
☐ Others – please specify: _____
☐ None

If you are seeking fertility care with a partner, please have your partner complete the intake questionnaire as well.

SAVE