# HOPE
Fertility & Reproductive
MEDICINE CENTRE

where dreams are born

# FERTILITY EVALUATION FORM

## PERSONAL MEDICAL HISTORY – FEMALE

| | | |
|---|---|---|
| Last Name: | First Name: | |
| Name on OHIP card: | Health Card Number: | Letters: |
| Date of Birth (mm/dd/yy): | Age: | |

| | | | |
|---|---|---|---|
| Home Address: | City: | Province: | Postal Code: |
| Telephone - Home: | Telephone - Work: | Occupation: | |
| Partner's Name: | Name of Referring M.D.: | Telephone #: | |

| | | | |
|---|---|---|---|
| Height: | | Weight: | |
| Major Health Problem? | NO / YES | Describe: | |
| Are you taking any medication? | NO / YES | Describe: | |
| PID (Pelvic Inflammatory Disease) | NO / YES | Describe: | |
| STI (Sexually Transmitted Infections) | NO / YES | Date(s) and Treatment: | Admitted to Hospital? NO / YES |
| Birth Control: | | | |
| High Blood Pressure: | NO / YES | | |
| Diabetes: | NO / YES | | |
| Caffeine use: | NO / YES | | |
| Tobacco use: | NO / YES | Packs per day? | How many years? |
| Alcohol use: | NO / YES | How much? | |
| Street Drug use: | NO / YES | What/How much? | |
| Allergies: | NO / YES | List: | |
| Illnesses/Surgeries: | | | |

| REPRODUCTIVE HISTORY - FEMALE | |
|---|---|
| Do you know the cause of your infertility? NO / YES | Describe: |
| First day of last period (dd/mm/yy): | |
| Age at onset of menstration: | Periods Regular? NO / YES |
| Number of days between periods: | Number of days of flow: |
| Painful periods? NO / YES | Painful Intercourse? NO / YES |
| Frequency of Intercourse: | Lubrication? |
| Previous Pregnancies/Miscarriages/Therapeutic Abortions: | |
| How many times have you been pregnant? | Last Pap Date: Result was normal? NO / YES |
| Martial Status: | Duration of Relationship: |
| Duration of Infertility: | Have you had previous treatment? NO / YES |

| PREVIOUS DIAGNOSTIC TESTS | | IMMEDIATE FAMILY MEDICAL HISTORY | |
|---|---|---|---|
| Basal Body Temperatures: | NO / YES | Diabetes: | NO / YES |
| Laparoscopy: | NO / YES | Endometriosis: | NO / YES |
| Post-coital Test: | NO / YES | Cancer: | NO / YES |
| Endometrial Biopsy: | NO / YES | High Blood Pressure: | NO / YES |
| Use of Ovulation Kit: | NO / YES | Heart Disease: | NO / YES |
| HSG (Tubal Patency): | NO / YES | | |
| Hormone Profile: | NO / YES | | |

| PERSONAL MEDICAL HISTORY – MALE | | | |
|---|---|---|---|
| Male Last Name: | | First Name: | |
| Name on OHIP card: | Health Card Number: | | Letters: |
| Date of Birth (mm/dd/yy): | Age: | Occupation: | Partner's Name: |
| Major Health Problem? NO / YES | | Describe: | |

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| REPRODUCTIVE HISTORY - MALE | | | |
|---|---|---|---|
| Semen analysis – Date: | | Result: | |
| History of Sexually Transmitted Infections: | NO / YES | Date (s) and Treatment: | Admitted to Hospital? NO / YES |
| Undescended Testicles: | NO / YES | Trauma to Testicles: | NO / YES |
| Tobacco Use: | NO / YES | Difficulty with Erection or Urination: | NO / YES |
| Caffeine Use: | NO / YES | Masturbation: | NO / YES |
| Exposure to Chemicals/Radiation: | NO / YES | | |
| Mumps: | NO / YES | When? | |
| Do you have any children from a previous relationship? | NO / YES | | |

***THIS FORM MUST BE SIGNED & DATED FOR IT TO BE COMPLETE***

Female Signature: ______________________________ Date: ______________________

Male Signature: ______________________________ Date: ______________________

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