

KUTTEH KE FERTILITY ASSOCIATES OF MEMPHIS, PLLC

80 Humphreys Center, Suite 307

Memphis, TN 38120-2363

Tel: (901) 747-BABY (901) 747-2229 Fax: (901)747-4446

Initial Female Evaluation

Today's Date: _____

Name: _____ What is your age? _____ Date of birth: _____

Occupation? _____ Who referred you to our care? _____

Currently married? Yes No Is this your first marriage? Yes No Spouse's name: _____

PRESENTING PROBLEMS (Circle as many as apply)

- 1. Infertility (_____ years)
- 2. Blocked or damaged tube(s)/Tubes tied
- 3. Amenorrhea (no periods)
- 4. Oligomenorrhea (light or infrequent periods)
- 5. Hirsutism (excess facial/body hair)
- 6. Galactorrhea (breast discharge)
- 7. Endometriosis
- 8. Leiomyomata (fibroids)
- 9. Male infertility/ low sperm count
- 10. Recurrent pregnancy loss (miscarriages)
- 11. Premature menopause
- 12. Menorrhagia (heavy periods)
- 13. Pelvic pain
- 14. Pelvic adhesions (scar tissue)

Other (Specify) _____

G: P:

Have you been treated with these medications? (Please circle)

- | | |
|--|---------------------------------------|
| Provera (medroxyprogesterone acetate) | Progesterone (Prometrium, Crinone) |
| Clomiphene citrate (Serophene, Clomid) | hCG (Profasi, Pregnyl, Ovidrel) |
| Letrozole (Femara) | Bromocriptine, cabergoline (Dostinex) |
| Gonal F, Follistim, | Lupron, Cetrotide, or Antagon |
| Bravelle, Repronex, Menopur | Luveris |
| Glucophage, Avandia, or Avandamet | Heparin, Lovenox, Aspirin 81mg, IVIG |
| Other _____ | |

Have you ever had any of these treatments? (Please circle)

- | | |
|---------------------------------------|--|
| Ovulation induction (OI) therapy | Intrauterine insemination (IUI) |
| In vitro fertilization (IVF) | Donor sperm insemination |
| Embryo adoption | Donor egg IVF |
| Frozen (thawed) embryo transfer (FET) | Pre-implantation genetic diagnosis (PGD) |
| Surrogacy (gestational carrier) | GIFT, ZIFT |

YOUR PREGNANCY HISTORY (Please list ALL pregnancies)

Year of conception	How many months to conceive	Miscarriage or Abortion	Who is the Father?	Any Complications?
1. _____				
2. _____				
3. _____				
4. _____				
5. _____				
6. _____				

Bl. type: _____ Rub: I NI
RPR: NR R Hep B: - +
HIV: - + Hct: _____ %

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ANATOMIC-UTEROTUBAL ASSESSMENT

Have you had a hysterosalpingogram (x-ray dye test of the uterus/tubes)? **Yes No**

When: _____ Where: _____

Results: _____

Have you had surgery in your abdomen or pelvis? **Yes No**

Procedure: _____

When: _____ Where: _____

Procedure: _____

When: _____ Where: _____

Have you had surgery on your cervix, i.e., biopsy or conization? **Yes No**

Date of your last pap smear: _____ Was it normal? **Yes No**

Have you ever had: *(Circle as many as apply)*

- Ovarian cysts or tumors Endometriosis Ectopic (tubal) pregnancies
- Scar tissue in your pelvis Postcoital Test Scar tissue inside your uterus
- Uterine fibroids Uterine polyps Uterine birth defects
- Chlamydia Gonorrhea Pelvic inflammatory disease

Any other sexually transmitted infection (e.g. herpes, genital warts, HPV, others)

ENDOCRINOLOGIC-OVULATION ASSESSMENT

Do you have regular, cyclic, predictable, spontaneous menstrual periods? **Yes No**

Age of your first period: _____ First day of your last period: _____

How many days from the first day of one period to the first day of the next? _____

How many days does your period last? _____

Do you have pre-menstrual breast pain, bloating, mood change, etc.? **Yes No**

Are your periods painful? **Yes No**

Do you have pelvic pain between your periods? **Yes No**

If your periods are *not* regular, then explain: _____

If you do not have periods, when did they stop? _____

Has your doctor ever prescribed pills or injections to start your periods? **Yes No**

Do you have or have you ever had: *(Please circle)*

- Progesterone blood test FSH blood test Thyroid test Glucose or insulin test
- Nipple discharge At least 10lb weight gain or loss in the past year
- Hot flashes Unwanted hair on ___face___ chest ___abdomen
- Hair loss Acne Daily exercise
- Diabetes Adrenal disease Thyroid disease

What have you used for birth control? _____ When did you stop? _____

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SEXUAL HISTORY

How often do you and your husband have sexual intercourse? _____

Do you try and time intercourse to your ovulation? **Yes No**

Do you use any lubricants during intercourse? **Yes No**

Do you have any pain with intercourse? **Yes No**

Any difficulties with penile erection or ejaculation? **Yes No**

As a couple, do you have any other sexual difficulties? **Yes No**

Explain: _____

IMMUNOLOGIC ASSESSMENT:

Do you have an autoimmune disease (e.g. lupus, rheumatoid arthritis, etc) **Yes No**

Have you ever had any of these:

- | | | |
|------------------------|---------------------|-----------------------------|
| Positive syphilis test | Lupus anticoagulant | Anticardiolipin antibodies |
| Embryotoxic assay | PTT | Antiphospholipid antibodies |
| Rheumatoid factor | Immunologic therapy | Antinuclear antibodies |

Have you had any other test of your immune system? **Yes No**

Explain: _____

THROMBOPHILIC ASSESSMENT:

Do you have a history of blood clots? **Yes No**

Does your family have a history of blood clots? **Yes No**

- | | | |
|---------------------------------------|-----------------|-----------|
| Have you ever had any of these tests: | Factor V Leiden | Protein C |
| Prothrombin II | Homocysteine | Protein S |
| Antithrombin | | |

Have you ever been on a blood thinner? Heparin Coumadin Baby Aspirin

Explain: _____

GENETIC ASSESSMENT:

Have you had a karyotype (chromosome) test? **Yes No** When: _____ Result: _____

Have your husband had a karyotype test? **Yes No** When: _____ Result: _____

Has a karyotype test been performed on a miscarriage? **Yes No**

Have you or your husband had any other genetic tests? **Yes No**

Explain: _____

Does anyone in your family have a genetic or birth defect? **Yes No**

Does anyone in your family suffer from mental retardation? **Yes No**

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OTHER MEDICAL HISTORY [Circle any conditions that you are known to have (or have had)]

- | | | | |
|--------------------------|--------------------------|-------------------------------|-----------------------|
| High blood pressure | Heart disease | Stroke | Mitral valve prolapse |
| Lung disease/Asthma | Cystic fibrosis | Hepatitis | Gallbladder disease |
| Bowel disease | Liver disease | Blood in stool | Skin disease |
| Psychiatric disease | Headaches | Neurological disease/seizures | |
| Urinary tract infections | Kidney disease | Blood in urine | Cancer |
| Bleeding Disorder | HIV infection | Breast disease | Chicken Pox |
| Vision/hearing defects | Sickle cell anemia/trait | Other anemia or blood disease | |

Other _____

Surgery or hospitalizations (Give dates): _____

Date of your last mammogram: _____ Was it normal? **Yes** **No**

Current Medications (include dosage, frequency, and any over-the counter or herbal drugs)

Medication Allergies _____

Habits: Do you use tobacco? **Yes** (cig/day: _____) **No** Ex-smoker?

Do you drink alcohol? **Yes** (drinks/week: _____) **No**

Caffeine drinks per day: _____ Illicit drug use? **Yes** **No**

FAMILY HISTORY

	<u>Age</u>	<u>Age at Death</u>	<u>Medical Problems</u>
Mother:	_____	_____	_____
Mother age at menopause?	_____		
Father:	_____	_____	_____
Sisters:	_____	_____	_____
	_____	_____	_____
Brothers:	_____	_____	_____

Any family history of breast or ovarian cancer? _____ Yes No

Any family history of other cancers? _____ Yes No

Any diseases which run in your family? _____ Yes No

What is your ethnic background? _____

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HP HNP N/A

Initial Male Evaluation

Name: _____ Date of Birth: _____

Occupation: _____ Name of urologist (if applicable): _____

Wife's Name: _____ Wife's Date of Birth: _____

Have you fathered any previous pregnancies? **Yes No**

Has your sperm been tested? **Yes No**

Have you: been told you have a varicocele of the scrotum? **Yes No**

had genital surgery, trauma, or genital infections? **Yes No**

had genital problems or hernias as a child? **Yes No**

seen a urologist for any reason? **Yes No**

Do you have any health problems? **Yes No**

Explain: _____

Do you take any medications on a regular basis? **Yes No**

Which medications: _____

Have you had an illness with a fever in the past six months? **Yes No**

Do you : smoke or use tobacco? **Yes (cig/day: ____) No**

use alcohol? **Yes (drinks/week: ____) No**

use illicit drugs? **Yes No**

allergies to any medications? **Yes (which ones?: _____) No**

Does infertility run in your family? **Yes No**

Are there any diseases that run in your family? **Yes No**

Explain: _____

OFFICE USE ONLY.

MALE DIAGNOSIS:

1) _____ CPT: _____

2) _____ CPT: _____

3) _____ CPT: _____

SA Sperm culture Retrograde analysis ASAb CF mutation analysis Sperm cryo/banking

LH/FSH Prolactin TSH Total testost. Free testost. Estradiol

HIV I/II RPR CMV IgG CMV IgM Hepatitis B sAg Hepatitis C Ab

Karyotype Y-chromosome microdeletion Refer to urology: Dr. _____

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PHYSICAL EXAMINATION

Ht: _____ Weight: _____ BMI: _____ kg/m² BP: _____ RR: _____ Temp: _____

HEENT incl. thyroid N AbN

Skin incl. hirsutism N AbN

Neurological N AbN

Heart/CV N AbN

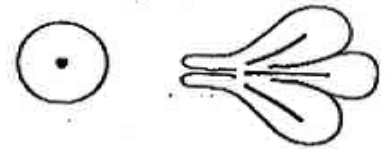
Respiratory N AbN

Breasts incl. axilla N AbN

Ext. Genitalia/Vagina/Cervix N AbN

Adnexae N AbN

Uterus Size: _____ Position: _____



FEMALE DIAGNOSIS

1) _____

CPT: _____

2) _____

3) _____

4) _____

5) _____

LMP: _____ Today is cycle day: _____

Chlamydia	Mycoplasma	Varicella titre	Urine C&S	Urine hCG	Quant. βhCG	
PNS	CBC	CMP	PTT	Platelet	Iron Profile	
TSH	PRL	CD3 FSH/LH/E2	Random FSH/LH	CD21 P4	Total T	Free T
Fasting Insulin	Glucose	2 hour GTT	HgA1c	17-OHP	SHBG	DHEAS
8 AM Cortisol	Lipid Profile	Anti-adrenal Ab	FMR1 PCR	Serum Ca		
LAC	APA	Karyotype-wife	Homocysteine	Antithrombin	Factor II (Prothrombin) mutation	
APCR	FVL	Pro C Act	Pro S Act			
HSG	TT	GYN USG	DAY 3 USG	Sonohysterogram		

Need HSG films from: _____ Book OR: _____

Need records from: _____ F/U Appt: _____

Date _____ NP _____ MD _____