FERTILITY ASSOCIATES OF MEMPHIS
80 Humphreys Center, Suite 307
Memphis, TN 38120-2363
Tel: (901) 747-2229 Fax: (901) 747-4446

FEMALE PARTNER'S EVALUATION Todayøs Date: ______________

Name: ____ Age: ______________________ Date of birth: ________________

Occupation: ____ Partnerøs Name:____

Who referred you to our care?_________________________ Who is your OB/Gyn? ____________________________ FAX________________

THE MAIN PURPOSE OF TODAY'S VISIT IS: *(Please circle as many as apply)*

1. Infertility (_________ years)
2. Blocked or damaged tube(s) / Tubes tied
3. Amenorrhea (no periods)
4. Polycystic ovaries (PCOS)
5. Irregular menstrual cycles (irregular periods)
6. Hirsutism (excess facial/body hair)
7. Endometriosis
8. Leiomyomata (fibroids)
9. Male infertility/ Low sperm count
10. Pelvic pain / Pelvic adhesions (scar tissue)
11. In vitro fertilization (IVF)
12. Recurrent pregnancy loss (miscarriages)
13. Pregnancy complication / Stillbirth
14. Menorrhagia (heavy periods)
15. Premature menopause
16. Other (Specify)_______________________

PHYSICIAN USE ONLY

Total number of pregnancies _____
- Full term (>37 weeks) _____
- Pre term(20 to 37 wks) _____
- Miscarriage (<20 wks) _____
- Termination _____
- Ectopic (tubal) _____
- Living children _____

Have you been treated with these medications? *(Please circle as many as apply)*

Provera, Medroxyprogesterone acetate
Clomiphene, Serophene, Clomid
Letrozole, Femara
Gonal F, Follistim
Bravelle, Repronex, Menopur
Glucophage, Metformin, Avandamet
Progesterone, Prometrium, Crinone
hCG, Profasi, Pregnyl, Ovidrel, Novaryl
Bromocriptine, Cabergoline, Dostinex
Lupron, Ganirelix, Cetrotide, Antagon
Synthroid, Levothyroxine
Heparin, Lovenox, Aspirin 81mg, IVIG
Other ____

Have you ever had any of these treatments? *(Please circle, and indicate number of treatments)*

Intrauterine insemination (IUI)__________
In vitro fertilization (IVF)______________
Embryo adoption_____________________
Frozen embryo transfer (FET)___________
Tubal / uterine surgery________________
Donor sperm________________________
Donor egg__________________________
Other______________________________

YOUR PREGNANCY HISTORY *(Please include ALL pregnancies)* Blood Type?__________

	Year of delivery or loss	How many months to get pregnant?	How long did the pregnancy last?	Who is the father?	Any complications?
1.					
2.					
3.					
4.					
5.					
6.					

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FERTILITY WORK-UP

Have you had a hysterosalpingogram (HSG; x-ray õdye testö of the tubes)? **Yes** **No**

When? ________________ Where? ___________________________________

Results: ____

Have you had a sonogram (Ultrasound of the pelvis / uterus / ovaries)? **Yes** **No**

When? ________________ Where? ___________________________________

Results: ____

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

When? ________________ Where? ___________________________________

Procedure: ____

Procedure: ____

Have you had surgery (Biopsy / cone / LEEP / cryo / freezing) on your cervix? **Yes** **No**

Have you ever had an abnormal Pap smear? **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 Uterine septum Scar tissue inside your uterus

Uterine fibroids Uterine polyps Uterine birth defects

Chlamydia Gonorrhea Pelvic inflammatory disease

Other sexually transmitted infection (e.g., Herpes, genital warts, HPV, etc.)

OVULATION ASSESSMENT

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

Age of your first period: ___________ How many days does your period last? ________________________

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

Do you ever have spotting in between periods? ____

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

Are your periods heavy, either now or in the past? ____

Do you have premenstrual symptoms? **Yes** (____Cramps ____Breast pain ____Bloating ____Mood changes) **No**

Do you have pain or cramps with your periods? **Yes** (_____Mild _____Moderate _____Severe) **No**

Do you have pelvic pain between your periods? **Yes** (With ovulation?_____________________________) **No**

What medicine or action helps decrease the pain? ____

What have you used for birth control?_____________________ When did you stop? ___________________

Have you ever taken medicine to start your periods? **Yes** (When? ______ What?______________________) **No**

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

Blood test for: Progesterone FSH TSH (thyroid) Glucose Insulin Hemoglogin A1c

Nipple discharge Hot flashes Night sweats Hair loss Acne Diabetes Thyroid disease

Unwanted hair on _____Chin_____Sideburns _____Mustache _____Chest _____Abdomen

What is your weekly exercise? ____

What is your weight? Currently_______ Ideally_______ One year ago_______ Five years ago_______

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PAST MEDICAL HISTORY / SYSTEMS REVIEW *(Please circle any conditions that you 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	Depression / Anxiety	Neurological disease / seizures
Urinary tract infections	Kidney disease	Blood in urine	Cancer
Bleeding disorder	HIV infection	Breast disease	Vision or hearing defects
Sickle cell anemia / trait	Blood disease (Anemia)	Diabetes	Thyroid disease

Other ____

Surgeries or hospitalizations *(Please give dates)*: ____

____

____

Date of your last mammogram: __________ Was it normal? **Yes** **No** (Explain_________________________)

Current Medications: *(Please include dosage, frequency, and any over-the counter drugs, herbs, and vitamins)*

____

____

____

Food / Medication / Latex Allergies: ____

____

Habits: Do you use tobacco? **Yes** (_______cig/day; ______total # of years) **No**

Are you a former smoker? **Yes** (Congratulations! When did you quit?_____________) **No**

Do you drink alcohol? **Yes** (# of drinks/week: _________) **No**

Illicit drug use? **Yes** (Type?____________ How often?_________________) **No**

# of caffeinated drinks per day: ____________________

FAMILY HISTORY

	Age	Age at Death	Medical or Pregnancy-Related Problems	
Mother:	____	_______	____	**None**
	Is she menopausal? **Yes** (What age? _____ Did she have a hysterectomy?______________)			**No**
Father:	____	_______	____	**None**
Brother/Sister:	_____	_______	____	**None**
Brother/Sister:	_____	_______	____	**None**
Brother/Sister:	_____	_______	____	**None**

Any cancer? **Yes** (____Breast ____Ovarian ____Colon ____Other_________________________________) **No**

Any blood clots? **Yes** (Who, and where?____) **No**

Any autoimmune diseases? **Yes** (Who, and what type?____) **No**

Anyone with: _______Genetic or inherited diseases? _______Birth defects? _______Mental retardation? **No**

Any medical diseases not listed? **Yes** (Who, and what type? ____________________________________) **No**

What is your ethnic background?____

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COUPLE'S SEXUAL HISTORY

How often do you and your partner have sexual intercourse? ___________________________________

Do you time intercourse to ovulation? **Yes** (___Calendar ___Phone App ___Urine predictor kits ___Other) **No**

Do you use any lubricants during intercourse? **Yes** (What kind? _______________________________) **No**

Do you have any pain with intercourse? **Yes** (Where? ____) **No**

Do you have any other sexual difficulties as a couple? **Yes** (Please explain ______________________) **No**

HAVE YOU HAD ≥2 MISCARRIAGES? Yes____*(Please answer below)* **No** ____*(Please skip to next section)*

Genetic Factors:

Have you had a karyotype (chromosome) test? **Yes** (When?_________Result?_______________________) **No**

Has your partner had a karyotype test? **Yes** (When?_________Result?_______________________) **No**

Have you had a karyotype test on a miscarriage? **Yes** (When?________Result?_______________________) **No**

Have you/your partner had any other genetic tests? **Yes** (When?______Result?_______________________) **No**

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

Have you had any abnormal immune tests? (*Please circle as many as apply*) **No**

Positive syphilis test	Lupus anticoagulant	Anticardiolipin antibodies
Antithyroid antibody	PTT dRVVT	Antiphospholipid antibodies
Rheumatoid factor	Immunologic therapy	Antinuclear antibodies

Other immune tests (Describe____)

Thrombophilic Factors:

Do you have a history of blood clots? **Yes** (When? ____ Where?_______________________________) **No**

Have you been tested for:	Factor V Leiden	Factor II (prothrombin)	MTHFR
(*Please circle as many as apply)*	Protein S	Antithrombin	Protein C

Have you ever been on a blood thinner? **Yes** (____Heparin ____Lovenox ____Coumadin ____Baby aspirin) **No**

Reason:____

MALE PARTNER'S EVALUATION Not Applicable P NP

Name: ____ Date of Birth:_________________

Occupation: _______________________________Name of urologist (if applicable): _________________________

Any previous pregnancies? **Yes** (Year and Outcome ______________________________________) **No**

Has your sperm been tested? **Yes** (When?_______ Result?_____________________________________) **No**

Have you had a varicocele of the scrotum? **Yes** (Reason:____) **No**

Have you seen a urologist for any reason? **Yes** (Reason:____) **No**

Have you had: _____Genital surgery? _____Genital trauma? ______ Genital infections? _____Hernias? **No**

What health problems do you have?____ **None**

What medications / vitamins do you take?____ **None**

Do you : Smoke or use tobacco? **Yes** (_______cig/day; ________total # of years) **No**

Use alcohol? **Yes** (# of drinks/week: ________________________) **No**

Use illicit drugs? **Yes** (Type?_____________________ How often? ___________) **No**

Do you have allergies to any food, drugs, or latex? **Yes** (____) **No**

What diseases run in your family?____ **None**

Does infertility run in your family? **Yes** (Whom?____) **No**

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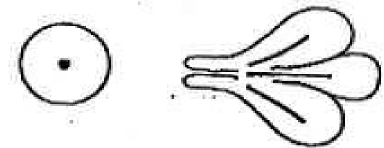
PHYSICIAN USE ONLY: PHYSICAL EXAMINATION

Height: ________ Weight: ____________ BMI: ___________ kg/m^2 BP: ____________ RR: __________ Temp: _____________

HEENT, incl. thyroid	N	AbN
Skin, incl. hirsutism	N	AbN
Neurological	N	AbN
Heart / CV	N	AbN
Respiratory	N	AbN
Ext. Genitalia / Vagina / Cervix	N	AbN
Adnexae	N	AbN



Uterine size: _________________ Position: ______________________

FEMALE DIAGNOSES:

1) CPT ____________________________________ CPT ___________
2) CPT ____________________________________ CPT ___________
3) CPT ____________________________________ CPT ___________
4) CPT ____________________________________ CPT ___________
5) CPT ____________________________________ CPT ___________
6) CPT ____________________________________ CPT ___________

MALE DIAGNOSES:

1)_____________________________ CPT _________
2)_____________________________ CPT _________
3)_____________________________ CPT _________
4)_____________________________ CPT _________

LMP: __________________ Today is cycle day: ____________________ Urine hCG Result:________

MICRO: Chlamydia Mycoplasma Aero/Anaerob Culture Urine Analysis Urine C&S

GENERAL: PNS CBC CMP Platelet Iron Profile Sickle cell Screen LDH 25OH-Vitamin D3

REI: CD3 FSH/LH/E2 Random FSH/LH/E2 CD _____ P4 AMH Quant hCG

ENDO: TSH PRL HgBA1C Fasting Insulin Free Testos Total Testos Lipid Profile
8am Cortisol 17-OHP SHBG DHEAS

GENETIC: Karyotype- female FMR1 PCR CF mutation analysis Carrier Screening

ANATOMIC: HSG GYN USG DAY 3 USG Sonohysterogram Trial Transfer

IMMUNE: LAC APA anti- 2GP1 Anti-adrenal Anti-thyroid ANA anti-DS-DNA

THROMB: Factor V Leiden Factor II MTHFR Prot C Act Prot S Act Antithrombin

MALE: Semen analysis Sperm culture Retrograde analysis AS Ab Refer to Urology

MALE ENDO: FSH LH PRL TSH Total T Free T

MALE STD: HIV I/II RPR Hepatitis B sAg Hepatitis C Ab

MALE GENETIC: Karyotype- male Y-chromosome microdeletions CF mutation analysis CryoBank

Need HSG films/Records from: ____________________________________Book OR:_________F/U Appt:_________

INFO/ADVICE

Start PNV / DHA
PCOS / Metformin
Clomid / Letrozole
Gonadotropins
DOR
CoQ10 / DHEA
RPL
LSC/HSC
APA/Heparin
Lovenox
IUI
IVF ICSI PGT
Stop Smoking
Weight Loss
Male Fertility
Genetic Testing
Donor Egg/Embryo
Donor Sperm
MedsøPreg Categ
Endometriosis
Fibroids
Decrease Caffeine

Date _____________ Nurse/Resident_________________________ MD __________________________ Dictated _______________

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Patient Name:________________________________ **DOB:**_______________________

Consent for Genetic Carrier Screening

Universal genetic carrier screening allows couples to screen for a variety of genetic disorders prior to becoming pregnant. Genetic carrier screening is a simple blood or saliva test that evaluates an individual's DNA to determine if s/he is a carrier of any genetic abnormalities. Most individuals who are carriers of these genetic mutations do not have any symptoms. If both partners are carriers of the same genetic mutation, however, the couple is at risk of passing on the disease to their offspring.

The most common genetic disorders that are tested for include: Cystic Fibrosis, Fragile X Syndrome, Spinal Muscular Atrophy, Tay-Sachs, and Sickle Cell Anemia. In addition to those conditions, genetic carrier screening can also identify other more rare diseases. A full list of diseases can be provided upon request.

If both genetic parents of the child are genetic carriers, the risk of their child having the genetic condition is 25%. If one parent is a carrier, the child has a 50% chance of being a carrier as well and a much lower risk of actually having the condition or disease. Therefore, while we recommend the screening of at least one partner, we offer both partners genetic carrier screening. It is also recommended that you have genetic counseling to assess other genetic risks based on these tests and your family history and personal medical history.

Although universal genetic carrier screening is incredibly accurate, receiving a negative result cannot completely eliminate the chance that you will not have a child with a genetic disorder. More importantly, if a positive finding is reported in both you and your partner, we can offer specific treatment options to help reduce the chance of the disease being passed on to your offspring. **We recommend genetic carrier screening to all individuals of reproductive age. We strongly recommend that all individuals discuss genetic testing with a licensed genetic counselor and by signing this form I verify that I have been given this contact information:**

Natera Horizon Carrier Screening: Phone (650-249-9090) and www.natera.com

There is a chance that your insurance company may not pay for some or all of the cost of the test. If this is the case, you will be responsible for payment. If you do not have insurance, the out-of-pocket cash price depends on the lab utilized and is available upon request.

Prior to beginning any fertility treatment we request that you review universal genetic carrier screening with your physician and as a couple you decide to decline or accept this testing.

☐ I consent to genetic carrier screening ☐ I decline genetic carrier screening

Patient Signature ______________________________ Date: ___________________

Physician Signature ____