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

Today's Date: ____________

Name: ______________________ Age: __________ Date of birth: ____________

Occupation: ______________________ Partner's 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 "dye test" 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**
Father:	____	______	______________________	**None**
Brother/Sister:	____	______	______________________	**None**
Brother/Sister:	____	______	______________________	**None**
Brother/Sister:	____	______	______________________	**None**

(Mother) Is she menopausal? **Yes** (What age? _____ Did she have a hysterectomy?____________) **No**

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

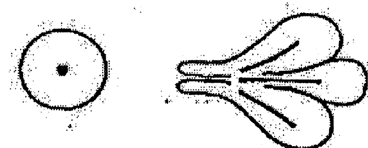
Heart / CV N AbN

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-β2GP1 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
Meds' Preg Categ
Endometriosis
Fibroids
Decrease Caffeine

Date ____________ Nurse/Resident______________________ MD ________________________ Dictated ______________