

GENETICS HISTORY:

Have either you or your husband (or male partner), or anyone of either of your families ever had any of the following disorders? For each "yes" answer, please provide details of the problem and relationship of the affected individual to you or your husband.

- | | | | |
|-----|---|-----|----|
| 1. | Mental Retardation | Yes | No |
| 2. | Down's syndrome or other chromosomal abnormality | Yes | No |
| 3. | Any birth defects (i.e. cleft lip or palate, limb defects, etc.) | Yes | No |
| 4. | Spina bifida (open spine), anecephaly, neural tube defect. | Yes | No |
| 5. | Hydrocephalus (water on the brain) | Yes | No |
| 6. | Congenital blindness or deafness | Yes | No |
| 7. | Blood disorders (anemia's) | Yes | No |
| 8. | Cystic fibrosis | Yes | No |
| 9. | Epilepsy or seizures | Yes | No |
| 10. | Heart defects | Yes | No |
| 11. | Hemophilia (bleeding) | Yes | No |
| 12. | Huntington's chorea | Yes | No |
| 13. | Kidney diseases | Yes | No |
| 14. | Mental illness | Yes | No |
| 15. | Muscular dystrophy | Yes | No |
| 16. | Myotonic dystrophy | Yes | No |
| 17. | Neurofibromatosis | Yes | No |
| 18. | Phenylketonuria or hyperphenylalaninemia | Yes | No |
| 19. | Stillbirth | Yes | No |
| 20. | 3 or more miscarriages | Yes | No |
| 21. | Diabetes | Yes | No |
| 22. | Other birth defects or inherited disorders not listed above | Yes | No |
| 23. | Are either you or your husband of Jewish or French Canadian Ancestry. If yes, have you or any of your relatives been tested For Tay Sachs disease? | Yes | No |
| 24. | Are you or your husband of African ancestry? If yes, do either of you or any of your relatives have sickle cell anemia or been tested (+) for sickle cell trait? | Yes | No |
| 25. | Are either you or your husband of African, Asian, Middle Eastern, East Indian, or Mediterranean (Greek, Italian, etc.) Ancestry. If yes, do either of you or your relatives have thalassemia or been tested (+) for thalassemia trait | Yes | No |
| 26. | Are you or your husband related, such as first or second cousins? | Yes | No |

Male Factors

Has he fathered pregnancies *in a different relationship*:

None Total # of pregnancies: _____ Liveborn children: _____
 Miscarriages: _____ Terminations: _____

Infertility Testing

	<input type="checkbox"/> Not done	<input type="checkbox"/> Done	<u>Date</u> _____	<u>Results</u> <input type="checkbox"/> Normal Other: _____
Blood tests (hormone levels)			_____	<input type="checkbox"/> Normal Other: _____
Semen analysis (sperm counts)			_____	<input type="checkbox"/> Normal Other: _____
Hysterosalpingogram (X-ray test of tubes)			_____	<input type="checkbox"/> Normal Other: _____
Laparoscopy (surgery to look at tubes)			_____	<input type="checkbox"/> Normal <input type="checkbox"/> Endometriosis <input type="checkbox"/> Adhesions <input type="checkbox"/> Other: _____
Hysteroscopy (surgery to look in uterus)			_____	<input type="checkbox"/> Normal Other: _____
Sonohysterogram (ultrasound with saline infusion)			_____	<input type="checkbox"/> Normal Other: _____

Other tests (list): _____

Infertility Treatment

<u>Intrauterine Inseminations (IUI)</u>	<u># cycles</u>	<u>Date of last cycle</u>	<u>Outcome</u>		
Natural cycle IUI	_____	_____	_____		
Clomid + IUI	_____	_____	_____		
Injectable fertility drugs*+IUI	_____	_____	_____		
<u>Fertility Drugs Alone</u>					
Clomid	_____	_____	_____		
Injectable fertility drugs*	_____	_____	_____		
<u>In Vitro Fertilization (IVF)</u>	<u># eggs</u>	<u># embryos</u>	<u># transferred</u>	<u># frozen</u>	<u>Outcome</u>
Cycle #1 (date _____)	_____	_____	_____	_____	_____
Cycle #2 (date _____)	_____	_____	_____	_____	_____
Cycle #3 (date _____)	_____	_____	_____	_____	_____

* Injectable fertility drugs are purified FSH and LH and are marketed under trades names like: Pergonal, Repronex, Bravelle, Gonal-F and Follistim

San Diego Fertility Center

New Patient Questionnaire

Personal Data

Female Name: _____ DOB _____ Age _____
Male Name: _____ DOB _____ Age _____

Married for _____ years. 1st marriage 2nd marriage Other
Infertility of # years: _____ Unprotected sex for # years? _____ Well-timed intercourse for # years _____
Sexual intercourse: frequency _____ / week Important details (if any): _____
Do you?: Smoke _____ pks/d drink alcohol _____ drinks/week
Does he?: Smoke _____ pks/d drink alcohol _____ drinks/week

Previous Pregnancies

None Total # of pregnancies: _____ Liveborn children: _____
Miscariages: _____ Terminations: _____
Ectopic pregnancies: _____ Adopted children: _____

Medical History

Height: _____ Weight: _____

List any significant medical illnesses or problems? (1) _____
(2) _____ (3) _____

List any **medications** you take regularly: (1) _____
(2) _____ (3) _____

Do you have any **allergies** to medications? (list): (1) _____
(2) _____ (3) _____

If yes, what was the reaction? _____

Menstrual Factors

Regular cycles Irregular cycles since I started my periods
 Irregular cycles since _____

Date of last period _____ Interval between menstrual cycles (from start to start) _____
Duration of bleeding (days) _____ Spotting between periods _____

Previous Surgery & Tubal Factors

List all surgical procedures and year? (1) _____
(2) _____ (3) _____

Others: _____

Have you ever had? Chlamydia Herpes Pelvic inflammatory disease (PID)
 Gonorrhea Tuberculosis Sexually transmitted diseases (other)
 Appendicitis an IUD Human papilloma virus (HPV)
 Endometriosis Ovarian cysts Abnormal PAP smears