Ontario Network of Experts in Fertility
life through knowledge

Affiliated with McMaster University

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FERTILITY SERVICES PERSONAL HISTORY

Date:	Primary Contact Number:
Age:	
Height:	Secondary Contact Number:
Weight:	
Email Address:	
Referred By:	Occupation:
Family Doctor Name:	Send Updates to Family Doctor? Yes □ No □
Family Doctor Phone Number:	
Family Doctor Address:	How did you hear about ONE Fertility? □ Medical Provider □ Family/Friend □ Internet □ Other, Please Specify _____
Are you in a relationship currently? Yes □ No □	
If you are currently trying to conceive, how long have you been trying to become pregnant? Years: _____	What is the reason you have come to see us?

SECTION ONE: PREVIOUS INFERTILITY INVESTIGATIONS AND TREATMENTS

1) Have you had any previous fertility treatments? Yes □ No □

a) Have you ever had any treatment with Clomid? Yes □ No □

i) Did you take Clomid with intrauterine inseminations (IUI)? Yes □ No □

ii) Did you take Clomid with natural intercourse? Yes □ No □

iii) How many months did you take Clomid for? _____

iv) What dosage of Clomid did you take used? _____

v) How were your responses to the medication monitored? (Select all that apply)
Ultrasound □ Bloodwork □ Ovulation predictor kits □

vi) Did any pregnancies occur? Yes □ No □

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b) Have you previously used any of the following Follicle Stimulating Hormones with treatment? Gonal-F, Puregon, FSH, Repronex, Metrodin Yes □ No □

i) If yes, how many cycles did you take the medication? _____

ii) Did you take them with intrauterine inseminations (IUI)? Yes □ No □

iii) Did any pregnancies occur? Yes □ No □

c) Have you used donor sperm? Yes □ No □

i) How many cycles did you use donor sperm? _____

ii) Did any pregnancies occur? Yes □ No □

d) Have your previously done In-Vitro Fertilization (IVF)? Yes □ No □

i) How many cycles of IVF did you do? _____

ii) Where did these cycles take place? _____

iii) Did it also involve intracytoplasmic sperm injections (ICSI)? Yes □ No □

iv) Were there any complications? (Ex. Ovarian Hyper Stimulation Syndrome)

Yes □ No □ If yes, please specify:

_____

_____

v) Did any pregnancies occur? Yes □ No □

2) Are there any other treatments you have previously tried?

_____

_____

3) Have you had an x-ray dye test of your uterus (hysterosalpingogram-HSG): Yes □ No □

a) Where was the test done? _____

b) When was test done? _____

c) What were the results?

i) Tubes open? Yes □ No □

ii) Normal Uterus? Yes □ No □

4) Have you had a sonohysterogram done? Yes □ No □

a) Where was the test done? _____

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b) When was test done? _____

c) What were the results?

i) Tubes open? Yes □ No □

ii) Normal Exam? Yes □ No □

SECTION TWO: MENSTRUAL HISTORY

1) What was your age when your menstrual periods began? _____

2) When was your last menstrual period (date of first day of last period)? _____

3) What is the average number of days from the start of one period to the start of the next? _____

a) Have your menstrual periods always been like this? Yes □ No □

b) What is the longest time between periods in the last year? _____

c) What is the shortest time between periods in the last year? _____

d) Do you or have you ever required medication to bring on a period? Yes □ No □

If yes, please specify: _____

4) What is the flow of your periods? Light □ Moderate □ Heavy □

5) Are your periods painful? Yes □ No □

a) What medications do you take for the pain? _____

b) Do your menstrual periods keep you from going to work or school? Yes □ No □

c) How many days of your period does the pain last? _____

SECTION THREE: SEXUAL HISTORY

1) Are you currently sexually active? Yes □ No □

If yes, how many times per week do you have intercourse? _____

2) How many partners do you have? _____

3) Is intercourse painful? Yes □ No □

a) Does the pain ever make you stop during intercourse? Yes □ No □

4) Do you use lubricants/foams with intercourse? Yes □ No □

If yes, please specify: _____

5) Have you ever been forced to have intercourse without your consent? Yes □ No □

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SECTION FOUR: GYNECOLOGIC HISTORY

1) Do you experience fluid, discharge, or leaking from your breast? Yes □ No □

If yes, please specify: _____

a) When did this begin? _____

b) When does this occur? _____

c) What does it look like? _____

2) Please indicate if you have hair growth in the following areas (select all that apply):

Lip □ Chin □ Sideburns □ Neck □ Chest Lower □ Abdomen □ Inner Thighs □ Buttocks □ Back □

a) How do you treat it? Shaving □ Plucking □ Medication □ Other □

If other, please specify: _____

3) Do you have problems with acne? Yes □ No □

a) Please indicate where: _____

4) Have you previously used birth control? Yes □ No □

a) Please indicate which form of birth control you have used (select all that apply):

Birth Control Pill □ IUD □ Other □

If other, please specify: _____

b) How long did you use birth control for? _____

c) When did you stop using birth control? _____

5) Do you have a history of endometriosis? Yes □ No □

6) Pap smears:

a) When was your last Pap smear? _____

b) What was the result? _____

c) Have you ever had an abnormal Pap smear result? Yes □ No □

i) When? _____

ii) Did you receive any treatment? Yes □ No □

If yes, please specify _____

d) Have you had normal pap smears since then? Yes □ No □

7) Do you have a history of Pelvic Inflammatory Disease? Yes □ No □

8) Do you have a history of sexually transmitted diseases? (Select all that apply)

Herpes □ Gonorrhea □ Chlamydia □ other □

If other, please specify: _____

a) Were you treated? Yes □ No □

If yes, please specify: _____

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b) If you had a partner at the time, was your partner treated? Yes □ No □ N/A □
If yes, please specify: _____

SECTION FIVE: PREGNANCY HISTORY

	Year	Current Partner?	Time taken to become pregnant	Miscarriage/ Therapeutic Abortion	Ectopic- Treatment (surgical or medical)	Weeks of Pregnancy	Live Births
1							
2							
3							
4							
5							

Were there any difficulties becoming pregnant with any of these pregnancies? Yes □ No □
If yes, please specify:
_____

SECTION SIX: MEDICAL HISTORY

1) Do you have any history of the following medical illnesses or diseases?

Illness or Disease	Not applicable	Admission to Hospital (Yes or No)	Medications	Treatments
Diabetes				
Thyroid Disease				
Asthma				
Cancer				
Epilepsy				
Other				

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2) Have you ever been diagnosed with a mental illness? Yes □ No □

a) If yes, please specify: _____

b) Have you ever been diagnosed with depression? Yes □ No □

3) What prescription(s) do you take regularly?

_____

4) Do you take a folic acid or a prenatal vitamin? Yes □ No □

If yes please specify: _____

5) What medications do you take occasionally?

_____

6) Do you take any herbal or natural products? Yes □ No □

If yes, please specify:

_____

7) Do you have an allergy to latex? Yes □ No □

8) Do you have any allergies to medications? Yes □ No □

If yes, please specify:

_____

a) What happens when you take these medications?

_____

9) Do you have any other allergies? Yes □ No □

If yes, please specify:

_____

10) Do you currently smoke? Yes □ No □

If yes, how many cigarettes/packs per day? _____

Have you ever smoked? Yes □ No □

If yes, when did you quit? _____

11) Do you drink alcohol? Yes □ No □

If yes, how many drinks per week? _____

12) Do you take any street drugs? Yes □ No □

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If yes, please specify: _____

a) How often do you use? _____

13) Have you been vaccinated for Hepatitis B in the past? Yes □ No □

If yes, when were you vaccinated? _____

SECTION SEVEN: SURGICAL HISTORY

1) Have you ever had any problems with anesthesia? Yes □ No □

If yes, please specify: _____

2) Please list any surgeries you have had:

Year	Type of Surgery	Which physician performed the surgery?	What were the findings?

SECTION EIGHT: SOCIAL HISTORY

1) Are you currently in a relationship? Yes □ No □

a) Number of years in current relationship? _____

2) What is your occupation? _____

a) Are you exposed to hard chemicals in your job? Yes □ No □

If yes, please specify: _____

b) What type of exposure (skin, breathing, etc.) _____

c) Does your job involve heavy lifting? Yes □ No □

If yes, please specify: _____

3) Where do you live? Urban □ Rural □

4) What is your source of drinking water? _____

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SECTION NINE: FAMILY HISTORY

1) Is there a family history of any of the following?

	Yes	No	Relationship	Please Provide Details
Breast Cancer				
Ovarian Cancer				
Bowel Cancer				
Other Cancers				
Endometriosis				
Stillbirths				
Neural Tube Defect				
Intellectual Disabilities				
Childhood Death				
Recurrent Pregnancy Loss				
Genetic (chromosome) Abnormalities				
Others - Please specify				

2) What is your family's origin/ethnic background?

_____

_____