Ontario Network of Experts in Fertility
life through knowledge

Affiliated with McMaster University

ONE FERTILITY KITCHENER WATERLOO
4271 King St E., Suite 200
KITCHENER, Ontario N2P 2X7
P 519-650-0011 **F** 519-650-0033
www.onefertilitykw.com

FERTILITY SERVICES PERSONAL HISTORY

Date:	Primary Contact Number:
Age:	
Height:	Secondary Contact Number:
Weight:	
Email Address:	
Sex/Gender: Male □ Female □	
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: GYNECOLOGIC HISTORY

Section A: General Gynecological History

If not applicable due to sex and/or gender, please check not applicable and skip to section B.

Not Applicable □

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? _____

Ontario Network of Experts in Fertility
life through knowledge

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: _____

b) If you have a partner, was your partner treated? Yes □ No □

If yes, please specify: _____

Ontario Network of Experts in Fertility
life through knowledge

SECTION B: UROLOGIC HISTORY

If not applicable due to sex and/or gender, please check not applicable and skip to section C.

Not Applicable □

1) Have you previously had a semen analysis completed? Yes □ No □

If yes,

a) When was it complete? _____

b) Where was it done? _____

c) What was the result? _____

2) Any children or pregnancies in a previous relationship? Yes □ No □

a) What was the pregnancy outcome (I.E. healthy child?) _____

3) Do you have any history of injuries to the penis or scrotum? Yes □ No □

If yes, please specify:

_____

4) Have you had surgery for any of the following?

a) Hernia repair? Yes □ No □

b) Varicocele? Yes □ No □

c) Have you had a vasectomy? Yes □ No □

If yes, please specify when and which physician: -

_____

d) Have you had a vasectomy reversal? Yes □ No □

If yes, please specify when and which physician:

_____

e) Please list any other surgeries you've had previously:

_____

_____

_____

_____

SECTION C: MENSTRUAL HISTORY

If not applicable due to sex and/or gender, please check here and skip to section two.

Not Applicable □

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

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

Ontario Network of Experts in Fertility
life through knowledge

3) What is the average number of days from the start of one period to the start of the following period? ____ days.

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

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

SECTION D: PREVIOUS INFERTILITY INVESTIGATIONS AND TREATMENTS

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

a) Where was the test done? _____

b) When was the test done? _____

c) What were the results?

i) Tubes open? Yes □ No □

ii) Normal Uterus? Yes □ No □

2) Have you had a Sonohysterogram test done? Yes □ No □

a) Where was the test done? _____

b) When was the test done? _____

c) What were the results?

i) Tubes open? Yes □ No □

ii) Normal exam? Yes □ No □

Ontario Network of Experts in Fertility
life through knowledge

3) Have you had any surgeries related to infertility investigations? Yes □ No □

a) Have you had a laparoscopy? Yes □ No □

i) If yes, when and where was it done? _____

ii) What did the test show? _____

b) Have you had a hysteroscopy? Yes □ No □

i) If yes, When and where was it done? _____

ii) What did the test show? _____

4) 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? _____

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 □

b) Have you previously used injectable medications? (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 you previously done In-Vitro Fertilization (IVF)?

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 □

Ontario Network of Experts in Fertility
life through knowledge

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

Yes □ No □ If yes, please specify:

_____

_____

_____

v) Did any pregnancies occur? Yes □ No □

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

_____

_____

_____

SECTION TWO: HOROMONES FOR GENDER/SEX TRANSITIONING

If not applicable due to sex and/or gender, please check here and skip to section three.

Not Applicable □

1) Are you currently taking hormones for gender or sex transitioning purposes?

If yes, please specify type and duration: _____

2) Have you used transitioning hormones in the past? Yes □ No □

If yes, a) Please specify type and duration: _____

b) Did you experience any complications?

_____

_____

_____

3) What types, if any, sex reassignment surgeries have you had?

_____

_____

_____

4) What types, if any, other feminizing or masculinizing procedures have you had?

_____

_____

_____

Ontario Network of Experts in Fertility
life through knowledge

5) What types, if any, complications have you experienced following such surgeries and/or procedures?

_____

_____

_____

6) What concerns or questions, if any, do you have regarding gender/sex transitioning?

_____

_____

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 □

SECTION FOUR: PREGNANCY HISTORY

If not applicable due to sex and/or gender, please check here and skip to section five.

Not Applicable □

	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							

Ontario Network of Experts in Fertility
life through knowledge

Were there any difficulties becoming pregnant with any of these pregnancies? Yes □ No □

If yes, please specify:

_____

_____

SECTION FIVE: 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				
Heart Disease or Murmur				
Cancer				
Epilepsy				
Other				

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 □

Ontario Network of Experts in Fertility
life through knowledge

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 any allergies?

a) To medications? Yes □ No □

If yes, please specify:

_____

_____

b) What happens when you take this medication?

_____

_____

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

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

If yes, please specify:

_____

_____

9) Do you currently smoke? Yes □ No □

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

a) Have you ever smoked? Yes □ No □

i) When did you quit? _____

Ontario Network of Experts in Fertility
life through knowledge

10) Do you drink alcohol? Yes □ No □

If yes, how many drinks per week? _____

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

If yes, please specify: _____

a) How often do you use? _____

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

If yes, when were you vaccinated? _____

SECTION SIX: 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 SEVEN: SOCIAL HISTORY

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

a) Number of years in current relationship? _____

Ontario Network of Experts in Fertility
life through knowledge

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? _____

SECTION EIGHT: FAMILY HISTORY

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

	Yes	No	Who	Please Provide Details
Breast Cancer				
Ovarian Cancer				
Bowel Cancer				
Other Cancers				
Endometriosis				
Stillbirths				

Continued Next Page

	Yes	No	Who	Please Provide Details
Neural Tube Defect				
Intellectual Disability				
Childhood Death				
Genetic (chromosome) Abnormalities				
Any others-please specify				

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

_____

_____

TO BE COMPLETE BY HEALTH CARE PROVIDER

Physical Examination:

_____

_____

_____

_____

Summary:

_____

_____

_____

_____

Ontario Network of Experts in Fertility
life through knowledge

Concerns:

1) _____

2) _____

3) _____

4) _____

Discussion Topics:

_____

_____

_____

_____

PLAN

Test	Please check if test ordered	Requisitions Given
1) Day 3 FSH, LH, Estradiol, Prolactin, TSH		
2) AMH		
3) CBC, Rubella, PN Blood Screens		
4) Infection Diseases Screen		
5)Cervical Cultures		
6) HSG		
7) Pelvic Ultrasound		
8) Sonohysterogram		
9)PCOS Screen-without 2 hour 75gm GTT with 2 hours insulin and 2 hour GTT		
10) Genetic Screen i) Cystic Fibrosis ii) Other Genetic Screens Ordered	i) ii)	i) ii)

Physician signature: _____

Dictation Number: _____

Letters sent to: _____

Ontario Network of Experts in Fertility
life through knowledge

Fertility Investigations

Before you leave today:

Please proceed to reception for

☐ **1. AMH (for females only)**
- To be done at our clinic
- A fee of **$85**
- Results may take up to 4 weeks to come back

☐ **2. Book appointment for Sperm Function Test (for males only)**
- To be done at our clinic (Monday-Thursday) by appointment only
- A fee of **$200** will be due on the day of the appointment
- Please refer to the sperm function test information sheet

****Abstain from sexual activity/ejaculation for minimum of 2 days, but no longer than 7 days, prior to appt****

☐ **3. Book appointment for Fertility Group Session (for both partners)**
- Discussion on natural method to enhance your fertility
- Discussion on common fertility diagnoses and treatment options
- Discuss strategies for coping with stress of infertility
- Discuss any questions you may have

☐ **4. Book a Follow-up Review Appointment (for both partners)**
- Please schedule a review appointment for **4-6 weeks** from now, for both partners to attend, to review results, diagnosis and discuss next steps

☐ **5. Others:**
- _____
_____

In the next few days:

Go to your nearest laboratory (LifeLabs, Dynacare etc.) for blood and/or urine tests:

☐ **1. Infectious Disease Screening Bloodwork (for both partners)**
- Results can take up to 4 weeks to be returned to our office

☐ **2. Fasting Bloodwork (for females only)**
- Nothing to eat or drink, except water, for 8-12 hrs prior to blood draw

☐ **3. Other Tests:**
- _____
_____

On the first day of your next menstrual period (cycle day 1):

*Call our reception **(519) 650-0011** to book an appointment for*

☐ **1. Cycle Day 3 Bloodwork & Full Bladder Ultrasound**
- To be done at our clinic. Please drink 3 glasses of water 1hr prior to appt.

☐ **2. Sonohysterogram (SONO)**
- To be done at our clinic between day 5-12 of your cycle. Reception will let you know when
- Please review SONO information sheet

☐ **3. Diagnostic Cycle Monitoring**
- Results can take up to 4 weeks to be returned to our office
- Usually done on Day 10, 12 and 14 and monitored up until ovulation occurs
- You will see the nurse after each visit for further instruction

☐ **4. Others:**
- _____
_____

**** All results will be discussed at your next follow-up appointment ****

Please contact us with any questions at (519) 650-0011