

# FERTILITY EVALUATION FORM

FILL IN COMPLETELY – Please Print

Date: \_\_\_\_\_

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## PERSONAL MEDICAL HISTORY – FEMALE

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Name on OHIP card: \_\_\_\_\_

Health Card Number: \_\_\_\_\_ Letters: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ (mm/dd/yy) Age: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone: Home ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_

Occupation: \_\_\_\_\_

Partner's Name: \_\_\_\_\_

Name of Referring M.D.: \_\_\_\_\_ Telephone( ) \_\_\_\_\_

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Height \_\_\_\_\_ Weight \_\_\_\_\_

Major Health Problem? NO • YES •

Describe \_\_\_\_\_

Are you taking any medication? NO • YES •

Describe \_\_\_\_\_

PID (Pelvic Inflammatory Disease) NO • YES •

STI (Sexually Transmitted Infections) NO • YES •

Date (s) and

Treatment \_\_\_\_\_

\_\_\_\_\_ Admitted to Hospital? NO • YES •

BirthControl: \_\_\_\_\_

High Blood Pressure: NO • YES •

Diabetes: NO • YES •

Caffeine use: NO • YES •

Tobacco use: NO • YES •

Packs per day? \_\_\_\_\_ How many years? \_\_\_\_\_

Alcohol use: NO • YES • How much? \_\_\_\_\_

Street Drug use: NO • YES • What/How much? \_\_\_\_\_

Allergies: NO • YES • List: \_\_\_\_\_

Illnesses/Surgeries: \_\_\_\_\_

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**REPRODUCTIVE HISTORY – FEMALE**

Do you know the cause of you infertility? NO • YES •

Describe? \_\_\_\_\_

First day of last period? (D/M/Y) \_\_\_\_\_

Age at onset of menstruation \_\_\_\_\_ Periods regular? NO • YES •

Number of days between periods \_\_\_\_\_ Number of days of flow \_\_\_\_\_

Painful periods? NO • YES •

Painful Intercourse? NO • YES •

Frequency of Intercourse \_\_\_\_\_ Lubrication? \_\_\_\_\_

Previous Pregnancies/Miscarriages/Therapeutic Abortions:

\_\_\_\_\_  
\_\_\_\_\_

How many times have you been pregnant? \_\_\_\_\_

Last Pap Date \_\_\_\_\_ Result was normal? YES • NO •

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Marital Status \_\_\_\_\_ Duration of Relationship \_\_\_\_\_

Duration of Infertility \_\_\_\_\_

Have you had previous treatment? NO • YES •

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**PREVIOUS DIAGNOSTIC TESTS**

Basal Body Temperatures NO • YES •

Laparoscopy NO • YES •

Post-coital Test NO • YES •

Endometrial Biopsy NO • YES •

Use of Ovulation Kit NO • YES •

HSG (Tubal Patency) NO • YES •

Hormone Profile:

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**IMMEDIATE FAMILY MEDICAL HISTORY**

Diabetes: NO • YES •

Endometriosis: NO • YES •

Cancer: NO • YES •

High Blood Pressure: NO • YES •

Heart Disease: NO • YES •

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**PERSONAL MEDICAL HISTORY – MALE**

Male Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Name on OHIP card: \_\_\_\_\_

Health Card Number: \_\_\_\_\_ Letters: \_\_\_\_\_ Date of Birth:

\_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_ Partner's Name: \_\_\_\_\_

Major Health Problem? NO • YES •

Describe \_\_\_\_\_

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**REPRODUCTIVE HISTORY -MALE**

Semen analysis – Date \_\_\_\_\_

Result \_\_\_\_\_

History of Sexually Transmitted Infections: NO • YES • Date (s) and

Treatment \_\_\_\_\_

\_\_\_\_\_ Admitted to Hospital? NO • YES •

Undescended Testicles: NO • YES •

Tobacco Use: NO • YES •

Caffeine Use: NO • YES •

Exposure to Chemicals/Radiation: NO • YES •

Mumps: NO • YES • When? \_\_\_\_\_

Trauma to Testicles: NO • YES •

Difficulty with Erection or Urination NO • YES •

Masturbation NO • YES •

Do you have any children from a previous relationship? NO • YES •

Female Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Male Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**\*\*\*THIS FORM MUST BE SIGNED & DATED FOR IT TO BE COMPLETE\*\*\***