

# FERTILITY HISTORY 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

Birth Control: \_\_\_\_\_

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 your 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\*\*\***