

FEMALE INFORMATION

Name: _____	Birth date: _____	Age: _____
Occupation: _____	Race: _____	<input type="checkbox"/> Married <input type="checkbox"/> Single
Height: _____ ft _____ inches	Total number pregnancies: _____	Pre-term births: _____
Weight: _____ pounds	Term births: _____	Miscarriages/Abortions: _____
		Ectopic: _____

How long have you been trying to achieve a pregnancy? _____ months of unprotected intercourse

How long have you been trying to achieve a pregnancy with current partner? _____ months

PREGNANCY INFORMATION

Date (Mo/Yr)	Gender	Current Partner?	Months to Conception	Difficulty Conceiving?	Fertility Treatment?	Outcome	Delivery Type
_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what treatment? _____	<input type="checkbox"/> Term <input type="checkbox"/> Pre-Term <input type="checkbox"/> Ectopic <input type="checkbox"/> Abortion <input type="checkbox"/> Miscarriage <input type="checkbox"/> Living	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section <input type="checkbox"/> Other: _____
_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what treatment? _____	<input type="checkbox"/> Term <input type="checkbox"/> Pre-Term <input type="checkbox"/> Ectopic <input type="checkbox"/> Abortion <input type="checkbox"/> Miscarriage <input type="checkbox"/> Living	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section <input type="checkbox"/> Other: _____
_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what treatment? _____	<input type="checkbox"/> Term <input type="checkbox"/> Pre-Term <input type="checkbox"/> Ectopic <input type="checkbox"/> Abortion <input type="checkbox"/> Miscarriage <input type="checkbox"/> Living	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section <input type="checkbox"/> Other: _____
_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what treatment? _____	<input type="checkbox"/> Term <input type="checkbox"/> Pre-Term <input type="checkbox"/> Ectopic <input type="checkbox"/> Abortion <input type="checkbox"/> Miscarriage <input type="checkbox"/> Living	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section <input type="checkbox"/> Other: _____

Please check here, if you have had more than four pregnancies.

MENSTRUAL CYCLE HISTORY

(Answer these questions about your menstrual (bleeding) pattern).

At what age did you begin having periods? _____ years old

When was the date of your last menstrual period? _____ mm/dd/yyyy

What is the average length of time your period lasts? _____ days of flow

What is the average length of time from the start of one period until the start of the next? _____ days

Within the last year, have your periods *usually* come (without medication) every 26-32 days? Yes No

If no, have your periods always been irregular? Yes No

Do you ever have bleeding in between periods? Yes No

Do you currently need to take medication in order to get a period? Yes No

If yes, please check all that apply:

Premarin Estrace Birth Control Pills

Progesterone (if Progesterone, please specify type, below)

Provera Cycrin Aygestin Crinone Prometrium Other: _____

Do you have pelvic pain with your periods? Yes No

If yes, please indicate the level of pain that you usually experience:

Mild Moderate Severe

Do you often experience pelvic pain in between periods? Yes No

If yes, do you take medication for pain? Yes No

If yes, which one(s)? _____

If yes, does the medication relieve pain? Yes No

Have you ever used home ovulation predictor kits? Yes No
 If yes, what evidence for ovulation did you see? (A positive test Color change Other: _____
 If yes, what day or range of days does it turn positive on? _____ (Example: Day 14-15)

Have you ever used any contraceptives? Yes No
 If yes, please check all that apply:
 Birth Control Pills Injectable Hormones Hormone patch
 Intrauterine device (IUD) Tubal Ligation (Tubes tied) Other: _____

Are you currently using any contraceptives? Yes No
 If yes, please check all that apply:
 Birth Control Pills Injectable Hormones Hormone patch
 Intrauterine device (IUD) Tubal Ligation (Tubes tied) Other: _____

GYNECOLOGIC HISTORY

Is your pap smear current? Yes No
 If not, when was the last pap done? _____ mm/dd/yyyy

Have you ever had an abnormal pap? Yes No
 If yes, what was the abnormality? _____

Is your mammogram current? Yes No
 If not, when the last mammogram was done? _____ mm/dd/yyyy

Do you have any breast discharge? Yes No

Do you currently have acne? Yes No

Do you have unwanted (facial, arm, chest, or other male pattern) hair growth that requires cosmetic removal? Yes No

What is your sexual orientation?
 Heterosexual Homosexual Never been sexually active

What is the number of sexual partners you have had in the past 2 years? _____

Do you have a history of sexual abuse? Yes No
 If yes, have you received counseling? Yes No
 Would you like us to make a referral for counseling? Yes No

Do you often have pain with intercourse? Yes No

How frequently do you have intercourse? _____ per week

Have you ever had any of the following procedures performed?

If yes, please check all that apply:

Procedure	Date (Mo/Yr)	Findings	Procedure	Date (Mo/Yr)
<input type="checkbox"/> Colposcopy	_____		<input type="checkbox"/> Cryosurgery	_____
<input type="checkbox"/> Cone Biopsy	_____		<input type="checkbox"/> Laser treatment	_____
<input type="checkbox"/> LEEP procedure	_____			

Have you had any exposure to or have been treated for any sexually transmitted disease or pelvic infection? Yes No

If yes, please check all that apply:

- Gonorrhea Chlamydia Herpes
 Syphilis HIV/AIDS HPV (Human Papilloma Virus)

MEDICAL HISTORY

What is your blood type? _____

Do you have long-standing medical conditions? Yes No

If yes, please list:

	Medical Condition	Comments/Findings
1		
2		
3		
4		
5		

Please check here, if you have more than five medical conditions.

Have you ever needed or used thyroid medication? Yes No

If yes, please check all that apply:

Synthroid Levoxyl Other: _____

Are you currently taking any medication? Yes No

If yes, please list:

	Medications	Reason / Comments
1		
2		
3		
4		
5		

Please check here, if you are taking more than five medications.

Have you had the following vaccinations? Yes No

If yes, please check all that apply:

	Vaccination	Date (Mo/Yr)		Vaccination	Date (Mo/Yr)
<input type="checkbox"/>	Measles	_____	<input type="checkbox"/>	Tuberculosis	_____
<input type="checkbox"/>	German Measles (Rubella)	_____	<input type="checkbox"/>	Polio	_____
<input type="checkbox"/>	Hepatitis A	_____	<input type="checkbox"/>	Tetanus	_____
<input type="checkbox"/>	Hepatitis B	_____	<input type="checkbox"/>	Influenza	_____
<input type="checkbox"/>	Chickenpox (Varicella)	_____			

Are you allergic to or have had any adverse reaction to any drugs? Yes No

If yes, please list:

	Medications	Reaction / Comments
1		
2		
3		
4		
5		

Please check here, if you are allergic to or have adverse reaction to more than five medications.

Have you had any surgeries? Yes No

If yes, please list:

	(Mo/Yr)	Indication	Surgery	Findings	Complications
1	_____				<input type="checkbox"/> Yes <input type="checkbox"/> No
2	_____				<input type="checkbox"/> Yes <input type="checkbox"/> No
3	_____				<input type="checkbox"/> Yes <input type="checkbox"/> No
4	_____				<input type="checkbox"/> Yes <input type="checkbox"/> No
5	_____				<input type="checkbox"/> Yes <input type="checkbox"/> No

Please check here, if you have had more than five surgeries.

Have you ever been diagnosed with HIV? Yes No

ENVIRONMENTAL FACTORS

Do you smoke? Yes No

If yes, how much? _____ (# of cigarettes/day)

Have you ever smoked? Yes No

If yes, how much? _____ (# of cigarettes/day) when did you quit? _____ (Mo/Yr)

Do you drink alcohol? Yes No

If yes, how would you describe your drinking habits?

- Socially _____ drinks / week
- Daily _____ drinks / day
- Alcoholic _____ drinks / _____ (how often?)

Do you have alcohol dependence? Yes No

Do you consume caffeinated beverages? Yes No

If yes, how much? 1-2 per day 3-4 per day More than 5 per day

Do you currently use "recreational" drugs? Yes No

If yes, what? _____

Do you use herbal remedies or medications? Yes No

If yes, how much per day? _____

Do you engage in long distance running or similar strenuous exercise? Yes No

If yes, how much (often) per week? _____

GENETIC / FAMILY HISTORY

Do you or anyone in your family have any of the following medical conditions? Yes No

If yes, please check all that apply

Medical Condition	Self	Mother	Father	Brother	Sister	Child	Grand Mother	Grand Father
Early menopause (before age 45)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infertility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent Miscarriage / Pregnancy loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Retardation - Chromosomal Testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Retardation - Testing for Fragile X Mutation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Birth Defects - Chromosomal testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delayed puberty or pituitary tumor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cervical Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uterine Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chromosome Disorder (e.g. Down's Syndrome)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Huntington's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Polycystic Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurofibromatosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marfan Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have a birth defect or familial disorder not listed above? Yes No

If yes, Please describe? _____

What is your mother's ancestry? _____

What is your father's ancestry? _____

Have you or your significant other in this or any previous relationship had a stillborn child or more than two first trimester miscarriages? Yes No

Eastern European /Jewish Acedstry

Have you had Tay Sach's screening tests? Yes No

If yes, when? _____ (Mo/Yr). What were the findings? Normal Abnormal: _____

Have you had a Canavan Screening Test? Yes No

If yes, when? _____ (Mo/Yr). What were the findings? Normal Abnormal: _____

Have you had Bloom Screening Test? Yes No
 If yes, when? _____ (Mo/Yr). What were the findings? Normal Abnormal: _____

Have you had Gaucher Screening Test? Yes No
 If yes, when? _____ (Mo/Yr). What were the findings? Normal Abnormal: _____

Have you had Fanconi Anemia Screening Test? Yes No
 If yes, when? _____ (Mo/Yr). What were the findings? Normal Abnormal: _____

Have you had Neimman-Pick Screening Test? Yes No
 If yes, when? _____ (Mo/Yr). What were the findings? Normal Abnormal: _____

African Ancestry

Have you had Sickle cell screening tests? Yes No
 If yes, when? _____ (Mo/Yr). What were the findings? Normal Abnormal: _____

European Ancestry or Family member with cystic fibrosis

Have you been tested for Cystic fibrosis? Yes No
 If yes, when? _____ (Mo/Yr). What were the findings? Normal Abnormal: _____

Italian, Greek, Mediterranean or Southeast Asian Ancestry

Have you had screening for inherited forms of anemia such as thalassemia? Yes No
 If yes, when? _____ (Mo/Yr). What were the findings? Normal Abnormal: _____

INFERTILITY TESTS

Have you had any of the following fertility tests in the past?

Ultrasound of the uterus and/or ovaries when NOT pregnant?
 If yes, when? _____ (Mo/Yr). What were the findings? Normal Abnormal: _____

Hysterosalpingogram (HSG)? An x-ray test of the uterus and tubes during which dye is injected into the uterus to "see" it
 If yes, what were the findings? Normal uterus Abnormal uterus
 Both tubes open One tube blocked Both tubes blocked
 Other: _____

Hysterosonogram (also called sonohysterogram)? An ultrasound test in which saline (salt water) is injected and an ultrasound is used to "see" the uterus.
 If yes, what were the findings? Normal uterine cavity Abnormal uterine cavity: _____

Laparoscopy? A telescope is placed through the belly button to see inside your abdomen

Date (Mo/Yr)	Indication	Surgery	Findings	Complications
_____				<input type="checkbox"/> Yes <input type="checkbox"/> No
_____				<input type="checkbox"/> Yes <input type="checkbox"/> No
_____				<input type="checkbox"/> Yes <input type="checkbox"/> No

Please check here, if you have had more than three Laparoscopy tests.

Hysteroscopy? A telescope is placed through the vagina into the uterus in order to see the inside of the uterus.

Date (Mo/Yr)	Indication	Surgery	Findings	Complications
_____				<input type="checkbox"/> Yes <input type="checkbox"/> No
_____				<input type="checkbox"/> Yes <input type="checkbox"/> No
_____				<input type="checkbox"/> Yes <input type="checkbox"/> No

Please check here, if you have had more than three Hysteroscopy tests.

Other tests to specifically look at possible causes of infertility, miscarriage, or problems with menstrual cycle?

	Test	Date (Mo/Yr)	Results
<input type="checkbox"/>	Day 3 FSH	_____	
<input type="checkbox"/>	CCCT - Day 3 FSH	_____	
<input type="checkbox"/>	CCCT - Day 10 FSH	_____	

	Test	Date (Mo/Yr)	Results
<input type="checkbox"/>	Semen Analysis (Partner)	_____	
<input type="checkbox"/>	Blood Test to verify ovulation	_____	
<input type="checkbox"/>	Basal Body Temperature Chart (BBT)	_____	
<input type="checkbox"/>	Endometrial Biopsy	_____	
<input type="checkbox"/>	Inhibin	_____	
<input type="checkbox"/>	Post Coital Test	_____	
<input type="checkbox"/>	Anti-sperm antibodies (Female)	_____	
<input type="checkbox"/>	Chromosome Analysis (Karyotype) - Female	_____	
<input type="checkbox"/>	Chromosome Analysis (Karyotype) - Male Partner	_____	
<input type="checkbox"/>	Anti-Phospholipid Antibodies	_____	
<input type="checkbox"/>	Lupus-Anticoagulant	_____	
<input type="checkbox"/>	TSH	_____	
<input type="checkbox"/>	Prolactin	_____	
<input type="checkbox"/>	LH	_____	
<input type="checkbox"/>	Progesterone	_____	
<input type="checkbox"/>	Other	_____	

PAST FERTILITY TREATMENTS

Have you ever had any **Clomiphene citrate (Clomid, Serophene)** cycle? Yes No

If yes, please list the last four (most recent) information below:

Mo/Yr	Dose	Monitoring	Method of Sperm Delivery	Complications	Outcome?	Delivery Type?
	1 pill = 50 mg 2 pills = 100 mg	Sono= ultrasound	IUI = insemination or placement of sperm into the uterus	Please explain	OHSS = Ovarian Hyperstimulation Syndrome	
_____	_____ mg	<input type="checkbox"/> None <input type="checkbox"/> Ovulation kit <input type="checkbox"/> Blood/Sono	<input type="checkbox"/> Intercourse <input type="checkbox"/> IUI		<input type="checkbox"/> Pregnancy <input type="checkbox"/> No ovulation <input type="checkbox"/> No pregnancy <input type="checkbox"/> OHSS <input type="checkbox"/> Birth Defect/ Abortion <input type="checkbox"/> Miscarriage <20 wks	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section <input type="checkbox"/> Other: _____
_____	_____ mg	<input type="checkbox"/> None <input type="checkbox"/> Ovulation kit <input type="checkbox"/> Blood/Sono	<input type="checkbox"/> Intercourse <input type="checkbox"/> IUI		<input type="checkbox"/> Pregnancy <input type="checkbox"/> No ovulation <input type="checkbox"/> No pregnancy <input type="checkbox"/> OHSS <input type="checkbox"/> Birth Defect/ Abortion <input type="checkbox"/> Miscarriage <20 wks	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section <input type="checkbox"/> Other: _____
_____	_____ mg	<input type="checkbox"/> None <input type="checkbox"/> Ovulation kit <input type="checkbox"/> Blood/Sono	<input type="checkbox"/> Intercourse <input type="checkbox"/> IUI		<input type="checkbox"/> Pregnancy <input type="checkbox"/> No ovulation <input type="checkbox"/> No pregnancy <input type="checkbox"/> OHSS <input type="checkbox"/> Birth Defect/ Abortion <input type="checkbox"/> Miscarriage <20 wks	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section <input type="checkbox"/> Other: _____
_____	_____ mg	<input type="checkbox"/> None <input type="checkbox"/> Ovulation kit <input type="checkbox"/> Blood/Sono	<input type="checkbox"/> Intercourse <input type="checkbox"/> IUI		<input type="checkbox"/> Pregnancy <input type="checkbox"/> No ovulation <input type="checkbox"/> No pregnancy <input type="checkbox"/> OHSS <input type="checkbox"/> Birth Defect/ Abortion <input type="checkbox"/> Miscarriage <20 wks	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section <input type="checkbox"/> Other: _____

Please check here, if you have had more than four Clomiphene cycles.

Have you ever had any **Gonadotropins** (Pergonal, Metrodin, Repronex, Humegon, Fertinex, Gonal-F, Follistim, Cetrotide, Antagon, Lupron) cycle? Yes No

If yes, please list the last three (most recent) Gonadotropin cycles information below:

Mo/Yr	Dose (Amps/Vials per day)	Medication	No. of days	Method of Sperm Delivery	Complications	Outcome?	Delivery Type?
_____	_____	_____	_____	<input type="checkbox"/> Intercourse <input type="checkbox"/> IUI		<input type="checkbox"/> Pregnancy <input type="checkbox"/> No ovulation <input type="checkbox"/> No pregnancy <input type="checkbox"/> OHSS <input type="checkbox"/> Birth Defect/ Abortion <input type="checkbox"/> Miscarriage <20 wks	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section <input type="checkbox"/> Other: _____
_____	_____	_____	_____	<input type="checkbox"/> Intercourse <input type="checkbox"/> IUI		<input type="checkbox"/> Pregnancy <input type="checkbox"/> No ovulation <input type="checkbox"/> No pregnancy <input type="checkbox"/> OHSS <input type="checkbox"/> Birth Defect/ Abortion <input type="checkbox"/> Miscarriage <20 wks	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section <input type="checkbox"/> Other: _____
_____	_____	_____	_____	<input type="checkbox"/> Intercourse <input type="checkbox"/> IUI		<input type="checkbox"/> Pregnancy <input type="checkbox"/> No ovulation <input type="checkbox"/> No pregnancy <input type="checkbox"/> OHSS <input type="checkbox"/> Birth Defect/ Abortion <input type="checkbox"/> Miscarriage <20 wks	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section <input type="checkbox"/> Other: _____
_____	_____	_____	_____	<input type="checkbox"/> Intercourse <input type="checkbox"/> IUI		<input type="checkbox"/> Pregnancy <input type="checkbox"/> No ovulation <input type="checkbox"/> No pregnancy <input type="checkbox"/> OHSS <input type="checkbox"/> Birth Defect/ Abortion <input type="checkbox"/> Miscarriage <20 wks	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section <input type="checkbox"/> Other: _____

Please check here, if you have had more than four Gonadotropins cycles.

Have you ever had any **In-Vitro Fertilization (IVF)** cycle? Yes No

If yes, please list the last three (most recent) IVF cycles information below:

Mo/Yr	Egg source	Medication	Dose (Amps/Vials per day)	ICSI?	No. Inseminated Eggs	Number fertilized of eggs	Transfer Day	Number of embryos transferred	Number frozen	Outcome?	Delivery Type?
_____	<input type="checkbox"/> Own <input type="checkbox"/> Donor	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____	_____	<input type="checkbox"/> Pregnancy <input type="checkbox"/> No ovulation <input type="checkbox"/> No pregnancy <input type="checkbox"/> OHSS <input type="checkbox"/> Birth Defect/ Abortion <input type="checkbox"/> Miscarriage <20 wks	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section <input type="checkbox"/> Other: _____
_____	<input type="checkbox"/> Own <input type="checkbox"/> Donor	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____	_____	<input type="checkbox"/> Pregnancy <input type="checkbox"/> No ovulation <input type="checkbox"/> No pregnancy <input type="checkbox"/> OHSS <input type="checkbox"/> Birth Defect/ Abortion <input type="checkbox"/> Miscarriage <20 wks	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section <input type="checkbox"/> Other: _____
_____	<input type="checkbox"/> Own <input type="checkbox"/> Donor	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____	_____	<input type="checkbox"/> Pregnancy <input type="checkbox"/> No ovulation <input type="checkbox"/> No pregnancy <input type="checkbox"/> OHSS <input type="checkbox"/> Birth Defect/ Abortion <input type="checkbox"/> Miscarriage <20 wks	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section <input type="checkbox"/> Other: _____
_____	<input type="checkbox"/> Own <input type="checkbox"/> Donor	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____	_____	<input type="checkbox"/> Pregnancy <input type="checkbox"/> No ovulation <input type="checkbox"/> No pregnancy <input type="checkbox"/> OHSS <input type="checkbox"/> Birth Defect/ Abortion <input type="checkbox"/> Miscarriage <20 wks	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section <input type="checkbox"/> Other: _____

Please check here, if you have had more than four Gonadotropins cycles.

Have you ever had any **Frozen Embryo** cycle? Yes No

If yes, please list the last three (most recent) Frozen Embryo cycles information below:

Mo/Yr	Natural or Medicated Cycle	Transfer Day	# Thawed	# Survived	# Transferred	Outcome?	Delivery Type?
_____	<input type="checkbox"/> Natural <input type="checkbox"/> Medicated	<input type="checkbox"/> 3 <input type="checkbox"/> 5	_____	_____	_____	<input type="checkbox"/> No ovulation <input type="checkbox"/> No pregnancy <input type="checkbox"/> OHSS <input type="checkbox"/> Birth Defect/ Abortion <input type="checkbox"/> Miscarriage <20 wks _	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section <input type="checkbox"/> Other: _____
_____	<input type="checkbox"/> Natural <input type="checkbox"/> Medicated	<input type="checkbox"/> 3 <input type="checkbox"/> 5	_____	_____	_____	<input type="checkbox"/> No ovulation <input type="checkbox"/> No pregnancy <input type="checkbox"/> OHSS <input type="checkbox"/> Birth Defect/ Abortion <input type="checkbox"/> Miscarriage <20 wks _	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section <input type="checkbox"/> Other: _____
_____	<input type="checkbox"/> Natural <input type="checkbox"/> Medicated	<input type="checkbox"/> 3 <input type="checkbox"/> 5	_____	_____	_____	<input type="checkbox"/> No ovulation <input type="checkbox"/> No pregnancy <input type="checkbox"/> OHSS <input type="checkbox"/> Birth Defect/ Abortion <input type="checkbox"/> Miscarriage <20 wks _	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section <input type="checkbox"/> Other: _____
_____	<input type="checkbox"/> Natural <input type="checkbox"/> Medicated	<input type="checkbox"/> 3 <input type="checkbox"/> 5	_____	_____	_____	<input type="checkbox"/> No ovulation <input type="checkbox"/> No pregnancy <input type="checkbox"/> OHSS <input type="checkbox"/> Birth Defect/ Abortion <input type="checkbox"/> Miscarriage <20 wks _	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section <input type="checkbox"/> Other: _____

Please check here, if you have had more than four Frozen Embryo cycles.

Have you ever had any **Gestational Surrogacy or Donor Egg Cycles**? Yes No

If yes, what was the indication: _____

Have you ever been an egg donor? Yes No