APPOINTMENT REQUEST FORM – DETAILED

Use this form to organize pertinent information. If submitted before the appointment, it may help us address your immediate concerns, avoid unnecessary repeat testing and quickly suggest a treatment strategy. If not, bring it filled out to your appointment with all the results from prior testing.  
\* = required field.

\***Female Patient** First Name:\_\_\_\_\_\_\_\_\_\_\_ Family Name:\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Date of Birth:\_\_/\_\_/\_\_\_\_

\***Male Partner** First Name:\_\_\_\_\_\_\_\_\_\_\_ Family Name:\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Date of Birth:\_\_/\_\_/\_\_\_\_

\* **Nationality** Female:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Telephone Daytime:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Were you referred to us by another physician?:** No Yes, his name is (optional):\_\_\_\_\_\_\_\_\_\_\_\_\_\_ from the city/town of:\_\_\_\_\_\_\_\_\_\_\_ and he is: Infertility specialist\General Ob&Gyn\Family or other

**What is the Reason for your appointment request**: Infertility investigation Infertilty counselling Infertility treatment Referral for IVF+ET Banking/Donation/Surrogacy PGD/PGS Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HISTORY and BACKGROUND – Female:**

How old are you?: \_\_\_\_\_\_\_\_\_ years.

Your Height is:\_\_\_\_\_ cm and your Weight:\_\_\_\_\_ kg.

How long have you been married or in the current relationship?: \_\_\_\_\_\_\_\_\_ years.

How long have you been trying to get pregnant?: \_\_\_\_\_ years \_\_\_\_\_ months.

How many times a month do you have intercourse?…….\_\_\_\_\_\_\_\_\_\_\_\_

**Gynecological history**

Number of days between menstrual periods……….……. \_\_\_\_\_\_\_days (typically 25-35 days)

How many days do you bleed during your period?.…… \_\_\_\_\_\_\_days (typically 3-6 days)

**Comments**

Do you have painful menses (dysmenorrhea)?: No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is intercourse often painful (dyspareunia)?: No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been diagnosed with endometriosis?: No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been diagnosed with PCOS (Polycystic ovaries)?: No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a pelvic infection (PID) or STD (Chlamydia, Mycoplasma, Gonorrhea)?: No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have discharge from your breasts? No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel you have excessive hair growth?: No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you experienced an eating disorder (anorexia / bulimia)?: No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous Pregnancies?:** No (skip to next question) Yes, how many?:\_\_\_\_\_\_\_

How many were as a result of infertility treatments?:\_\_\_\_\_\_\_\_\_\_\_\_

How many abortions?: \_\_\_\_\_\_\_\_ miscarriages, \_\_\_\_\_\_\_ terminations

Did you have any ectopic (extrauterine) pregnancies?: No Yes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many deliveries (births)?:\_\_\_\_\_\_\_\_ how many by Cesarean Section?:\_\_\_\_\_\_\_\_

Did you have any serious pregnancy/delivery complications?: No Yes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did any of your children have a congenital anomaly (birth defect)?: No Yes:\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous Infertility Investigations** – list any previous fertility tests

**Please bring to the appointment all the relevant documents!**

Basal body temperature (BBT)?: Yes No

Blood Progesterone Day-21 (ovulation detection)?: Yes No

Urine LH kit (Ovulation predictor)?: Yes No

Hysterosalpingogram (HSG) Yes No

Hysteroscopy?: Yes No

Laparoscopy?: Yes No

Endocrine tests (FSH/LH, Prolactin)?: Yes No

Thyroid function tests (FT4/TSH)?: Yes No

Semen analysis (current partner)?: Yes No

Chromosome study (Karyotype)?: Yes No

Comment on abnormal results:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any **previous fertility treatments**, including no of cycles:

**Please bring to the appointment all the relevant documents!**

Ovulatory drugs – tablets (Clomiphen: Clomid / Serophone)?: No Yes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ovulatory drugs – injections (Gonadatropins: Pergonal / Humegon/ Fertinex /Metrodin)?: No Yes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Intrauterine insemination (IUI)?: No Yes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In vitro fertilization (IVF) with/out Micromanipulation (ICSI)?: No Yes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgery (Removal of adhesions, Endometriosis, Myoma, septum…)?: No Yes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other?: No Yes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous Surgeries:**

Did you have a sterilization procedure?: No Yes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you have any gynecological operations (Cervical conization or Cautery, Removal of Fallopian tube/s for ectopic/disease, Removal of ovary or ovarian cyst/s)?: No Yes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you have any other surgery (operation)?: No Yes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical & Family history**

Have you ever been treated for Cancer (Chemotherapy, Irradiation) ?: No Yes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any other medical problems, unrelated to your fertility (Asthma, Diabetes, Hypertension, Epilepsy or other neurologic disorder, Depression/Anxiety or other psychiatric disorder, Thyroid or other endocrine disorder, Immunologic disorder)?: No Yes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any allergies to medications?: No Yes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take medications regularly?: No Yes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there anything remarkable in your Family and Genetic History (Cystic fibrosis, Tay-Sachs disease, Sickle-cell anemia, Thalassemia or other blood disorder, Structural/anatomic birth defect; Mental retardation, Chromosomal abnormality or genetic mutation)?: No Yes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social history**

Do you smoke, or have smoked, cigarettes?: No Yes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol more than occasionally?: No Yes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use any recreational drugs?: No Yes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your occupation?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and do you work?: full- / part- time or not regularly

Do you have any chemical exposures at work you are concerned about?: No Yes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Additional Information** (\_\_/\_\_/\_\_ =Date tested)

What is your blood type?\_\_\_\_\_\_\_\_ Rh: + / -

Cervical smear (PAP) \_\_/\_\_/\_\_ Normal Abnormal

Mammogram \_\_/\_\_/\_\_ Normal Abnormal

Rubella serology \_\_/\_\_/\_\_ Negative Positive

VDRL serology \_\_/\_\_/\_\_ Negative Positive

Chlamydia \_\_/\_\_/\_\_ Negative Positive

Hepatitis B/C \_\_/\_\_/\_\_ Negative Positive

HIV \_\_/\_\_/\_\_ Negative Positive

Karyotype \_\_/\_\_/\_\_ Normal Abnormal

Thalassemia trait \_\_/\_\_/\_\_ Negative Positive

**HISTORY and BACKGROUND – Male:**

How old are you?: \_\_\_\_\_\_\_\_\_ years.

Your Height is:\_\_\_\_\_ cm and your Weight:\_\_\_\_\_ kg.

How long have you been married or in the current relationship?: \_\_\_\_\_\_\_\_\_ years.

How many children/pregnancies do you have with the current partner?:\_\_\_\_\_\_\_\_

How many children/pregnancies do you have with previous partner(s)?:\_\_\_\_\_\_\_\_

How many times a month do you have intercourse?…….\_\_\_\_\_\_\_\_\_\_\_\_

**Comments**

Do you have any difficulties with your erection?: No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any difficulties with ejaculation?: No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any serious injuries to your genitals?: No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any STD (sexually transmitted infections of the penis, testicles, prostate)?: No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been diagnosed with an undescended testis?: No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been diagnosed with a varicocele?: No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any other problems with your genitals?: No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a semen analysis (sperm count) performed?: No Yes: once / more than once

If yes, was it Normal / Abnormal?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please bring to the appointment all the results of semen analysis!**

Did you have a Chromosome study (Karyotype)?: No Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comment on abnormal results:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous Surgeries:**

Did you have a sterilization procedure (Vasectomy)?: No Yes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you have any genital operations (Torsion/Hernia repair/Varicocele)?: No Yes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you have a testicular biopsy or SSR (Surgical sperm removal: TESE, PESA…)?: No Yes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you have any other surgery?: No Yes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical & Family history**

Have you ever been treated for Cancer (Chemotherapy, Irradiation) ?: No Yes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Social history**

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Do you drink alcohol more than occasionally?: No Yes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you frequently take saunas, steam baths or hot Jacuzzis?: No Yes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use any recreational drugs(i.e., Marijuana)?: No Yes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your occupation?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and do you work?: full- / part- time or not regularly

Do you have any chemical exposures at work you are concerned about?: No Yes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Additional Information** (\_\_/\_\_/\_\_ =Date tested)

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Hepatitis B/C \_\_/\_\_/\_\_ Negative Positive

HIV \_\_/\_\_/\_\_ Negative Positive

Karyotype \_\_/\_\_/\_\_ Normal Abnormal

Thalassemia trait \_\_/\_\_/\_\_ Negative Positive