EmpowHer's Infertility/Recurrent Miscarriage/Fertility Optimization Intake

Name: _____

DOB: _____

Date: _____

Social Hx:

Occupation: _____

Work Hours: _____

Preferred phone number: _____

Spouse/Partner

Full Name: _____

DOB : _____

Occupation: _____

Married? Y/ N

Preferred phone number: _____

Who referred you? Or how did you hear about us?

Name: _____

Number/ Address: _____

Primary physician: _____

Number/Address: _____

Reason for Visit:

☐ **Infertility**	☐ **Recurrent miscarriage**	☐ **Optimize Fertility**

Menstrual History

Age at first period: _____

Age when you first noticed:

Breast Development ____	Pubic Hair _____	Underarm Hair _____

Current menstrual cycle pattern: Regular _____ Irregular _____

(If irregular - circle all that apply:)

☐ <25 days	☐ >35 days	☐ No periods	☐ Heavy
☐ Light	☐ Bleeding after periods	☐ Bleeding after sex	☐

Number of days from start of one cycle to the start of the next	
How many periods do you have in a year?	
How many days of bleeding do you have?	
First date of last 2 menstrual cycles	_/_/___, _/_/____
Do you have menstrual cramps?	Yes __ No __ Occ __

Contraceptive History

Please circle all that apply and provide dates of use/procedure

Type	Dates
None	
Condoms	
IUD: Hormone ____ Paragard ____	
Birth Control Pills/Ring/Patch	
Injectables - Depo - Provera	
Nexplanon/Rod	

Spermacide / Phexxi	
Sterilization	
Other	

Sexual History

How many months have you had sex without birth control?		
How many times do you have sex per week?		
Have you used over-the-counter strips/kits to time intercourse?	Y	N
Do you have pain with sex?	Y	N
Do you use lubricants during intercourse? What type? _____	Y	N

Have you been treated/diagnosed with a STD? Check all that apply.

☐ Chlamydia	☐ Gonorrhea	☐ Herpes	☐ Hepatitis B
☐ PID	☐ HIV	☐ Syphilis	☐ Hepatitis C

Have you been diagnosed or treated with one of the following problems?

☐ Ovarian failure	☐ Fibroids	☐ Endometriosis
☐ Tubal disease	☐ Uterine polyps	☐ Adrenal Disease
☐ Pelvic Inflammatory Disease	☐ PCOS	☐ Thyroid disease
☐ Ovarian cyst	☐ Type of Cyst _____	☐ Other _____

Pap Smear History

When was your last pap smear?	____/_____/_____

Have you ever had an abnormal pap smear?	Y ___ N____
If yes, when was your last abnormal pap smear?	____/____/_____

Have you had any of the following treatments for abnormal pap smear?

☐ Colposcopy	☐ Cryosurgery	☐ Laser
☐ Conization	☐ LEEP	☐

Breast History:

Have you ever had an abnormal breast exam, sonogram or mammogram? ___Y ____N

If yes, when? __/___/____ Result _____

Pregnancy Summary:

Total number of all pregnancies	
Number of living children	
Miscarriages <20 weeks	
Ectopic Pregnancies	
Full term deliveries	
Premature Deliveries <36 weeks	
Any pregnancies with birth defects? Please specify	
Any pregnancies with chromosomal abnormalities? Please specify	

Date pregnancy ended or delivered	**Months to conception**	**Treatment to conceive**	**Delivery type D&C Complications**	**Current partner?** **Y/N**
1.				
2.				

3.				
4.				
5.				
6.				

Medical History:

Are you allergic to any foods or medicines? If so, list with reaction.

Food/med	Reaction

List all medications, including over-the-counter, herbal remedies and vitamins

Medication/supplement	Dose	Why are you taking this?

Please list all medical problems below:

None_____

Medical Problem	Diagnosis date	Treatments

Surgical History

☐ none

Year	Reason/Type

Any anesthesia complications? N ___ Y ___ explain: _____

Social History

Number of caffeinated beverages/day ____

Do you smoke/vape cigarettes/cigars/tobacco?

___N Quit when? ____
___Y Number of years? ____ Number of nicotine products/day? _____

Do you drink alcohol? ___N ___Y

Number of drinks /month: Beer ____ Wine ____ Liquor _____

Do you or have you used recreational drugs including over the counter substitutes?

___N ___Y _____(describe)

Do you exercise? ___N ____Y Number of minutes/week _____

Type: _____

Eating

Describe your diet:

Well-balanced ___ Vegan/Vegetarian ____ Fast Food _____ Eating out _____

Do you have nausea? ____ No ____ With meds ____ With eating

Do you have vomiting? ____ No ____ With meds ____ With eating

Have you ever had an eating disorder? ____ No ____ Yes

Review of Systems: any concerns/complaints?

Type: some examples	**Explain**
General: weight changes/fatigue/etc	
Head/ears/etc: deafness, blindness	
Respiratory: asthma, pneumonia	
Hormonal: thyroid, hot flashes, cold	
Breast: discharge, mass	
Neurological: headaches, seizures	
Mental: depression,anxiety	

Kidney/Urinary : bladder infections,stones	
Cardiovascular: chest pain, murmer	
Blood: anemia, blood clots, transfusion	
Skin: rashes, hair loss, excess hair	
Gastrointestinal: colitis, diarrhea	
Immune: lupus, myasthenia gravis	

Family History

Family	**Living?**	**Age/cause of death**	**Fertility issues? _____ explain**
Mother	Y - age___	N __	
Father	Y - age___	N __	
Brothers __ #	Y - age___	N __	
Sisters __#	Y - age___	N __	
Mom's mom	Y - age___	N __	
Mom's dad	Y - age___	N __	
Dad's mom	Y - age___	N __	
Dad's dad	Y - age___	N __	

Did your mother take DES to prevent miscarriage? ___Y ____N _____ Don't Know

Disorders in Your Family:

Disorder	Yes	Relationship to You	No	Unsure
Breast Cancer				
Ovarian Cancer				

Colon Cancer				
Cancer _____				
Diabetes				
Thyroid				
Heart Disease				
Blood Clots				
Mental Illness				
Tuberculosis				
Endometriosis				
Menopause <40 yrs old				
Recurrent Miscarraige				
Infertility				
Incompetent Cervix				
PCOS				

Cystic Fibrosis				
Tay Sachs				
Bloom Syndrome				
Gaucher Dz				
Fanconi Anemia				
Canavan Dz				
Familial Dysautonomia				
Muscular Dystrophy				

Neural Tube Defects				
Bone Defects				
Dwarfism				
Developemental Delay				
Autism				
Polycystic Kidneys				
Heart Defects				
Down Syndrome				
Marfan Syndrome				
Hemophilia				
Sickle Cell Trait				
Other chromosomal defect				
Other birth defect				
Thalassemia				
Deafness/Blindness				
Hemochromatosis				

Race/Ethnicity?

☐ African American	☐ American Indian/Native American
☐ Ashkenazi Jewish	☐ Asian American
☐ Cajun/French American	☐ Caucasian/White
☐ Eastern European	☐ Hispanic/Caribbean
☐ Northern European	☐ Southern European
☐ Other:	☐ Unsure

Emotional Status: Please rate on a scale of 1 (best) to 10 (worst)

How to do estimate your average level of stress to be? 1 2 3 4 5 6 7 8 9 10

Over the past 2 weeks:

	Not at all	Several Days	More than half days	Nearly Every Day
Have you felt little pleasure in doing things?	☐	☐	☐	☐
Have you felt down, hopeless?	☐	☐	☐	☐

Do you see a counselor? ___N ____Y For how long? _____ How often? _____

Name of counselor : _____

Do you feel safe at home? __N ___Y

Vaccinations:

Vaccine	No	Yes - date	Don't know
Chicken Pox			
MMR (measles, mumps, rubella)			
Hepatitis B			
Tuberculosis			
Hepatitis A			
Tetanus			
Influenza			
HPV			
Other: _____			

Prior Fertility Testing and Treatment:

Have you ever had prior fertility testing or treatment? __N ___Y

Prior Test	Date	Results
Basal body temp chart		
Thyroid tests		
Ovulation test kit		
Day 3 FSH lab		
AMH Lab		
Prolactin Lab		
Hysterosalpingogram		
Laparoscopy Surgery		
Hysteroscopy Surgery		
Pelvic sonogram		

Prior Treatments:

Procedure	# of cycles	Dates (mo/yr)	Outcome
IUI		__/__to__/__	☐pregnant ☐delivered ☐ectopic ☐miscarriage ☐not pregnant
Clomid or letrizole with timed intercourse Dose max: _____			☐pregnant ☐delivered ☐ectopic ☐miscarriage ☐not pregnant
Clomid or Letrizole with IUI Dose max: _____			☐pregnant ☐delivered ☐ectopic ☐miscarriage ☐not pregnant
Fertility drug injections with IUI			☐pregnant ☐delivered ☐ectopic ☐miscarriage ☐not pregnant
IVF Cycles			☐pregnant ☐delivered ☐ectopic ☐miscarriage ☐not pregnant
Frozen IVF Cycles			☐pregnant ☐delivered ☐ectopic ☐miscarriage ☐not pregnant

Canceled IVF Cycles			

Any other prior treatments?

_____

I confirm that I have reviewed the information above:

Provider Signature	Print Name and Title	Date	Time

Male Medical History and Information

Complete with male partner if applicable

Have you ever?	Yes	No
Been seen by a urologist	☐	☐
Conceived with another woman?		
Had a semen analysis?		
Was the result normal? Explain _____		
Had difficulty with erections?		
Had retrograde ejaculation?		
Had a history of undescended testicles?		
Had scrotal or testicular pain?		
Had a history of mumps?		
Injury to your testicles? _____		
Fever in the last 3 months?		
Had a vasectomy?		

Reversal? Date : _____		
Had a varicocele?		
Had a varicocele repair?		
Had hernia surgery?		
Had penile surgery or bladder surgery?		
Had prolonged heat exposure at work or sauna?		
Had chemotherapy?		
Had exposure to harmful chemicals?		
Had a STD? Chlamydia __ Gonorrhea__ Herpes __ Hepatitis __ HIV__ Syphillis ___ Warts ___		
Have you been diagnosed with ? diabetes __ Multiple Sclerosis ___ Cancer __ Prostrate infection ___ High blood pressure ___ Neurologic issues ____ Urinary Infections ____		
Other?		

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List all medications, including over-the-counter, herbal remedies and vitamins

Medication/supplement	Dose	Why are you taking this?

Please list all medical problems below:

None_____

Medical Problem	Diagnosis date	Treatments

Social History

Number of caffeinated beverages/day ____

Do you smoke/vape cigarettes/cigars/tobacco?

___N Quit when? ____
___Y Number of years? ____ Number of nicotine products/day? _____

Do you drink alcohol? ___N ___Y

Number of drinks /month: Beer ____ Wine ____ Liquor _____

Do you or have you used recreational drugs including over the counter substitutes?

___N ___Y _____(describe)

Do you exercise? ___N ____Y Number of minutes/week _____

Type: _____

Disorders in Your Family:

Disorder	Yes	Relationship to You	No	Unsure
Breast Cancer				
Ovarian Cancer				
Colon Cancer				
Cancer _____				
Diabetes				
Thyroid				
Heart Disease				
Blood Clots				
Mental Illness				
Tuberculosis				
Endometriosis				
Menopause <40 yrs old				
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☐ Eastern European	☐ Hispanic/Caribbean
☐ Northern European	☐ Southern European
☐ Other:	☐ Unsure

Spouse /Male Partner printed: _____

Patient signature	Date	Time

Provider notes: Office use only: