HART Fertility Centre

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Managing Fertility to Realize Your Dreams

New Patient Form

PERSONAL INFORMATION Date:____________________

First Name:__________________________________ Last Name: ______________________________________

Date of Birth: ______________________/__________________/__________________ Age: ____________________
Day Month Year

Health Card Number: _____________________________ Version: ______________

Address: ____ Apt: _________________
Number Street
City: _______________________________Province: _________________ Postal Code: ______________________

Home Phone: (____)_____________________ Work Phone: (_____)_________________ Ext: __________

Cell Phone: (_____)______________________ Other: (_____)_______________________

Email: ____

Occupation: ____

Referring Doctor: ____

Family Doctor: ___________________________________

How did you contact us:
_____Doctor referral
_____Personal recommendation
____ Google
Other:

SEXUAL HISTORY:

1. **Duration of unprotected intercourse in current relationship? _________ Years**
2. **How many times per week do you and your partner have intercourse? ____________**
3. **Is intercourse painful?**
   a. Does this pain ever make you stop during intercourse?
4. **Are there any problems with intercourse for the male?** **YES** **NO**
5.
   a. Pain for the male?
   b. Premature ejaculation?
   c. Problems gaining or maintaining an erection?

6. **Do you use lubricants/foams with intercourse?** **YES** **NO**

7. **How long have you been trying to become pregnant? _________ Years**

PREGNANCY HISTORY

Pregnancies	Year	Time taken to become pregnant	Miscarriage/ therapeutic abortion	Ectopic-treatment (surgical or medical)	Weeks of pregnancy	Live births	Current partner?
1							
2							
3							
4							

Did you have any difficulty becoming pregnant with any of these pregnancies?

PREVIOUS INFERTILITY INVESTIGATIONS AND TREATMENTS

0. **Have you had an x-ray dye test of your uterus (hterosalpingogram-HSG):** **YES** **NO**
   a. Where was it done?

   b. When was it done?

   c. What were the results?
      - Tubes open? YES NO

      - Normal uterus? YES NO

1. **Semen Analysis:**
   a. Where was it done?

   b. When was it done?

   c. What was the Result?

3. **Previous surgeries related to infertility investigation:** **YES** **NO**
   a. Laparoscopy?

      When and were was it done?

      What did it show?

   b. Hysteroscopy?

      When and were was it done?

      What did it show?

4. **Previous fertility treatments:** **YES** **NO**
   a. Clomid cycles: YES NO

      With intrauterine inseminations? YES NO

      Natural intercourse? YES NO

      Number of months used? _______ Months

Dosage used?_______________

Monitoring of response? Ultrasound/ Blood work/ Ovulation predictor kits

Resulted in pregnancy? YES NO

5. **Other treatments:**

MENSTRUAL HISTORY

1. **Last menstrual period (date of first day of last period):** _____________/____________
   Day Month
2. **Age when periods began?**____________
3. **Average number of days from the start of one menstrual period to the start of the next?** ____ **Days**
   a. Have they always been like this?
   b. What is the longest time between periods in the last year?
   c. What is the shortest time between periods in the last year?
   d. Do you require medication to bring on a period?
4. **What is the flow of your periods like?** **Light** **Moderate** **Heavy**
   a. How many days does your period last? ____________days
5. **Are your periods painful?** **YES** **NO**
   a. What medications do you take for the pain?
   b. Do they keep you from going to work or school?
   c. How many days of your period does the pain last?

GYNECOLOGIC HISTORY

1. **Do you experience fluid, discharge or leaking from your breasts?** **YES** **NO**
   a. When did it begin?
   b. When does it occur?
   c. What does it look like?
2. **Do you have any unwanted hair growth on your body?** **YES** **NO**
   a. Where?
   b. How do you treat it? Shaving/ Plucking/ Medication/ Laser
   c. How often?
3. **Do you have problems with acne?** **YES** **NO**

4.

a. Where?

5. Previous use of birth control? **YES NO**

a. Type of birth control pill:

b. Type of IUD:

c. Other:

d. Duration of use?

e. When did you stop using it?

6. Do you have a history of endometriosis? **YES NO**

7. Pap smears?

a. When was your last pap?_______/_________/_________ Result:__________________

Day Month Year

b. Have you ever had an abnormal pap? YES NO

Treatment:

Normal paps since then? YES NO

8. History of PID (Pelvic inflammatory disease) **YES NO**

9. History of sexually transmitted diseases **YES NO**
(Herpes/Gonorrhea/Chlamydia)

a. Were you treated? YES NO

b. Was your partner treated? YES NO

SURGICAL HISTORY

Year	Type	Who did the surgery?	Findings

Have you ever had any problems with anesthesia? YES NO

Please describe these problems:

MEDICAL HISTORY

Have you suffered from any of the following?

Illness or disease	Medication	Treatment	Admission to hospital	
			YES	NO
Diabetes				
Thyroid disease				

Asthma				
Heart Disease or murmur				
Cancer				
Epilepsy or seizure disorder				
Other				

1. **Do you suffer from any mental illness?** **YES** **NO**
2. **Do you suffer from depression?** **YES** **NO**
3. **What prescription medication do you take regularly?**
4. **Do you take folic acid or Materna?** **YES** **NO**
5. **What medications do you take occasionally?**
6. **Do you have allergies?** **YES** **NO**
   a. To medications? YES NO
   b. What happens if you take this medication?
   c. Any other allergies?
   d. Allergy to latex: YES NO
7. **Do you smoke?** **YES** **NO**
   a. Have you ever smoked? YES NO
   b. When did you stop?
   c. How much do you smoke?
8. **How many alcoholic drinks a week do you take?**
9. **Do you use any recreational drugs?** **YES** **NO**
   a. How often?

FAMILY HISTORY

Is there a family history of any of the following:

	YES	NO	WHO	PROVID DETAILS
Breast cancer				

Ovarian cancer				
Bowel cancer				
Other cancer				
Premature menopause <40 years				
Endometriosis				
Stillbirths				
Neural tube defects				
Mental illness				
Genetic problems (chromosomes)				
Recurrent pregnancy loss				
Any others- What are they?				

What is your family origin/ethnic background?

What is your height? ____________ What is your weight?____________

TO BE COMPLETED BY HEALTH PROVIDER:

PHYSICAL EXAMNIATION:

BP: Pulse:

General appearance:

Breast exam:

Thyroid exam:

Cardiovascular exam:

Respiratory exam:

Abdomen:

Pelvic exam:

MALE PARTNER HISTORY

First Name:________________________________ Last Name: ________________________

Date of Birth: ________/________________/______________ Age: _________
Day Month Year

Health Card Number: ________________________________ Version: _________

Address: ______________________________ Apt: __________
Number Street

City: ________________ Province: ____________ Postal Code: __________

Home Phone: (____)____________ Work Phone: (____)____________ Ext: ______

Cell Phone: (____)____________ Other: (____)______________

Email: ________________________________

Occupation: ____________________________

Ethnic Origin: __________________________

1. **Any children from a previous relationship?** **YES** **NO**
   a. Pregnancy outcome? (i.e. healthy child?)

2. **Any history of injuries of the penis or scrotum?** **YES** **NO**

3. **Any history of prostate infection, gonorrhea, chlamydia, herpesor genital warts?** **YES** **NO**

4. **Undescended testicles as a baby?** **YES** **NO**
   a. Was this corrected with surgery? YES NO
   b. At what age did this surgery occur?

5. **Have you had surgery in any of the following?**
   a. Hernia repair? YES NO
   b. Varicocele YES NO
   c. Previous vasectomy? YES NO
      Year: ____________
   d. Pervious reversal vasectomy? Year__________
   e. Any other type of surgery?

6. **Are you under a doctor's care for past or ongoing medical problems?** **YES** **NO**
   a. What medications?

7. **What prescription medications do you take regularly?**

8. **Do you use any over the counter medications or complementary and alternative medications? If YES please list:**

9. **Do you have any allergies?**
   a. To medications? YES NO
   b. To latex? YES NO

1. **Do you smoke?**
   a. How much do you smoke?

2. **How many alcoholic drinks do you have per week?**

3. **Are you exposed to any chemicals in your home and/or workplace?**
   a. What kind of exposure?

4. **Are you exposed to excessive heat to the testicles (hot-tub, work-related)**

5. **Family history:**

	YES	**NO**	**WHO**	**PROVIDE DETAILS**
Stillbirths				
Neural tube defects				
Mentally challenged				
Recurrent pregnancy loss				
Genetic problems (chromosomes)				
Any others- What are they?				