Fertility Centers OF ILLINOIS

Date: _____

Patient's Name: _____ Date of Birth: _____

Height: _____ Weight: _____

Partner's Name: _____ Date of Birth: _____

Referring Physician: _____

1. How long have you and your partner been trying to conceive with unprotected intercourse?	
2. Have you ever had a pregnancy with your current partner? Yes ☐ No ☐ If Yes, how many pregnancies? How many went to term?	
3. Have you ever had a pregnancy with another partner? Yes ☐ No ☐ If Yes, how many pregnancies? How many went to term?	
4. If yes to question 2 or 3, how many boys and how many girls, and how old are they?	
5. Has your current partner ever been pregnant with another partner? Yes ☐ No ☐ If Yes, how many pregnancies? How many went to term?	
6. Have you ever taken Clomid? Yes ☐ No ☐ If yes, for how long?	

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7. Have you ever had a varicocele operation?

Yes ☐ No ☐

If yes, which side and when? Right ____/_____ Left ____/_____

8. Have you had any other types of fertility treatments (medication, IUI, IVF, vasectomy)?

Yes ☐ No ☐

If yes, explain briefly:

9. Have you had a recent (within the past year) infection with a fever?

Yes ☐ No ☐

If yes, when? _____/_____ How High?

10. Did you have mumps when you were a child?

Yes ☐ No ☐

If yes, did it affect your testes? Yes ☐ No ☐

11. Have you ever been treated for a sexually transmitted disease?

Yes ☐ No ☐

If yes, what disease? When? _____

12. Have you ever been diagnosed with tuberculosis?

Yes ☐ No ☐

If yes, when? _____

13. Have you ~~traveled~~ to a known Zika country in the last 3 months? ☐ Yes ☐ No

https://travel.state.gov/content/travel/en/international-travel/before-you-go/your-health-abroad/zika-virus-information-for-travelers.html

14. At work, are you exposed to chemicals or pesticides?

Yes ☐ No ☐

If yes, what chemicals?

15. Have you ever been exposed to a large amount of radiation, or exposed for a long time?

Yes ☐ No ☐

If yes, when? _____/_____ How long?

Why?

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16. Have you ever had chemotherapy? Yes ☐ No ☐ If yes, what kind? From _____/_____ to _____/_____?	
17. Have your testes had to be surgically brought into the scrotum? Yes ☐ No ☐ If yes, how old were you? If yes, which side and when? Right _____ Left _____	
18. Have you ever had a hernia operation? Yes ☐ No ☐ If yes, which side and when? Right _____ Left _____	
19. Did you ever have a bladder operation? Yes ☐ No ☐ If yes, what was done? When? ____/_____	
20. When you were younger, did your testes ever twist, requiring surgery to untwist them? Yes ☐ No ☐ If yes, which side and when? Right ____/_____ Left ____/_____	
21. Did you ever have major trauma to your testes? Yes ☐ No ☐ If yes, which side and when? Right ____/_____ Left ____/_____	
22. How old were you when puberty started?	
23. Do you use lubricant(s) during intercourse? Yes ☐ No ☐ If yes, what brand?	
24. Have you had any problems with erections?	☐ Yes ☐ No
25. How often do you have intercourse?	

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26. How often do you have any sexual activity?	
27. Do you have diabetes?	☐ Yes ☐ No
28. Do you have high blood pressure?	☐ Yes ☐ No
29. Besides diabetes and high blood pressure, have you had or do you have any other major medical illness(es)? Yes ☐ No ☐ If yes, what illness(es)?	
30. Have you ever had any surgery besides a varicocele operation? Yes ☐ No ☐ If yes, what surgery and when?	
31. Are you currently taking any medication on a regular basis? Yes ☐ No ☐ If yes, what medications and dose?	
32. Are you allergic to any medications? Yes ☐ No ☐ If yes, what medications and what happens when you take them?	
33. Do any blood relatives have cystic fibrosis?	☐ Yes ☐ No
34. Have any blood relatives had difficulty to conceive children? Yes ☐ No ☐ If yes, which relatives (eg. Mother's uncle, etc):	
35. Do you currently smoke cigarettes? Yes ☐ No ☐ If yes, how many packs a day? For how long?	

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36. Did you stop smoking? (answer no if you have never smoked) Yes ☐ No ☐	
37. Do you currently use marijuana? Yes ☐ No ☐ If yes, for how long? If edible, how many mg/week? What form (ie: smoke, edible)?	
38. Have you used any other recreational drugs in the last 3 months? Yes ☐ No ☐ If yes, which drugs? How often?	
39. Have you ever used anabolic steroids or body-building drugs? Yes ☐ No ☐ If yes, which drugs? When?	
40. Do you drink alcoholic beverages? Yes ☐ No ☐ If yes, how many drinks (beers, glasses of wine, tumblers, etc) per week?	
41. Has your current partner been diagnosed with an obstruction of her tubes?	☐ Yes ☐ No
42. Does your current partner have or ever had endometriosis?	☐ Yes ☐ No
43. Has your current partner ever had a serious gynecological infection?	☐ Yes ☐ No
44. Has your current partner needed medication to stimulate her ovaries?	☐ Yes ☐ No
45. Does your current partner have irregular menstrual cycles?	☐ Yes ☐ No

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