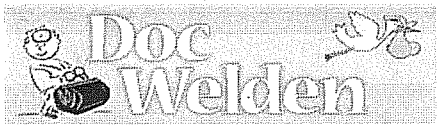
NEW PATIENT INFERTILITY



Date_____ Name_____ Age _____

Reason for today's visit_____

Describe in your own words, any prior evaluation or treatments leading up to today's visit:

_____

Marital Status S M D Sep Spouse/Partner name_____

Spouse/Partner age _____ Spouse/Partner occupation _____

Date your last menstrual period started_____ Periods regular Y/N Describe_____

Have you had any tests to check if your tubes are open? _____ Describe results_____

Have you had any tests to see if you are ovulating? Y/N Describe results _____

Has a sperm count been done? _____ Describe results _____

Frequency of intercourse _____ Pain? Y/N Describe _____

Please list ALL prior surgeries _____

Please list any and all medical problems you have been diagnosed with_____

_____

Please list all current medications, herbs, etc you are taking: _____

_____

EMPLOYEES ONLY			
HT:	WT:	B/P:	LMP :