OBSTETRICS & GYNECOLOGY

Infertility / Reproductive Medicine — Patient History Form

SECTION 1: PATIENT DETAILS

Name of Patient: _____

Age: _____

Married Life(No. of years): _____

Age of Spouse: _____

Consanguinity: _____

Family History: _____

SECTION 2: PAST MEDICAL HISTORY (Wife)

Thyroid Disorder	☐ Yes ☐ No	Details: _____
Hypertension (HTN)	☐ Yes ☐ No	Details: _____
Diabetes Mellitus (DM)	☐ Yes ☐ No	Details: _____
Autoimmune Disease	☐ Yes ☐ No	Details: _____
H/o Tuberculosis (T.B.)	☐ Yes ☐ No	Details: _____
Any Known Allergies	☐ Yes ☐ No	Details: _____
Others	☐ Yes ☐ No	Details: _____

Pre-Surgical History: _____

SECTION 3: INFERTILITY HISTORY (Wife)

H/o PCOS → Ovulation Induction:

No. of Cycles: _____ Medications: _____ CC / Letrozole: _____

☐ IUI — No. of Cycles: _____ ☐ IVF — No. of Cycles: _____

HSG: ☐ Done ☐ Not Done Result: _____

Previous USS Reports: _____

H/o Any Surgical / Abdominal Surgery ☐ Yes ☐ No Details: _____

SECTION 4: HUSBAND'S DETAILS

Age: _____

Medical History:

☐ HTN ☐ DM ☐ Thyroid Disorder

Previous Infertility Treatment ☐ Yes ☐ No Details: _____

Social History:

☐ Smoker ☐ Alcohol

SECTION 5: SEMEN ANALYSIS

Semen Analysis Report: ☐ Available ☐ Not Done

USS — Scrotal Dopple: ☐ Done ☐ Not Done Findings: _____

H/o Taking Any Medications ☐ Yes ☐ No Details: _____

Autoimmune Disorders ☐ Yes ☐ No Details: _____

Ejaculatory Dysfunction ☐ Yes ☐ No Details: _____

H/o Medical Conditions: _____

ADDITIONAL NOTES

_____

_____

_____

_____ _____

Patient Signature Date