Hamilton Assisted Reproductive Technologies
102-1057 Main St. West, Hamilton, ON L8S 1B7
Tel: **905-972-8382** Fax: **905-972-8600**

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 ____ Google
_____Personal recommendation 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 us 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 (Herpes/Gonorrhea/Chlamydia)** **YES** **NO**
    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. Pervious 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?				