Date--------------------

Name-------------------------------------------- Job------------------

Husband’s name-------------------------- Tel-----------------------

Address---------------------------------------------------------------

Email---------------------------------------------------------------------

**Medical history:**

-How many years are you married? -----------------------------

-How many years are you trying to conceive? ----------------

-Did you visit a gynecologist? -----------------------------------

-How many times do you have intercourse per month? ----------------------------

**-Wife’s information:**

Age-------------- height-----------------Weight--------------------

Allergies---------------------------------------------------------------

Do you smoke or drink alcohol? How many? -----------------

Is your menstrual period regular? -------------------------------

How often? ------------------------------------------------------------

* Amount of bleeding: mild Moderate Severe
* Do you have any medical illnesses such as endometriosis….etc, please give details-------------------------------------------------------------------------------------------------------------------------------------------------------------.
* Are you taking drugs continuously? --------------------------------------------------------------------------------------------
* Did you suffer from pelvic inflammatory diseases before? ------------------------------------------------------------
* Did you undergo any surgical operations in the abdomen or pelvis? ------------------------
* When? And what were the results of the operations? ------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------
* Did you have any previous marriage before this one? --------------------

 \*If yes, how many times did you conceive? ------------

 \*How many times did you abort----------------------

- How many times did you conceive in the current marriage? --------------------------------------------------------------

-How many times did you abort in the current marriage (please give details)?

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- How many times did you have ectopic pregnancies? ----------------------------------------------------------------------

- How were the deliveries vaginal deliveries or caesarian deliveries? --------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

-Did you do these tests?

|  |  |  |
| --- | --- | --- |
| Test | Yes/No | results |
| Hysterosalpingiogram |  |  |
| Hysteroscopy |  |  |
| Laparoscopy |  |  |

Did you undergo any of the following programs:-

|  |  |  |  |
| --- | --- | --- | --- |
| program | Yes/No | How often | results |
| Ovulation induction with clomid + timing intercourse  |  |  |  |
| Ovulation induction with clomid + IUI |  |  |  |
| Ovulation induction with clomid+ injections + timing intercourse  |  |  |  |
| Ovulation induction with clomid+ injections + IUI |  |  |  |
| ICSI |  |  |  |

* Is there any information you want to add? -----------------------------------------------------------------------------------
* Are there any tests you have done before?

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**IF you underwent ICSI program:-**

* How many injections did you receive before? ----------
* How many follicles did you produce? ---------------------
* How many eggs were collected? --------------------------
* How many embryos were transferred? ------------------
* How many embryos were frozen? -------------------------

**Husband’s information:**

Name: ----------------------------------Age -----------------

 Job -------------------Height--------------weight--------------

Allergies------------------------------------------------

* Do you smoke or drink alcohol? How much? ---------------------------------------------------------------------------------
* Do you have any previous marriage? ---------------------
* How many times pregnancy had occurred? ------------
* Do you have sexual problem in erection/ejaculation? --------------------------------------------------------------------
* Do you have any chronic illnesses? ---------------------------------------------------------------------------------------------
* Are you taking medicines? What are they? ---------------------------------------------------------------------------------------------------------------------------------------------------------
* Have you done hormonal profile? -----------------------------------------------------------------------------------------------
* Did you undergo any surgical operations? ----------------------------------------------------------------------------------------------------------------------------------------------------------
* Did you have a family history of infertility? -----------------------------------------------------------------------------------
* Did you receive any infertility treatment before? What were they? --------------------------------------------------------------------------------------------------------------------
* Please send a photo of your semen analysis.
* Is there any information you want add?

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