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Initial Consult History

Name: _____ Date: _____
Date of Birth: _____ Age: _____
Marital Status: Single Married Divorced Separated Widow Domestic partner
Referred by: _____
Primary Care Physician: _____
Gynecologist: _____

Reason for visit: _____

Length of time attempting to conceive: _____ years, or _____ months

Partner's name: _____ not applicable
Partner's Date of Birth: _____ Age: _____
Children: No Yes, number fathered _____
Prior semen analysis: No Yes, date: _____ findings: _____
Smoker?: No Yes, _____ packs per day _____ years of smoking
Medication allergies: _____
Other significant medical history: _____
Primary care physician: _____
Urologist: _____

Previous Infertility Evaluation(s): none

Hysterosalpingogram (HSG) dye test: normal abnormal Date/Findings _____

Hysterosonogram: normal abnormal Date/Findings: _____

Laparoscopic or pelvic surgery: normal abnormal Date/Findings: _____

Previous Infertility Treatment(s): Dates / Number Cycles none

Clomid cycle(s): _____ Gonadotropin cycle(s): _____

Insemination cycle(s): _____ IVF cycle(s): _____

Previous laboratory testing: Dates / Results none

Bloodtype: _____ Cystic fibrosis screening: _____ Rubella titer: _____

Thyroid (TSH): _____ Prolactin: _____ Chicken Pox (VZV) titer: _____

Syphilis (VDRL): _____ HIV: _____ Hepatitis B titer: _____

Baseline (day3) FSH/Estradiol: _____

Other infertility evaluations, treatments or tests? _____

Name: _____ Date: _____

Pregnancy history: have never been pregnant

Date: _____ Outcome: _____ Current or Previous partner? _____
Date: _____ Outcome: _____ Current or Previous partner? _____
Date: _____ Outcome: _____ Current or Previous partner? _____
Date: _____ Outcome: _____ Current or Previous partner? _____

Gynecological history:

Date of last menstrual period: _____ Age when periods began: _____
Cycle length (days between one cycle and the next): _____
Cycle duration (days of bleeding): _____
Periods are regular irregular _____
Intermenstrual spotting or bleeding? No Yes, duration: _____
Date of last pap smear: _____ Normal Abnormal
History of abnormal pap: No Yes, Date: _____
Mammogram: Never Normal Abnormal Date: _____
Contraception used in the past: _____
History of pelvic infection(s): No Yes, type _____
History of endometriosis: No Yes

Medical History:

Medication allergies: none/denies _____

Current medications/dosage: none _____

Height: ___ft. ___in. Weight: _____ lbs.

Past medical history: (Please check and comment on all that apply) none/denies

Anemia _____	High Cholesterol _____
Anxiety/depression _____	Hypertension _____
Arthritis _____	Kidney disease _____
Asthma _____	Liver disease _____
Bleeding/clotting disorder _____	Lung disease _____
Bleeding tendencies _____	Musculoskeletal disorder _____
Blood transfusions _____	Neurological disorder _____
Cancer _____	Seizure/epilepsy _____
Chest pain _____	Shortness of breath _____
Diabetes _____	Stomach/GI disorder _____
Dizziness/fainting _____	Stroke _____
Fevers _____	Urinary tract infections _____
Headaches/migraines _____	Weight gain _____
Heart attack _____	Weight loss _____
Hepatitis _____	Other: _____

Comments: _____

Name: _____ Date: _____

Past Surgeries and/or Hospitalizations: List dates, procedure and findings. none/denies

Social History:

Tobacco use: No Yes, number of packs and years of use: _____

Alcohol use: No Yes, glasses per day / week: _____

Drug use: No Yes, _____

Intravenous drug use: No Yes, _____

Multiple sexual partners currently: No Yes, _____

Do you exercise regularly? No Yes, how often / how much? _____

Family History:

Mother's age: _____ Medical history: _____

Father's age: _____ Medical history: _____

Please check any that apply and indicate which family member has/had the disease.

Birth defect/genetic disorder _____	Hepatitis/liver disease _____
Blood clots/bleeding disorder _____	Kidney disease _____
Breast disease _____	Seizures/neurological disorder _____
Cancer _____	Stroke _____
Complications with anesthesia _____	Tuberculosis _____
Diabetes _____	Other: _____
Heart disease _____	

Other information: _____

Office Use:	Date reviewed:	Reviewed by:
	Updated:	Reviewed by:
	Updated:	Reviewed by:
	Updated:	Reviewed by: