REQUEST FOR GENERAL FERTILITY EVALUATION: (primary / secondary infertility)

LMP: __________________________   Parity:  ____  (full term)   ____  (preterm)   ____  (aborted/miscarried)   ____  (living)   ____  (ectopic)
Duration of infertility: _________________________

PLEASE INCLUDE COPIES OF BELOW LABS AND IMAGING PERFORMED
Prior laboratory testing:

☐ Semen analysis   ☐ AMH   ☐ TSH, Free T4   ☐ Blood Type and Screen   ☐ CBC   ☐ Prolactin
☐ Hemoglobin A1C   ☐ Vit D   ☐ HIV, Hep B, HCV AB, RPR   ☐ Rubella IgG   ☐ Varicella IgG

Prior imaging:
☐ Transvaginal ultrasound of uterus and ovaries including antral follicle count (AFC)
☐ Hysterosalpingogram (HSG)
☐ Saline sonogram (SIS)
☐ Other ___________________________________________________________________________________

Prior genetic testing: ______________________________ (i.e. carrier screening; Myriad / Counsyl)

Prior fertility therapies: _____________________________________________________________ (ovulation induction, insemination, in vitro fertilization)
*Please include last clinic note

Prior surgeries: _______________________________________________________________________

REQUEST FOR FERTILITY PRESERVATION PATIENTS:
(Oncofertility preservation prior to starting cancer treatment, egg freezing, sperm banking, lupron suppression, embryo freezing, fertility preservation prior to gender-affirming hormone therapy or surgery)

Diagnosis: ________________________________________________________________
Date of diagnosis: ______________________

Prior therapies: (surgery, chemotherapy, radiation) ______________________________________

Planned therapies: __________________________________________________________________

Timeline for therapy initiation (when planned): ___________________________________________

Fertility goals discussed with patient at time of diagnosis:  ☐ Yes  ☐ No  ☐ Unsure

WILL YOUR PATIENT REQUIRE SPECIAL ASSISTANCE DURING THE VISIT:
(please specify, i.e. wheelchair, interpreter)

__________________________________________________________________________________