MEDICAL EVALUATION

(If current patient of IRH, Parental Hope will obtain completed form. If not a current patient of IRH, your treating physician must complete this form.)

Patient's Name:_____ Age: _____ Weight:_____ Height:_____

Patient's Partner's Name:_____ Age: _____ Weight:_____ Height:_____

Medical Information:

A. Length of Trying to Conceive:_____

B. Medical History Related to Fertility:_____

_____

_____

C. Fertility Testing:

a. AMH:_____

b. Antral Follicle Count:_____

c. FSH/Estradiol:_____

d. Uterine Cavity Evaluation:_____

e. Semen Analysis:

i. Volume: _____ ii. Concentration: _____

iii. Motility: _____ iv. Morphology: _____

D. Fertility Treatment:

a. Has patient undergone a IUI? If so, what were the outcomes? What were the medications used?

_____

_____

_____

b. Has patient undergone IVF? If so, what were the outcomes? _____

_____

_____

_____

E. Fertility Diagnosis:

a. What is the fertility diagnosis for patient? _____

_____

_____

_____

b. What is the fertility diagnosis for patient's partner? _____

_____

_____

_____

c. What is the recommended treatment for patient and patient's partner? _____

_____

_____

_____

_____

_____

d. What is the likelihood of conceiving without IVF? _____

_____

e. What is the likelihood of conceiving with IVF? _____

_____

THANK YOU FOR COMPLETEING THIS FORM ON BEHALF OF PATIENT!!

THIS FORM HAS BEEN COMPLETED BY:

_____(please print) Clinic Name:_____

_____ (signature) Date:_____