Medical Evaluation

The Stork Foundation for infertility

Personal Information

Patient's Name: _____

Age: _____ Height: _____ Weight: _____ BMI: _____

Total number of Pregnancies: _____ Total number of live births: _____ Total number of miscarriages: _____

Length of Infertility: _____

Cause of Infertility: _____

Surgical History:

Ovarian Reserve:

FSH/E2: _____ AMH: _____ Antral Follicle Count: _____

HSG Result: _____ Date: _____

Hydrosonogram: _____ Date: _____

Hysteroscopy: _____ Date: _____

Male Evaluation:

Volume (ML): _____ Sperm Concentration: _____

Motility: _____ Normal Morphology: _____

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Treatment Plan

Number of IUIs: _____ Number of Egg Retrievals: _____ Number of Transfers: _____

Results from IVF Cycle 1:

Eggs Retrieved: ____ Fertilized: ____ Blasts: ____ Transferred: ____ Frozen: ____

Results from IVF Cycle 2:

Eggs Retrieved: ____ Fertilized: ____ Blasts: ____ Transferred: ____ Frozen: ____

Results from IVF Cycle 3:

Eggs Retrieved: ____ Fertilized: ____ Blasts: ____ Transferred: ____ Frozen: ____

Recommendations for next steps/treatment for patient:

_____

_____

_____

_____

Type of Protocol: _____

Will Patient Be Using Donor: Sperm Egg Embryo

Total Cost of Treatment: _____

Does cost include medications? Yes No

Validation:

Physician: _____ Clinic: _____

Phone: _____ Email: _____

_____ _____

Physician Name Printed: Date:

_____ _____

Signature: Date: