# MEDICAL EVALUATION – COMPLETED BY PHYSICIAN

| **Patient Information** | | | |
|---|---|---|---|
| Patient name: | | | |
| Date of birth: | Height: | Weight: | BMI: |
| Total number of pregnancies: | Total number of births: | Abortus: | Length of infertility: |
| Cause of infertility: | | | |
| Partner name: | | | |
| Partner date of birth: | Partner Height: | Partner Weight: | Partner BMI: |
| **Female Evaluation** | | | |
| Medical interference: | | | |
| Surgical history: | | | |
| Ovarian reserve:<br>FSH/E2_____ AMH: _____ Antral Follicle Count: _____ | | | |
| HSG result: | | | Date: |
| Hydrosonogram: | | | Date: |
| Hysteroscopy | | | Date: |

| **Prior Treatments** | | | |
|---|---|---|---|
| Number of IUI's | | Number of Egg Retrievals: | |
| Result from IVF cycle 1:<br><br>Eggs retrieved _____ Fertilized _____ Blasts _____ Transferred _____ Frozen _____ | | | |
| Result from IVF cycle 2:<br><br>Eggs retrieved _____ Fertilized _____ Blasts _____ Transferred _____ Frozen _____ | | | |
| Result from IVF cycle 3:<br><br>Eggs retrieved _____ Fertilized _____ Blasts _____ Transferred _____ Frozen _____ | | | |
| Date of last procedure: | Patient currently in treatment: Y / N | | |
| If yes, please provide details: | | | |
| **Male Evaluation:** | | | |
| Volume (mL): | Sperm concentration (million/mL): | | Motility: |
| Normal morphology: | | | |

| **Treatment Plan** | | | |
|---|---|---|---|
| Recommended next step/treatment for patient? | | | |
| Type of protocol and medication volume: | | | |
| Total cost excluding medication:<br><br>$ _____ | | | |
| Physician cost:<br><br>$ _____ | Lab fees:<br><br>$ _____ | Anesthesia:<br><br>$_____ | Facility fee:<br><br>$ _____ |
| ICSI, embryo glue, etc.<br><br>$_____ | Other:<br><br>$ _____ | Approximate medication cost:<br><br>$ _____ | |

| VALIDATION | | |
|---|---|---|
| Physician: | Clinic: | |
| Address: | | |
| Phone: | Email: | Fax: |

_____ _____

Physician Name Printed Date

_____ _____

Signature Date