



Mrs.

Age:

Mr.

Age:

Address:

Phone:

E-mail:

WIFE

Illnesses _____ Allergies _____

Qx _____

Menarche: _____ Rythm: _____ FUM: _____ PAP test and results: _____

With the current partner:

Gestations _____ Births _____ Miscarriages _____ C-Sections _____ Ectopic _____ Molar _____

HSG (date and findings) _____

Hormone profile. Date _____ FSH _____ LH _____ E2 _____ PRL _____

Laparoscopy. _____

Hysteroscopy. _____

Height: _____ Weight: _____ BMI: _____

HUSBAND

IMER Spermogram: Yes _____ No _____ Date _____ Vol _____ Count / ml _____ days abs _____

Motility: A _____ B _____ C _____ D _____ Morphology _____ CTM: _____

Hormones and Others: _____

PREVIOUS TREATMENTS

HOC, Inseminations and previous TRA _____

DIAGNOSIS

Primary Sterility () Secondary Sterility () Duration _____

Etiology

() Polycystic Ovary. () Tubal Factor. () Male Factor

() Low Responder. () Adherent Dis. () Endocrine-Ovarian Factor

() Premature Ovarian Failure () Endometriosis. () Unexplainable.

() Anovulation (Others). () Uterine Factor.

Other Specifications: _____

EMBRYO TRANSFER

Doctor who performed the transfer: _____

() A, (Easy) () B (Difficult and/or with blood) () C (Very difficult and/or with pozzi).

Catheter: () Frydman. () Delphin. Others: _____ Repetition: _____ # of Retained Embryos: _____