THE STORK FOUNDATION

MEDICAL EVALUATION

FOR INFERTILITY

PERSONAL INFORMATION

Patient's Name :

Age : **Height :** **Weight :** **BMI :**

Total Number of Pregnancies Resulting in Live Births :

Cause of Infertility :

Total Number of Miscarriages :

Surgical History Related to Fertility :

Length of Infertility :

OVARIAN RESERVE

FSH/E2 :

AMH :
Check one box that applies

- ☐ <0.05
- ☐ 0.05
- ☐ 0.5-1
- ☐ 1-1.5
- ☐ 1.5-2
- ☐ >2

Is the uterine cavity normal?
If no, please select all that apply.

- ☐ Uterine Cavity is normal
- ☐ Fibroids
- ☐ Polyps
- ☐ Other :

_____

- ☐ Inflammation / Endometritis
- ☐ Intramural fibroids > 5cm
- ☐ Adhesions / Asherman Syndrome

MALE EVALUATION

Volume (mL)

Check one box that applies

- ☐ Greater than or equal to 1.5 mL
- ☐ Less than 1.5 mL

Motility

Check one box that applies

- ☐ Greater than or equal to 40%
- ☐ Less than 40%

Sperm Concentration

Check one box that applies

- ☐ Greater than or equal to 1 million per mL
- ☐ Less than 1 million per mL

Normal Morphology

Check one box that applies

- ☐ Greater than or equal to 4%
- ☐ Less than 4%

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MEDICAL EVALUATION

FOR INFERTILITY

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

NEXT STEPS

Recommendations for next steps / treatment for patient :

Type of Protocol

Total Cost of Treatment

Will patient be using a donor? Yes No

Does cost include medications? Yes No

Select the donor source the patient will use:

Egg : Embryo : Sperm : Not using a donor :

VALIDATION

Physician:

Clinic

Phone:

Email:

Signature :

Today's Date: