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SPECIAL ARTICLE

Gynecology

FIGO Fertility Passport: A tool for patients and their healthcare providers

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Abstract

Infertility is a condition with significant psychological, economic, and health implications. Investigations are generally conducted by a primary healthcare provider who then refers to a specialist; however, multidisciplinary care is often required. On occasion, patients move clinics, resulting in time delays and repeated investigations, further delaying treatment and adding to the patient's financial burden. To address this critical issue, FIGO's Committee on Reproductive Endocrinology and Infertility (REI) created the Fertility Passport. This passport should be provided to patients experiencing fertility issues so that it can be used during their infertility treatments. It documents basic investigations, diagnosis, treatments, and results. The REI Committee recommends the use of the passport to facilitate the diagnosis and treatment of fertility issues among patients accessing both domestic and cross-border care.

KEYWORDS
fertility, FIGO Fertility Passport, in vitro fertilization, infertility, intracytoplasmic sperm injection, intrauterine insemination

1 | INTRODUCTION

Infertility is a condition with significant psychological, economic, and health implications.[1] The World Health Organization (WHO) defines infertility as a disease of the reproductive system, characterized by inability to achieve a clinical pregnancy after 12 or more months of regular unprotected male/female sexual intercourse in women aged under 35 years; in addition, the American Society of Reproductive Medicine uses a timeframe of 6 or more months in women aged 35 years or older.[2,3] Although precise figures for the global prevalence of infertility are unavailable, it is estimated that approximately 72.4 million women worldwide experience fertility problems.[4] Globally, around one in six people of reproductive age experience infertility.[2] On September 14, 2020, the WHO acknowledged that the provision of high-quality fertility care services is central to reproductive health. Infertility leads to various medical, financial, and

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emotional challenges, which are particularly pronounced in low- and middle-income countries (LMICs).[5] These affect individuals of reproductive age, who often explore a variety of treatment options to address these challenges.

Cross-border care has gained increasing popularity as a strategy to treat infertility in the 21st century.[6] This trend reflects the growing need for accessible and effective healthcare solutions that cater to the diverse needs of individuals and couples experiencing infertility. Cross-border reproductive care enables patients to obtain full or partial treatment in countries outside their home nation, encompassing various medical and surgical procedures such as in vitro fertilization (IVF), intracytoplasmic sperm injection, oocyte and sperm donation, surrogacy, and preimplantation genetic testing (PGT). Some advanced procedures are only available in a limited number of countries. The reasons for seeking cross-border care vary, including differences in treatment availability, relocation to another country, differing legal regulations concerning gamete donation,[7] or combining medical treatment with travel. According to a 2010 study, approximately 20000–25000 couples travel abroad for infertility treatments, although this figure is now likely to be significantly higher.[6] Infertility treatments require follow-up and often depend on patient history of previous interventions. While formal medical record-keeping systems exist in many countries, patients frequently face challenges transferring their complete fertility treatment history when they choose to receive care in a secondary location.[8]

2 | FIGO FERTILITY PASSPORT

To address this critical issue, the FIGO Committee on Reproductive Endocrinology and Infertility (REI Committee) devised the Fertility Passport, which is available online as a free download that can be completed online or printed (Figure S1). The passport can include information on up to two patients who wish to have fertility care. The questions cover all details that are important for reproductive care, including medical history, pregnancy history, details of menstrual cycle, any symptoms associated with subfertility, surgical history, family history, allergies or medications, sperm parameters, previous diagnoses and treatments for subfertility, and other medical conditions. A three-step process for preparation of the passport was undertaken: (i) questions were thoroughly assessed, discussed, and decided on by REI Committee members, who are experts in the REI field globally; (ii) after the content had been created, independent clinicians working in REI units that accommodate high numbers of cross-border patients provided additional review; and (iii) after final discussion and agreement by the REI Committee, the passport was created. It is anticipated that the Fertility Passport will be provided to patients experiencing fertility issues to be completed during their infertility treatments. The REI Committee recommends using the Fertility Passport to facilitate diagnosis and treatment of fertility issues for patients accessing both domestic and cross-border care.

3 | DISCUSSION

3.1 | Patient 1 assessment

The FIGO Fertility Passport is a tool that can be used globally to enhance reproductive care, from primary to tertiary care. Taking a comprehensive history is the cornerstone of fertility treatment (page 1 of the passport). It is essential to determine whether the patient has primary or secondary subfertility and to document any history of pregnancy loss or termination. A detailed menstrual history can help diagnose conditions such as polycystic ovary syndrome, which is associated with oligomenorrhea, hirsutism, and acne. Primary ovarian insufficiency is associated with oligomenorrhea, hot flushes, and vaginal dryness, while endometriosis often presents with dysmenorrhea, menorrhagia, and dyspareunia. Postcoital bleeding and intermenstrual bleeding are pathological symptoms that might indicate benign or malignant disease. Recent or previous use of contraception such as injectables and implants can have a longer impact after discontinuation of use and must be taken into account when making a diagnosis of anovulation.[9] Past medical history should thoroughly document comorbidities such as hypertension, diabetes, cardiac disease, previously treated cancers, autoimmune conditions, or any other comorbidities that may affect fertility or pregnancy outcomes. Conditions that alter ovarian reserve and fertility prognosis, such as previous chemotherapy, should be identified. Other endocrinopathies should also be identified as treating these conditions is likely to improve fertility outcomes.

A good surgical history is equally important. Abdominal procedures, such as appendectomy for a ruptured appendix, can alert clinicians to pelvic adhesions and tubal disease. Previous cesarean birth raises the possibility of a cesarean scar niche, and other pelvic surgeries (e.g. for endometriosis) might facilitate diagnosis and appropriate referral to secondary care where necessary. Family history helps assess the risk of inherited diseases and potential future risks.

Patients trying to conceive should be advised to take folic acid supplements at least 1 month before and avoid all teratogenic medications. Some medications should be switched to safer alternatives when planning a pregnancy and all drug and other allergies recorded. Body mass index and lifestyle factors can significantly affect fertility outcomes. Height and weight measurements should be recorded, along with a history of smoking, alcohol consumption, and recreational drug use. Investigations should include a pelvic ultrasound to evaluate uterine–ovarian and pelvic pathologies, antral follicle count, and transvaginal accessibility for egg collection. Any history of gamete or embryo preservation should be recorded. A pelvic examination might be necessary for cervical cytology or to diagnose other pathologies.

Tubal patency can be performed by hysterosalpingogram when X-ray facilities are available or by saline sonography or hysterosonography when ultrasound facilities are available. In some cases, hysteroscopy or laparoscopy might be warranted. Measurement of anti-Müllerian hormone to evaluate ovarian reserve should be performed, when feasible. Luteal phase progesterone blood measurements assist in diagnosing ovulation or anovulation. Progesterone

levels above 25 nmol/L (7.7 ng/mL) are used to confirm ovulation and creation of corpus luteum.[10] When prolactin is elevated, the test should be repeated to ensure it is persistently elevated and associated with anovulation. If so, further management by cabergoline or referral to a specialist in reproductive endocrinology is indicated.

To avoid fetal rubella syndrome, either confirmation of vaccination or serological confirmation of immunity should be determined. If there is no evidence, vaccination should be administered if feasible. Sexually transmitted infection (STI) screening should be considered depending on the population and past history. In cases of recurrent pregnancy loss, other testing might be required, including genetic evaluation.

3.2 | Patient 2 assessment

Taking a history of patient 2 is equally important in fertility evaluation. It is important to document wherever the partner has previously had any children and any prior infertility investigations (page 4 of the passport). Assessment should include screening for erectile dysfunction or loss or lack of libido. A detailed medical history of medical comorbidities may guide toward potential causes of suboptimal sperm parameters. A detailed surgical history, especially of any groin or testicular surgery such as surgery for undescended testis, hydrocele, or varicocele, might facilitate diagnosis.

Family history helps identify inherited conditions that might affect fertility. All allergies should be documented. Lifestyle factors such as smoking, excessive alcohol, and recreational drug use may affect sperm parameters and should be thoroughly assessed.[11] Due to the variability of sperm count testing and sperm production, patients with low sperm counts warrant a repeat semen analysis to ensure accurate results.[12] For persistently low sperm counts, penile and testicular examination, karyotyping, and hormone testing (follicle-stimulating hormone, luteinizing hormone, and testosterone) might be necessary. Patients with severely low sperm counts have a higher incidence of testicular cancer and should undergo testicular ultrasound.[13] For azoospermic patients, additional genetic testing (karyotype), including Y-chromosome microdeletion and cystic fibrosis genes, might be indicated. STI screening should be performed when clinically relevant.

3.3 | Fertility treatments

Fertility treatments range from less invasive to more complex interventions. Treatments might include timed intercourse, intrauterine insemination, in vitro fertilization, intracytoplasmic sperm injection, and sometimes preimplantation genetic testing and other genetic evaluations. A detailed record of all fresh cycles, frozen cycles, and the pregnancy outcomes for those treatments and potential remaining cryopreserved gametes should be recorded. Documentation of complications such as ovarian hyperstimulation syndrome, infections, or hospital admissions is also essential (pages 3 and 6 of the passport).

4 | CONCLUSION

The FIGO Fertility Passport aims to prevent treatment delays by reducing the need to repeat tests and providing clarity about previous care. This document summarizes a patient's fertility journey, but it is not intended to replace clinical notes or need for a history or examination. There is still a need for a clinician to take a complete history. This tool has the potential to save a patient's time and reduce financial burden as they navigate their fertility journey. This resource is designed to be valuable across different healthcare settings, including both high-income and LMICs where healthcare resources might be limited. A link to the FIGO Nutrition Checklist to assess a patient's nutritional status is provided at the bottom of page 2 of the passport (www.figo.org/figo-resources/nutrition/figo-nutrition-checklist). It is hoped that this initiative will enhance global reproductive health care and improve outcomes for all patients. The FIGO REI Committee strongly encourages all reproductive healthcare providers to implement these standardized documentation tools into their practice.

AUTHOR CONTRIBUTIONS

All authors contributed to the conception of the paper, analysis of potential drafts, and critical revision of the manuscript. All authors provided their final approval for this version to be published. All authors agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work were appropriately investigated and resolved.

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CONFLICT OF INTEREST STATEMENT

The authors report no conflicts of interest.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

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REFERENCES

1. Kumar N, Singh AK. Trends of male factor infertility, an important cause of infertility: a review of literature. *J Hum Reprod Sci*. 2015;8:191-196.
2. World Health Organization [website]. Infertility. Accessed March 10, 2025. www.who.int/news-room/fact-sheets/detail/infertility
3. Practice Committee of the American Society for Reproductive Medicine. Definitions of infertility and recurrent pregnancy loss: a committee opinion. *Fertil Steril*. 2020;113(3):533-535. doi:10.1016/j.fertnstert.2019.11.025
4. Boivin J, Bunting L, Collins JA, Nygren KG. International estimates of infertility prevalence and treatment-seeking: potential need and demand for infertility medical care. *Hum Reprod*. 2007;22:1506-1512.
5. Ombelet W, Lopes F. Fertility care in low- and middle-income countries. *Reprod Fertil*. 2024;5:e240042.
6. Simopoulou M, Sfakianoudis K, Giannelou P, et al. Treating infertility: current Affairs of Cross-border Reproductive Care. *Open Med*. 2019;14(1):292-299. doi:10.1515/med-2019-0026
7. Henry L, Antsaklis A, Feldberg D, et al. FIGO position statement: Gamete donations. *Int J Gynaecol Obstet*. 2025;170:20-24.
8. Ethics Committee of the American Society for Reproductive Medicine. Cross-border reproductive care: an ethics committee opinion. *Fertil Steril*. 2022;117:954-962.
9. Taylor DJ, Halpern V, Brache V, Bahamondes L, Jensen JT, Dorflinger LJ. Ovulation suppression following subcutaneous administration of depot medroxyprogesterone acetate. *Contracept X*. 2022;4:100073.
10. Duncan WC. The inadequate corpus luteum. *Reprod Fertil*. 2021;2:C1-C7.
11. Boeri L, Capogrosso P, Ventimiglia E, et al. Heavy cigarette smoking and alcohol consumption are associated with impaired sperm parameters in primary infertile men. *Asian J Androl*. 2019;21:478-485.
12. World Health Organization. *WHO Laboratory Manual for the Examination and Processing of Human Semen*. 6th ed. WHO; 2021. Accessed June 11, 2025. https://www.who.int/publications/i/item/9789240030787
13. Jacobsen R, Bostofte E, Engholm G, et al. Risk of testicular cancer in men with abnormal semen characteristics: cohort study. *BMJ*. 2000;321:789-792.

SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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