Arizona Reproductive Medicine Specialists
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Phoenix, AZ85016
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PATIENT REGISTRATION FORM

(PLEASE PRINT)

Patient Name: _____ Partner Name: _____

Marital Status: ☐ Single ☐ Engaged ☐ Married (for ____ years) ____ Same Gender relationship (____ years)

Patient SSN: _____ Partner SSN: _____

Patient D.O.B: _____ Age: _____ Partner D.O.B: _____ Age: _____

Patient Race: _____ Partner Race: _____

Contact Phone: _____ Partner Contact Phone: _____

Patient Work Phone: _____ Partner Work Phone: _____

Billing Address: _____

Patient Email: _____ Partner Email: _____

Patient Occupation: _____ Partner Occupation: _____
Patient Employer: _____ Partner Employer: _____

EMERGENCY CONTACT **REFERRING PHYSICIAN:** _____

Nearest relative or partner: _____ **OBGYN:** _____
Phone Number(s): _____ **OBGYN Phone number**: _____

INSURANCE INFORMATION

Patient

Primary Insurance: _____
Policy#: _____ Group#: _____
Policy Holder: _____
Phone#: _____

Secondary Insurance: _____
Policy#: _____ Group#: _____
Policy Holder: _____
Phone#: _____

Partner

Same Insurance as patient? _____ *(Y/N)*
Primary Insurance: _____
Policy#: _____ Group#: _____
Policy Holder: _____
Phone#: _____

Secondary Insurance: _____
Policy#: _____ Group#: _____
Policy Holder: _____
Phone#: _____

Authorization to Release Information: I authorize the release of any medical records or other information to process my health claim.
Authorization for payment: As a condition for treatment by this office, I understand that the practice depends upon reimbursement from the patients for the costs incurred in their care. Care is to be paid for at the time of service. If I carry insurance, I understand that this office will HELP in obtaining prior authorization, however, it is my responsibility to ensure that authorization is in place for my services as needed. If authorization is not received prior to my appointment, I am responsible for payment. Any services not covered by my insurance company will be my financial responsibility.
I have read the above conditions of treatment and agree to their content.

Printed Name: _____ Signature: _____ Date: _____

PATIENT QUESTIONNAIRE

DATE/TIME OF PHONE APPT: _____ DATE/TIME OF CONSULTATION WITH DOCTOR: _____

OB/GYN: _____ Phone: _____

Address: _____

Primary Care Physician: _____Phone: _____

Address: _____

Referral Source: OB/GYN - PCP - Other: _____

Address: _____ Phone: _____

Did you request to see a specific doctor at ARMS? Yes / No If yes, which doctor? _____

Kindly let us know any comments that influenced your choice of doctors: _____

_____

_____

_____

Do we have your permission to send correspondence regarding your treatment with us to your OB/GYN and/or your referring physician(s)? ☐ Yes ☐ No

Circle the **main** reason for your visit to our facility: Infertility / PCOS / HRT Management / Irregular Menses / Other:

_____

_____

Briefly describe when and how you came to recognize this problem?

_____

_____

_____

_____

Do you have any adopted children? Yes / No If yes, please list the name, gender, and age of each child below:

_____

_____

_____

INFERTILITY TREATMENT QUESTIONNAIRE

Please complete your pregnancy history by indicating the appropriate number that applies:

Total pregnancies: _____	Therapeutic (Elective) Abortions: _____	Live Births: _____
Full Term Births: _____	Spontaneous Loss (Miscarriages): _____	Multiple Births: _____
Pre-Mature Births: _____	Ectopic – Left – Right - Unknown: _____	Still Births: _____

How many **cumulative** months or years have you been sexually active and not utilizing ANY form of contraceptive method, and not gotten pregnant? _____ Months / Years

Please request records from doctors and/or hospitals (especially records showing any ovarian stimulation treatment cycles at other infertility clinics) to be sent to us or bring them with you to your first appointment. ***Although we ask you to provide your previous medical records, we also ask you to fill in ALL the applicable areas below with as much detail as you can provide us with. This will allow our medical staff to optimize their time with you during your phone and consultation appointments.***

Have you had any of the following diagnostic procedures or labs performed? ____Yes ____ No
If you answered "Yes" please complete below:

Diagnostic Procedure:	Date(s):	Results:
☐ Post Coital Test (PCT)	_____	_____
☐ Endometrial Biopsy (EMB)	_____	_____
☐ Hysterosalpingogram (HSG)	_____	_____
☐ Diagnostic Laparoscopy	_____	_____
☐ Other _____	_____	_____

Lab Test:	Date(s):	Results:
☐ Prolactin (PRL)	_____	_____
☐ Thyroid Stim. Hormone (TSH)	_____	_____
☐ DHEAS	_____	_____
☐ AntiMullerian Hormone (AMH)	_____	_____
☐ Follicle Stim. Hormone (FSH)	_____	_____
☐ Luteinizing Hormone(LH)	_____	_____
☐ Estradiol (E2)	_____	_____
☐ Rubella Titer	_____	Immune / Not Immune / Unknown
☐ Other_____	_____	_____
☐ Semen Analysis (most recent)	_____	____ Normal ____ Abnormal

Have you ever monitored your BBT or used OPK's at home in natural (non-medicated) cycles ☐ Yes ☐ No (If yes, please complete below)

☐ Basal Body Temperature charting (BBT) How many natural cycles have you charted your BBT? _____

How many were Biphasic_____ Date of your most recent chart: _____

_____ Ovulation Predictor Kits (OPK's) How many natural cycles have you used OPK's? _____

How many cycles were positive_____ Date of your most recent chart: _____

What day of your cycle, or what cycle day range do you receive your positive result(s): _____

Do you ever get a positive result two or more days in a row ☐ Yes / No ☐ I have not tested after the first positive

INFERTILITY TREATMENT QUESTIONNAIRE

Have you had any previous infertility treatment? ☐ **Yes** ☐ **No** (If Yes please complete this page, otherwise skip to page 5)

Please indicate which of the following treatments you've done by entering the number of cycles you've done that particular type of treatment.(Circle &/or fill-in additional information where necessary)

Ovulation Induction *-Treatment given to people who DO NOT ovulate at all.*
Superovulation *- Treatment given to people who DO ovulate to get them to release more than one egg each month.*

# of Cycles	Type of Treatment	Date(s) of each treatment cycle
☐	Insemination Only (no meds)	_____
☐	Progesterone Only _____mg – Vaginal / Oral / Topical / IM	_____
☐	Ovulation Induction w/Clomid – Maximum dose was _____ mg	_____
☐	Ovulation Induction w/Femara – Maximum dose was _____ mg	_____
☐	Ovulation Induction w/Metformin	_____
☐	Ovulation Induction w/Metformin & Clomid / Femara	_____
☐	Ovulation Induction w/Injectible Medications	_____
☐	Superovulationw/Clomid _____ mg with / without insemination	_____
☐	Superovulationw/Femara _____ mg with / without insemination	_____
☐	Superovulationw/Clomid & Injectible Meds with / without insemination	_____
☐	Superovulationw/Femara & Injectible Meds with / without insemination	_____
☐	Superovulationwith Injectible Medications ONLY	_____
☐	In-Vitro Fertilization (IVF)	_____
☐	GIFT	_____
☐	ZIFT	_____

How were the above treatment cycles monitored?

Please circle ALL forms of monitoring that appl ☐ BBT ☐ OPK ☐ Ultrasound ☐ Bloodwork ☐ NONE

Did any of the above treatment cycles result in pregnancy? If so, please give details below:

_____

_____

Please indicate any/all of the following medications you have used during infertility treatment:

☐ Antagon	☐ Estrace	☐ Lupron	☐ Progesterone lozenges
☐ Baby Aspirin	☐ Femara	☐ Luveris	☐ Prometrium
☐ Bravelle Estrogen Patch	☐ Follistim	☐ Metformin	☐ Provera
☐ Climara Estrogen Patch	☐ Ganarelix	☐ Novarel	☐ Repronex
☐ Crinone Vaginal Cream	☐ Gonal-F	☐ Ovidrel	☐ Serophene
☐ Clomid	☐ Heparin	☐ Pergonal	☐ Terbutaline
☐ Estrodial	☐ Lovenox	☐ Profasi	☐ Other: _____
☐ Unknown oral medication	☐ Unknown injectible medication		☐ Unknown vaginal medication

PAST MEDICAL HISTORY - Female

ALLERGIES:

List any medications you are allergic to and the reaction you have when you take it: ☐ None

List any food and/or environmental allergies you have: ☐ None

MEDICATIONS:

List any fertility medications you are currently taking: ☐ None

List all other prescription medications you are currently taking along with dosages and start dates: ☐ None

List all vitamins & herbal supplements you are currently taking along with dosages and start dates: ☐ None

BLOOD TYPE:

Please circle your blood type: A+ / A- / B+ / B- / AB+ / AB- / O+ / O- / Unknown

What documentation do you have of this? ☐ None ☐ Medical Records ☐ Donor Card Other: _____

PAST MEDICAL HISTORY – Female

PAST MEDICAL ILLNESSES:

Please put an "X" next to each illness/condition listed below that you have had or currently have: _____None

- ☐ Abnormal Pap Smear
- ☐ Abuse
- ☐ Adenomyosis
- ☐ Alcoholism
- ☐ Anemia
- ☐ Angina
- ☐ Anorexia
- ☐ Anxiety Disorder
- ☐ Appendicitis
- ☐ Asherman's Syndrome
- ☐ Asthma
- ☐ ADD w/Hyperactivity
- ☐ Back Pain History
- ☐ Benign Tumors
- ☐ Bipolar Disorder
- ☐ Birth Defects
- ☐ Bladder Dysfunction
- ☐ Bladder Spasms
- ☐ Bleeding Problems
- ☐ Bleeding Tendencies
- ☐ Bowel Problems
- ☐ Cancer: _____
- ☐ Cardiac Disease
- ☐ Chickenpox
- ☐ Chlamydia
- ☐ COPD
- ☐ Crohn's Disease
- ☐ Cryptorchidism
- ☐ Cystic Fibrosis
- ☐ Cystitis
- ☐ Deep Vein Thrombosis
- ☐ Diabetes
- ☐ Depression
- ☐ Eating Disorder
- ☐ Elevated Testosterone
- ☐ Endocrine Problems
- ☐ Endometriosis
- ☐ Epilepsy
- ☐ Eye Conditions
- ☐ Factor V Leiden
- ☐ Female Reproductive Problems
- ☐ Fibroids
- ☐ Fibromyalgia
- ☐ Fragle X Syndrome
- ☐ Galactorrhea
- ☐ Gallbladder Problems
- ☐ Genetic Condition (Immediate Family)
- ☐ GERD
- ☐ Gestational Diabetes
- ☐ Glaucoma
- ☐ Gonorrhea
- ☐ Grave's Disease
- ☐ Hashimoto's Thyroiditis
- ☐ Hearing Loss
- ☐ Heart Problem/Condition
- ☐ Hematuria
- ☐ Hemophilia
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Herpes
- ☐ Hirsutism
- ☐ History of Psychiatric Problems
- ☐ HIV/AIDS
- ☐ Hodgkin's Disease
- ☐ Hormone Problems
- ☐ HPV
- ☐ Hydrosalpinx
- ☐ Hypercholesterolemia
- ☐ Hyperprolactinemia
- ☐ Hypertension (High BP)
- ☐ Hyperthyroidism
- ☐ Hypotension (Low BP)
- ☐ Hypothyroidism
- ☐ In-Utero Exposure to DES
- ☐ Incontinence
- ☐ Infection
- ☐ Infertility Factors: Cervical
- ☐ Infertility Factors: Sperm Problem
- ☐ Infertility Factors: low egg supply
- ☐ Infertility Factors: Endo Stage I
- ☐ Infertility Factors: Endo Stage II
- ☐ Infertility Factors: Endo Stage III
- ☐ Infertility Factors: Endo Stage IV
- ☐ Infertility Factors: Immunologic
- ☐ Infertility Factors: Ovulatory
- ☐ Infertility Factors: Tubal
- ☐ Infertility Factors: Unexplained
- ☐ Inguinal Hernia
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Infections
- ☐ Kidney Stones
- ☐ Leukemia
- ☐ Lipid Disorders
- ☐ Lung Problems
- ☐ Lymphoma
- ☐ Malignant Melanoma
- ☐ Malignant Hypertheria
- ☐ Measles
- ☐ Meningitis
- ☐ Migraines
- ☐ Mitral Valve Prolapse
- ☐ Molar Pregnancy
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Myasthenia Gravis
- ☐ Myocardial Infarction
- ☐ Nocturia
- ☐ Obesity
- ☐ Obsessive Compulsive Disorder
- ☐ Oliguria
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Ovarian Cysts
- ☐ PCOS
- ☐ Pleural Effusion
- ☐ PMS
- ☐ Pneumonia
- ☐ Premature Ovarian Failure
- ☐ Polyuria
- ☐ Poor Sense of Smell
- ☐ Protein C Deficiency
- ☐ Psoriasis
- ☐ Pulmonary Edema
- ☐ Pulmonary Embolism
- ☐ Recurrent UTI's
- ☐ Respiratory Problems
- ☐ Rh Negative
- ☐ Rh Sensitization
- ☐ Rheumatoid Arthritis
- ☐ Ruptured Spleen
- ☐ Sciatica
- ☐ Seasonal Allergies
- ☐ Sepsis
- ☐ Septate Uterus
- ☐ Sickle Cell
- ☐ Sinusitis
- ☐ Skin Cancer
- ☐ Skin Problems
- ☐ Suicide Attempt
- ☐ Thrombocytopenia
- ☐ Tonsillitis
- ☐ Tubal Problems
- ☐ Tuberculosis
- ☐ Tumors/Neoplasms
- ☐ Ulcer
- ☐ Ulcerative Colitis

CURRENT TREATMENT: List any conditions/illnesses you are currently being treated for: _____ None

_____

_____

_____

PAST MEDICAL HISTORY - Female

HOSPITALIZATIONS - List in the order they occurred ***(Please DO NOT include any surgeries)*:** _____ None

Date	# of Days	Reason

SURGERIES - List all surgeries you have had in the past in the order that they occurred: _____ None

Date	Name of Procedure	Reason/Diagnosis

PAST GYNECOLOGICAL HISTORY

What was the first day of your last menstrual period (LMP)? _____

How old were you when you first noticed breast development? _____

How old were you when you first noticed pubic hair growth? _____

How old were you when you had your first period? _____

At what age did your periods become regular? _____

INTERVAL: How many days is it from the first day of one period to the first day of your next period? _____

DURATION: How many total days of menstrual flow do you have? _____

How many 'heavy flow' days do you have during your period? _____

FLOW: (circle one) Very light / light / moderate / heavy / occasionally heavy / variable

COMPLICATIONS: Please "**X**" any of the following discomfort you have associated with your period: ____ NONE

___BLOATING ___ NAUSEA___HEADACHE___BACK PAIN ___CRAMPING – mild/moderate/severe

___BREAST PAIN ___CLOTS PRESENT: mild/moderate/severe ___PMS: mild/moderate/severe

___ SPOTTING or BLEEDING in between periods ___Other: _____

When does the discomfort start and how long does it last?

_____

Is your discomfort relieved by taking medication? If so, what kind? _____

How many pads do you use in a 24 hour period of time on your heaviest day of flow? ____ Liners / Mini Pads / Maxi Pads

How many tampons do you use in a 24 hour period of time on your heaviest day of flow? ____ Regular / Super / Super Plus

Do you have discomfort with intercourse ___Yes ___No If yes, please describe below:

_____

_____

Do you experience any bleeding or spotting during intercourse? Yes / No/ Occasionally

Do you experience any bleeding or spotting after intercourse? Yes / No / Occasionally

Do you use any kind of lubrication during intercourse? Yes / No / Occasionally

If so, what type/name brand? _____

On average, how many times per MONTH do you have intercourse? _____

Have you noticed any change in your sexual drive? ___Yes ___No If yes, please circle one: ___Increase ___Decrease

PAST GYNECOLOGICAL HISTORY

CONTRACEPTION: **Please mark <u>all</u> forms of contraception that you have used:** ☐ **None**

☐ Birth Control Pills ☐ Condoms ☐ IUD ☐ Diaphragm ☐ Norplant ☐ Nuva Ring ☐ Depo-Provera

☐ Sponge ☐ Spermicide ☐ Rhythm Method ☐ Vasectomy ☐ Tubal Ligation ☐ Hysterectomy

Please list below the name brand of eachform of contraception that you've used. Indicate the date you started using it, the date you stopped using it, and the reason for stopping it. (*If you have used multiple brands of birth control pills, please list <u>eachone</u> individually. Thank you.)*

Name Brand	Start Date	Stop Date	Reason For Stopping

Date of your last pap smear? _____ Result: ☐ Normal ☐ Abnormal

Have you ever had an abnormal PAP Smear? ☐ Yes ☐ No Date(s): _____

Classification/Result of abnormal: ☐ Mild / Moderate / Severe Dysplasia ☐ HPV ☐ Unknown ☐ Other _____

Treatment: None / Cryosurgery / LEEP / Cold knife cone biopsy / Laser / Medication / Other: _____

Date of your last mammogram? _____ ☐ I've never had one Result: ☐ Normal ☐ Abnormal

Please indicate if you have ever had any of the following infections/irritations of your pelvic organs: ☐ None

☐ Yeast Infection ☐ Bladder infection (UTI) ☐ Pelvic Inflammatory Disease (PID) ☐ Endometriosis

☐ Strep B ☐ Herpes ☐ Syphilis ☐ HPV ☐ Genital Warts ☐ Gonorrhea ☐ Chlamydia

☐ Crabs ☐ Trichomonas ☐ Vaginitis ☐ Bacterial Vaginosis ☐ Other: _____

PAST OBSTETRICAL HISTORY

Have you ever been pregnant? Yes / No ***If not skip to page 11 Otherwise, please complete the following:***

What is the shortest duration it took you to conceive? _____ months / years (circle one)

What is the longest duration it took you to conceive?_____ months / years (circle one)

List each pregnancy in the order it occurred:

1. Birthdate*(or date of miscarriage/ectopic/abortion/etc.)*: _____ Gender: M / F
   Status: (circle one) alive / deceased / ectopic / miscarriage / abortion / Other: _____
   Delivery method: Vaginal / Forceps / Vacuum / C-section / D&C / Tube removed– Right – Left
   Length of labor: _____ Birth weight ___lbs ___oz Duration of pregnancy (weeks) _____
   Complications: NONE / Placental abruption / Placenta previa / Breech / Eclampsia /PIH
   Failure of descent / Failure to progress / Fetal distress /Hemorrhage / Infection
   Premature labor / Seizures / Other: _____

2. Birthdate*(or date of miscarriage/ectopic/abortion/etc.)*: _____ Gender: M / F
   Status: (circle one) alive / deceased / ectopic / miscarriage / abortion / Other: _____
   Delivery method: Vaginal / Forceps / Vacuum / C-section / D&C / Tube removed– Right – Left
   Length of labor: _____ Birth weight ___lbs ___oz Duration of pregnancy (weeks) _____
   Complications: NONE / Placental abruption / Placenta previa / Breech / Eclampsia /PIH
   Failure of descent / Failure to progress / Fetal distress /Hemorrhage / Infection
   Premature labor / Seizures / Other: _____

3. Birthdate*(or date of miscarriage/ectopic/abortion/etc.)*: _____ Gender: M / F
   Status: (circle one) alive / deceased / ectopic / miscarriage / abortion / Other: _____
   Delivery method: Vaginal / Forceps / Vacuum / C-section / D&C / Tube removed– Right – Left
   Length of labor: _____ Birth weight ___lbs ___oz Duration of pregnancy (weeks) _____
   Complications: NONE / Placental abruption / Placenta previa / Breech / Eclampsia /PIH
   Failure of descent / Failure to progress / Fetal distress /Hemorrhage / Infection
   Premature labor / Seizures / Other: _____

4. Birthdate*(or date of miscarriage/ectopic/abortion/etc.)*: _____ Gender: M / F
   Status: (circle one) alive / deceased / ectopic / miscarriage / abortion / Other: _____
   Delivery method: Vaginal / Forceps / Vacuum / C-section / D&C / Tube removed– Right – Left
   Length of labor: _____ Birth weight ___lbs ___oz Duration of pregnancy (weeks) _____
   Complications: NONE / Placental abruption / Placenta previa / Breech / Eclampsia /PIH
   Failure of descent / Failure to progress / Fetal distress /Hemorrhage / Infection
   Premature labor / Seizures / Other: _____

PAST OBSTETRICAL HISTORY (continued)

5. Birthdate*(or date of miscarriage/ectopic/abortion/etc.)*: _____ Gender: M / F
Status: (circle one) alive / deceased / ectopic / miscarriage / abortion / Other: _____
Delivery method: Vaginal / Forceps / Vacuum / C-section / D&C / Tube removed– Right – Left
Length of labor: _____ Birth weight ____lbs ____oz Duration of pregnancy (weeks) _____
Complications: NONE / Placental abruption / Placenta previa / Breech / Eclampsia /PIH
Failure of descent / Failure to progress / Fetal distress /Hemorrhage / Infection
Premature labor / Seizures / Other: _____

6. Birthdate*(or date of miscarriage/ectopic/abortion/etc.)*: _____ Gender: M / F
Status: (circle one) alive / deceased / ectopic / miscarriage / abortion / Other: _____
Delivery method: Vaginal / Forceps / Vacuum / C-section / D&C / Tube removed– Right – Left
Length of labor: _____ Birth weight ____lbs ____oz Duration of pregnancy (weeks) _____
Complications: NONE / Placental abruption / Placenta previa / Breech / Eclampsia /PIH
Failure of descent / Failure to progress / Fetal distress /Hemorrhage / Infection
Premature labor / Seizures / Other: _____

7. Birthdate*(or date of miscarriage/ectopic/abortion/etc.)*: _____ Gender: M / F
Status: (circle one) alive / deceased / ectopic / miscarriage / abortion / Other: _____
Delivery method: Vaginal / Forceps / Vacuum / C-section / D&C / Tube removed– Right – Left
Length of labor: _____ Birth weight ____lbs ____oz Duration of pregnancy (weeks) _____
Complications: NONE / Placental abruption / Placenta previa / Breech / Eclampsia /PIH
Failure of descent / Failure to progress / Fetal distress /Hemorrhage / Infection
Premature labor / Seizures / Other: _____

8. Birthdate*(or date of miscarriage/ectopic/abortion/etc.)*: _____ Gender: M / F
Status: (circle one) alive / deceased / ectopic / miscarriage / abortion / Other: _____
Delivery method: Vaginal / Forceps / Vacuum / C-section / D&C / Tube removed– Right – Left
Length of labor: _____ Birth weight ____lbs ____oz Duration of pregnancy (weeks) _____
Complications: NONE / Placental abruption / Placenta previa / Breech / Eclampsia /PIH
Failure of descent / Failure to progress / Fetal distress /Hemorrhage / Infection
Premature labor / Seizures / Other: _____

SOCIAL HISTORY (Female)

Do you smoke tobacco? Yes /No If yes, how many packs? _____ per day / week / month for _____ years.

Do you drink alcohol? Yes / No If yes, how much? _____ per day / week / month / year
What kind? _____

Do you use recreational drugs? Yes / No
If so, which one(s)?_____

Do you drink caffeine? Yes / No If yes, how many sodas? _____ per day / week / month. How many cups of coffee? _____ per day / week / month. How many cups of hot tea / iced tea? _____ per day / week / month.

Do you exercise regularly? Yes / No If yes, how often? _____ times per week for _____ min. / hours each time?

Current weight? _____ What do you consider your "Ideal" weight to be? _____
Have you experienced any recent weight changes? Yes / No If yes, please explain below:
_____

Religious Preference: _____

Are you currently under significant stress? Yes / No If yes, please explain:
_____
_____
_____

Briefly describe your diet: (*Example*: vegetarian, typical American diet, low carbohydrate, etc)
_____
_____
_____

What is your job title? Briefly describe what kind of work do you do?
_____
_____

FAMILY HISTORY

(Female Patient only)

Please mark this box if you were adopted and do not know your biological family history: ☐

Otherwise, complete this form by filling in the appropriate abbreviation for each family member who has been affected with each illness/condition listed below. Also indicate whether they are alive or deceased by putting an A or a D next to their abbreviation, then specify their current age or their age at death.

Example:
If your mom's mom died of breast cancer at age 65 you would write: *MGM – D – 65* in the line next to Breast Cancer.

Please use <u>only</u>the following abbreviations:
(Maternal = Mother's side of the family, Paternal = Father's side of the family):

Mother – **M**
Maternal Grandmother – **MGM**
Maternal Grandfather – **MGF**
Maternal Aunt – **MA**
Maternal Uncle – **MU**

Father – **F**
Paternal Grandmother - **PGM**
Paternal Grandfather - **PGF**
Paternal Aunt – **PA**
Paternal Uncle – **PU**

Sister – **S**
Brother - **B**
Daughter – **D**
Son - **SON**
Cousin – **C**

Illness/Condition	Family Member(s) affected – A or D - Age		Illness/Condition	Family Member(s) affected – A or D - Age
Alzheimer's Disease			Lung problems	
Aneurysm			Lupus	
Angina			Lymphoma	
Asthma			Malignant melanoma	
Bleeding disorder			Mental illness	
Brain tumor			Mental retardation	
Breast problems			Migraines	
Cancer			Miscarriage	
Cholesterolemia			MS	
Coronary artery disease			Myasthenia gravis	
Crohn's			Neurological disease	
Cystic Fibrosis			Obesity	
Deep venous thrombosis			Osteoporosis	
Dementia			Parkinson's	
Diabetes			PCOS	
Diverticulitis			Pregnancy difficulties	
Endometriosis			Rheumatoid arthritis	
Fibroids			Seizures	
Gastrointestinal problem			Stroke	
GERD			Suicide	
Grave's disease			Thyroid disease	
Heart attack			Tuberculosis	
Heart failure			Ulcerative colitis	
Hepatitis			Undetermined cause of death	
Hodgkin's lymphoma			Wilson's disease	
Huntington's disease			Other Illness/Condition:	
Hypertension (high blood pressure)				
Hyperthyroidism (over-active thyroid)				
Hypothyroidism (under-active thyroid)				
Infertility problems				
Kidney disease				
Leukemia				
Liver disease				

Review of Systems: General health of the female patient. Please indicate whether or not you currently have, or if you have experienced any of the following in the most recent six months:

Yes	No	Problem
____	____	Abdominal Distention
____	____	Abrupt visual loss
____	____	Acne problems
____	____	Addiction to alcohol
____	____	Addictive tendencies
____	____	Allergic or immunologic symptoms
____	____	Anemia
____	____	Ankle swelling
____	____	Appetite poor or changed
____	____	Arm pain
____	____	Arthritic flare up
____	____	Asthma attack recently
____	____	Back pain
____	____	Binging and purging
____	____	Bleeding gums
____	____	Bleeding tendency
____	____	Blood in stool
____	____	Blood in urine
____	____	Breast discharge
____	____	Breathing difficulty
____	____	Bruise easily
____	____	Chest pain
____	____	Chest pressure
____	____	Cold feet
____	____	Cold hands
____	____	Cold intolerance
____	____	Constipation
____	____	Constitutional symptoms such as fever, headache, nausea, dizziness
____	____	Cough – productive
____	____	Coughing up excess sputum
____	____	Crushing sensation in chest
____	____	Crying jags
____	____	Cuts take longer to heal
____	____	Decreased libido
____	____	Depression
____	____	Diarrhea
____	____	Diplopia
____	____	Dry hair
____	____	Dry skin
____	____	Elevated blood pressure
____	____	Emotional or mental abuse
____	____	Excess hair growth
____	____	Extreme highs and lows
____	____	Feelings of hopelessness
____	____	Flushing
____	____	Frequent hot baths or showers
____	____	Hair loss
____	____	Headache
____	____	Heart palpitations
____	____	Heat intolerance
____	____	Hepatitis B carrier
____	____	Hot flashes
____	____	Inability to conceive
____	____	Induced vomiting
____	____	Irregular menstrual cycle
____	____	Irritability
____	____	Jaw pain
____	____	Joint pain
____	____	Loss of sensation
____	____	Loss of vision
____	____	Mid-cycle pain
____	____	Migraine
____	____	Nausea and vomiting
____	____	Night sweats
____	____	Psychiatric or emotional diff.
____	____	Rape or sexual abuse
____	____	Seasonal allergies
____	____	Sexual dysfunction
____	____	Shortness of breath
____	____	Skin sores
____	____	Sleep problems
____	____	Suicidal thoughts
____	____	Suicide attempt
____	____	Tightness in chest
____	____	Unusual fatigue
____	____	Urinary frequency
____	____	Urinary frequency at night
____	____	Urinary urgency
____	____	Varicosities
____	____	Weight gain
____	____	Weight loss, unintentional
____	____	Wheezing

INFERTILITY TREATMENT QUESTIONNAIRE
(Male)

List all medications you are allergic to and the reaction you have when you take it: ☐ None

_____

_____

List all medications you currently take including prescription medications, over the counter medications, vitamins, and/or herbal supplements, their dosages, and when you take them: ☐ None

_____

_____

_____

Please circle your blood type: A+ / A- / B+ / B- / AB+ / AB- / O+ / O- / Unknown

What documentation do you have of this? ☐ None ☐ Medical Records ☐ Donor Card ☐ Other: _____

Check if you have ever had any of the following illnesses/conditions: _____None

____Chickenpox	____Prostate infection	____Testicular problems	____Recent High Fevers
____Measles	____Penile infection	____Varicocele	____Arthritis
____Mumps	____Impotence	____Decreased libido	____Ulcers
____Appendicitis	____Urine infection	____Diabetes	____Migraines
____Tonsillitis	____Chlamydia	____Tuberculosis	____Pneumonia
____Asthma	____Herpes	____Hypertension	____Bronchitis
____Strep Throat	____Genital Warts	____Cancer	____GERD

List any additional significant illnesses/conditions you have had in the past:

_____

_____

List in the order they occurred, any surgeries you have had: _____ I have had no previous surgeries.

DATE	PROCEDURE	REASON
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all past semen analyses performed: _____None

DATE	VOLUME	COUNT	MOTILITY	MORPHOLOGY
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

How old were you when you began to develop pubic hair? _____

How old were you when you began to shave? _____ How often do you shave? _____

How many conceptions/pregnancies have you contributed to in the past? _____

How many times a month do you have intercourse? _____

List any difficulties you have with intercourse: ☐ None

_____

_____

_____

INFERTILITY TREATMENT QUESTIONNAIRE
(Male - continued)

Do you smoke / chew tobacco? Yes / NoIf yes, how many packs/cans? _____ per day / week / month for _____ years.

Do you drink alcohol? Yes / NoIf yes, how much? _____drinks per day / week / month/ year
What kind? _____

Do you use recreational drugs? Yes / No
If so, which one(s)?_____

Do you drink caffeine? Yes / NoIf yes, how many sodas? _____ per day / week / month. How many cups of coffee? _____ per day / week / month. How many cups ofhot tea / iced tea? _____ per day / week / month.

Do you exercise regularly? Yes / NoIf yes, how often? _____ times per week for _____ min. / hours each time.

Currentweight? _____ What do you consider your "Ideal" weight to be? _____
Have you experienced any recent weight changes? Yes / No If yes, please explain below:
_____

Religious Preference: _____

Are you currently under significant stress? Yes / NoIf yes, please explain:
_____
_____
_____

Briefly describe your diet: (*Example*: vegetarian, typical American diet, low carbohydrate, etc)
_____
_____
_____

Circle what type(s) of underwear you wear: Boxers / Boxer-Briefs / Briefs / Bikini / Garments / None / Other: _____

Check if you are or have been exposed to any of the following:

☐ Heat _____ Poisons _____ Lead _____ Cancer drugs _____ X-rays _____ Steroids

What is your job title, and what type of work do you do?
_____
_____

PHYSICAL EXAM
(To be completed by our physician)

VITALS : HT_____ WT_____ BMI_____ P_____ R_____ BP_____ T_____ LMP_____

GENERAL :_____

HEENT : WNL _____
THYROID : WNL_____
BREAST : WNL_____
HEART : WNL_____
LUNG : WNL_____
ABDOMEN : WNL_____
BACK : WNL_____
SKIN/HAIR WNL_____
EXTREM WNL_____
NEURO CN :NL_____
MOTOR :WNL_____
SENSORY :WNL_____
GU : EG BUS :WNL_____
CX/VAGINA :WNL_____
UTERUS : POSITION :_____
SIZE :_____
OTHER :_____
ADNEXA : R :WNL_____
L :WNL_____
RECTOVAG :CONFIRM_____
ULTRASOUND : NOT DONE OR SEE REPORT _____
_____

ASSESSMENT/PROBLEM LIST

_____
_____
_____
_____
_____
_____
_____

PLAN

_____
_____
_____
_____
_____
_____
_____

_____
Signature of Physician

Thank you for your assistance.

O Intake Done