Arizona Reproductive Medicine Specialists
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Phoenix, AZ85016
Phone :602-343-2767 Fax: 602-343-2766

PATIENT REGISTRATION FORM

(PLEASE PRINT)

Patient Name: _____ Partner Name: _____

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

Nearest relative or partner _____
Phone Number(s) _____

REFERRING PHYSICIAN: _____

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