

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Premier Fertility Center**

**2783 N.C. Highway 68, Suite 104**

**High Point, NC 27265**

**Phone (336) 841-7070 Fax (336) 841-7077**

Referring Physician: \_\_\_\_\_ Primary Physician: \_\_\_\_\_

Gynecologist: \_\_\_\_\_ Prior Infertility Clinic: \_\_\_\_\_

**Personal Data**

Name \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_

Marital Status:  Single  Married  Widowed  Divorced  Separated

Ethnicity:  Caucasian  African American  Hispanic  American Indian  Other

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

\_\_\_\_\_ Cell Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Email: \_\_\_\_\_

**Spouse/Partner** \_\_\_\_\_ **DOB** \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Occupation: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**Reason for Visit:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Past Medical History**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Accidents/Injuries/Broken Bones:** Please list any auto accidents, head injuries, serious burns or wounds.

Date	Injury	Any Limitations

**Surgical History** (including outpatient and inpatient surgery and procedures)

Date	Surgery	Hospital/Surgeon

**Hospitalizations**

Date	Problem	Treatment	Hospital/Physician

**Blood Transfusions:**

Dates \_\_\_\_\_ Reason \_\_\_\_\_

**Blood Type:** \_\_\_\_\_ **Unknown:** \_\_\_\_\_

**Childhood Illnesses:** \_\_\_ measles \_\_\_ mumps \_\_\_ rubella \_\_\_ chicken pox \_\_\_ rheumatic fever

Other: \_\_\_\_\_

**Immunizations:**

Have you had a rubella immunization? \_\_\_ yes \_\_\_ no \_\_\_ not sure

Have you had (list year)? Flu Shot \_\_\_\_\_ Hepatitis B vaccine \_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Allergies** : Please list all known allergies to drug, food, or other allergen and type of reaction

Drug/Allergen

Reaction

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**Medications**

**Current Prescription Drugs:**

Name

Dose

Prescribing Physician

Date started

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**Over the Counter Drugs** (including herbal products, vitamins, laxatives, antacids):

Name

Dose

Reason for taking

How Often

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Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Patient/Family and Social History**

Please check all that apply. Family includes your parents, children, siblings, aunts and uncles related by blood. (Please check all that apply)

<u>Condition</u>	<u>Patient</u>	<u>Family</u>	<u>Condition</u>	<u>Patient</u>	<u>Family</u>
Heart Disease	_____	_____	Ovarian Cancer	_____	_____
Elevated Cholesterol	_____	_____	Mental Retardation	_____	_____
High Blood Pressure	_____	_____	Breast Disease/Cancer	_____	_____
Stroke	_____	_____	Colon Cancer	_____	_____
Blood Clots	_____	_____	Seizure Disorders	_____	_____
Diabetes	_____	_____	Mental Illness	_____	_____
Respiratory Problems	_____	_____	Alcoholism	_____	_____
Thyroid Problems	_____	_____	Depression	_____	_____
Kidney Disease	_____	_____	Birth Defects	_____	_____
Arthritis	_____	_____	Tuberculosis	_____	_____
Sickle Cell Anemia	_____	_____	Hepatitis	_____	_____
Blood Disorder	_____	_____	Cystic Fibrosis	_____	_____
Skin Cancer	_____	_____	Osteoporosis	_____	_____

**Any history of:** \_\_\_\_\_ Anemia \_\_\_\_\_ Heart Murmur \_\_\_\_\_ Nausea/Vomiting with Anesthesia

Are you currently employed outside the home? \_\_\_\_\_ Yes \_\_\_\_\_ No

How stressful is your job? \_\_\_\_\_None \_\_\_\_\_Mild \_\_\_\_\_Moderate \_\_\_\_\_Severe

Have you had any major change in your life within the past year (e.g. death of family member, move, change in job, loss of partner)? **If yes**, list: \_\_\_\_\_

Do you have a support person/group available to you? \_\_\_\_\_ Yes \_\_\_\_\_ No

On a scale of 1 (no stress) to 10 (great stress), how is infertility affecting your:

Marriage: 1 2 3 4 5 6 7 8 9 10      Life: 1 2 3 4 5 6 7 8 9 10

Have you ever received counseling services? \_\_\_\_\_Yes \_\_\_\_\_No    What year? \_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Lifestyle/Health Promotion**

***Do You:***

Currently smoking? \_\_\_ Yes \_\_\_ No If yes, how much? \_\_\_\_\_

History of smoking? \_\_\_ Yes \_\_\_ No # of years: \_\_\_\_\_ Year you quit smoke: \_\_\_\_\_

Drink alcoholic beverages? \_\_\_ Yes \_\_\_ No

If Yes, how many drinks per week? \_\_\_\_\_

(1 drink = 12 oz. beer, 5 oz. wine, or 1.5 oz. of 80 proof liquor)

Any history of drug use? \_\_\_ Yes \_\_\_ No If yes, describe: \_\_\_\_\_

Exercise? \_\_\_ Yes (type, duration, how often) \_\_\_\_\_

\_\_\_ No

Have any concerns about your weight? \_\_\_ Yes \_\_\_ No

Current Weight \_\_\_\_\_ What is your desired body weight? \_\_\_\_\_

Height: \_\_\_\_\_ Have you had significant weight loss or gain in the past year? \_\_\_ Yes \_\_\_ No

**Diet and Nutrition**

How many servings of dairy products do you eat each day? \_\_\_\_\_

How many servings of fruit and vegetables? \_\_\_\_\_

Are you a vegetarian? \_\_\_ Yes \_\_\_ No

If yes, do you eat: \_\_\_ dairy products \_\_\_ animal protein including eggs \_\_\_ fish

Have you had your cholesterol level checked in the last 5 years? \_\_\_ Yes \_\_\_ No

Do you take calcium or vitamin D supplements? \_\_\_ Yes \_\_\_ No

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Gynecological History:**

A. First day of last period: \_\_\_\_\_ Age of first period: \_\_\_\_\_

How often do you get a period? \_\_\_\_\_ How long does it last? \_\_\_\_\_

Describe your typical period: \_\_\_light \_\_\_ moderate \_\_\_ heavy \_\_\_clots

Associated Symptoms: \_\_\_Pain/cramps \_\_\_moodiness \_\_\_bloating

Other symptoms: \_\_\_\_\_

\_\_\_\_\_

What relieves your symptoms: \_\_\_\_\_

\_\_\_\_\_

Hormone Replacement Therapy/Oral Contraceptive Use: \_\_\_\_\_

Satisfaction \_\_\_\_\_ with \_\_\_\_\_ HRT/OCP's:

\_\_\_\_\_

B. Sexually active: \_\_\_yes \_\_\_no Total number of sexual partners (past and present): \_\_\_\_\_

Frequency: \_\_\_\_\_ Sexual Concerns: \_\_\_\_\_

New partner (s) since last exam: \_\_\_ yes \_\_\_ no

Past Birth Control Use: \_\_\_\_\_

C. Last pap smear: \_\_\_\_\_ Results: \_\_\_\_\_ Hx. Abnl pap smears: \_\_\_\_\_

D. History of (check all that apply):

\_\_\_ cryo/laser surgery of the cervix \_\_\_ colposcopy \_\_\_ endometriosis

\_\_\_ frequent bladder infections \_\_\_ pelvic infection \_\_\_ tubal surgery

\_\_\_ sexually transmitted disease \_\_\_ vaginal infections \_\_\_ hysteroscopy

**Have you noticed or are you concerned about any of the following (check all that apply)?**

\_\_\_ irregular periods/spotting \_\_\_ pain with urination \_\_\_ Breast pain, discharge, lumps

\_\_\_ vaginal dryness \_\_\_ hot flushes/sweats \_\_\_ cold/heat intolerance

\_\_\_ abnormal vaginal discharge \_\_\_ dry skin \_\_\_ bleeding with intercourse

\_\_\_ frequent urination \_\_\_ leaking of urine \_\_\_ excessive thirst/urination

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Obstetrics History:**

How many months have you and your partner been trying to conceive? \_\_\_\_\_

Do you have any children or have you been pregnant in previous relationship? \_\_\_\_yes \_\_\_\_no

**List all your pregnancies in order and outcome of each:**

Year	Outcome (i.e. live birth, miscarriage, ectopic, prematurity, etc)	Complications in pregnancy or delivery

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Male History** (if applicable)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Do you have any children from a previous relationship? \_\_\_\_\_ If yes, list their ages: \_\_\_\_\_

Have you ever had a semen analysis? \_\_\_\_\_ If yes, where was this done \_\_\_\_\_

Date/Result \_\_\_\_\_

\_\_\_\_\_

**Past Male Medical History**

**Surgeries/Hospitalizations** (Please list any hospitalizations or surgeries)

<b>Surgery</b>	<b>Year</b>	<b>Reason</b>	<b>Doctor/Hospital</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Allergies:** \_\_\_\_\_

**Medications:** Please list all medications that you are currently taking or have taken within the last three months, including \_\_\_\_\_ prescriptions and over the counter medications and supplements:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Have you ever been diagnosed or had any of the following? (please check all that apply)**

\_\_\_ mumps

\_\_\_ undescended testes

\_\_\_ testicular/groin injury

\_\_\_ abdominal/pelvic surgery

\_\_\_ diabetes

\_\_\_ sexually transmitted disease

\_\_\_ fever within last three months

\_\_\_ hepatitis

\_\_\_ hypertension

**Family History (Male)**

**Please check all that apply. Your family includes your children, parents, siblings and aunts and uncles related by blood.**

\_\_\_ blood disorder

\_\_\_ diabetes

\_\_\_ cystic fibrosis

\_\_\_ hypertension/heart disease

\_\_\_ Sickle cell anemia

\_\_\_ cancer

\_\_\_ blood/bleeding disorder

\_\_\_ mental illness

\_\_\_ birth defects

**Lifestyle (Male)**

**Are you or have you been exposed to any of the following at home or work?**

\_\_\_ Pesticides

\_\_\_ Radiation

\_\_\_ Chemicals (mercury, lead, solvents, etc)

\_\_\_ Chemotherapy

\_\_\_ Hot tubs

\_\_\_ Second hand smoke

Currently smoking? \_\_\_ Yes \_\_\_ No If yes, how much? \_\_\_\_\_

History of smoking? \_\_\_ Yes \_\_\_ No # of years: \_\_\_\_\_ Year you quit: \_\_\_\_\_

Drink alcoholic beverages? \_\_\_ Yes \_\_\_ No

If Yes, how many drinks per week? \_\_\_\_\_

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Any history of drug use? \_\_\_ Yes \_\_\_ No If yes, describe: \_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Prior Infertility Testing**

<b>Tests</b>	<b>Date/Year</b>	<b>Results</b>
HSG/SIS		
Semen Analysis		
Post Coital Test		
Lab Values:		
Other:		

**Prior Infertility Treatment**

<b>Treatment</b>	<b>Year</b>	<b>Number of cycles</b>	<b>Results</b>
Fertility Pills (clomid/femara)			
Gonadotropins			
IUI			
IVF			
Other			