LA IVF - CLINICAL QUESTIONNAIRE

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Please complete this questionnaire as accurately as possible and fax or email a copy at least three days prior to your consultation. We look forward to your upcoming consultation.

Name of Female: _____ Birth Date: _____ Age _____

Name of Partner: _____ Birth Date: _____ Age _____

Address _____

City: _____ State: _____ Zip Code: _____

Telephone: (Home) _____ (Work) _____ (Fax) _____

(Cell) _____ Email Address_____

Social Security Number: _____ Partner's S.S. number: _____

Medical Insurance: _____ Partner's Insurance: _____

How were you referred to our center? Friend or Relative ___ Internet Search ____ Yelp _____

Google Ad ___ Bing Ad _____ Seminar ____ Ob-Gyn _____ Other _____

Referring Physician (Name and phone number):_____

Date of Consultation: _____ with Dr. Bayrak

OBSTETRICAL HISTORY:

How long have you been trying to have a baby? _____ years

Have you ever been pregnant before? Yes _____ No _____

Date	Current (C) or Prior Partner (P)	Live Birth (Y/N)	Miscarriage (M) Abortion (A) Ectopic (E)	Weeks	Fetal Heart (Y/N)	D&C (Y/N)	Vaginal (V) Cesarean (C)	Sex	Weight	Complication

GYNECOLOGIC HISTORY:

When was the first day of your last period? _____
Do you have regular periods? Yes _____ No _____
Age at first period? _____ Number of days of bleeding? _____
Number of days between the start of one period to the start of the next one? _____
Amount of bleeding: Light _____ Medium _____ Heavy _____
Do you have pain with menstruation? Yes _____ No _____
Degree of pain: Mild _____ Moderate _____ Severe _____
Pain relieved by over the counter medications? Yes _____ No _____
Starts with the onset of bleeding? Yes _____ No _____
Begins a few days prior to the onset of bleeding? Yes _____ No _____
Persists more than 48 hours? Yes _____ No _____
Do you have pain with ovulation? Yes_____ No_____
Do you experience pain with sexual intercourse? Yes _____ No _____
Pain is mostly on the exterior? Yes _____ No _____
Pain is mostly internal (deep penetration)? Yes _____ No _____
Are you experiencing a vaginal discharge? Yes _____ No _____
Associated with itching or burning? Yes _____ No _____
Associated with an unusual odor? Yes _____ No _____
What is the name and contact information of your Obstetrician/Gynecologist?
_____
When was your last Pap smear and the result? _____
Have you ever had an abnormal Pap smear? Yes _____ No _____
If yes, what follow up was needed? _____
Have you ever had a mammogram? Yes _____ No _____
If yes, what was the result and the date? _____
Have you ever had a sexually transmitted disease?
(i.e. Chlamydia, Gonorrhea, Syphilis, Herpes) Yes _____ No _____

When? _____Was it treated? Yes _____ No _____
Have you ever had Pelvic Inflammatory Disease (PID)? Yes _____ No _____
When? _____Were you hospitalized? Yes _____ No _____
Do you experience milky or any discharge from your breasts? Yes _____ No _____
Do you have uterine fibroids, ovarian cysts or endometriosis? Yes _____ No _____
Please indicate all that apply above.
Have you ever used an IUD or any other form of contraception? Yes _____ No _____
Have you ever used birth control pills? Yes _____ No _____
How many years? _____
When did you last use it? _____

PREVIOUS SURGERIES:

Have you ever had surgery? Yes _____ No _____

Procedure	Date	Indication	Outcome

MEDICAL CONDITIONS:

Do you have any of the following conditions?

Condition	Yes/No	Comments
Any Type of Cancer – Please specify		
Anxiety or Panic disorder		
Arthritis		
Asthma		
Bladder Infection		
Bleeding Tendency		
Breast Cancer		
Breast Lump or Cancer		
Bronchitis		
Clot Formation in Legs or Lung		
Diabetes		
Depression or Mood Disorders		
Gastric/Duodenal ulcer		
Glasses/Contact Lenses		
Heart Disease		
Heart Murmur		
Hepatitis		
High Blood Pressure		
Intestinal Bleeding		

Kidney Disease		
Kidney Infection		
Kidney Stones		
Lung Disease		
Migraine		
Neurological or Psychiatric Disorders		
Ovarian or Uterine Cancer		
Paralysis		
Pneumonia		
Polycystic Ovary Syndrome (PCOS)		
Problems with Anesthesia		
Rheumatic Fever		
Rheumatoid Arthritis		
Systemic Lupus Erythematosus		
Thrombophlebitis		
Thyroid Disease		
Tuberculosis		
Varicose Veins		
Other		

DRUG ALLERGIES:

Are you allergic to any medications that you know of? Yes _____ No _____

Medication	Reaction

CURRENT MEDICATIONS:

Are you currently taking any medications or supplements? Yes _____ No _____

Medication	Dose	Frequency

FAMILY HISTORY:

Is there a history of any of the following conditions in the family?

Condition	Yes/ No	Comments
Any Type of Cancer		
Birth Defects or Down's Syndrome		
Blood Clots in Legs or Lung		
Breast Cancer		
Cystic Fibrosis or Thalassemia		
Diabetes or Insulin Resistance		
Early Menopause or Ovarian Failure		
Genetic Diseases		
Heart Disease		
High Blood Pressure		
Infertility		
Kidney Disease		
Systemic Lupus Erythematosus (SLE)		
Mental Retardation		
Twins or Triplets		
Ovarian or Uterine Cancer		
Polycystic Ovary Syndrome (PCOS)		
Recurrent Miscarriages		
Sickle Cell Disease		
Thyroid Disease		
Other		

SOCIAL HISTORY:

Occupation: _____

Weight: _____ Height: _____
Do you use tobacco? Yes _____ No _____ #Packs/day _____
Do you use alcohol? Yes _____ No _____ #Drinks/wk _____
Have you ever used drugs? Yes _____ No _____
How long have you been together with your current partner? _____ yrs
Have you had problems conceiving in a previous relationship? Yes ____ No ____ N/A _____
How frequently do you have intercourse? _____week / month
Do you have to use a lubricant? Yes _____ No _____

BACKGROUND INFORMATION: (Please check all that apply)

Ashkenazi Jewish _____ Caucasian (Non-Hispanic) _____ Hispanic_____

African American _____ Asian American _____

Other (Please specify) _____

COMMENTS:

Please describe the nature of your problem.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

MALE HISTORY: Occupation: _____

Do you have any medical problems? Yes _____ No _____
Have you ever had any surgeries? Yes _____ No _____
Any family history of any major illnesses? Yes _____ No _____
(You may refer to Page 4 for illnesses) _____
Have you initiated any pregnancies in the past? #_____ Yes _____ No _____
Number with current partner? _____
When was the most recent pregnancy? _____
Have you been evaluated by a Urologist? Yes _____ No _____
Diagnosis: _____
Have you ever had a semen analysis? Yes _____ No _____
Result: Date: _____
Volume (ml or cc): _____
Count (million/ml): _____
Motility (% moving sperm): _____
Morphology (% normal forms): _____ (Kruger's or WHO Criteria?)
Have you ever had sperm DNA testing?
Sperm DNA fragmentation index (DFI): _____ %

High Density Stainability (HDS): _____ %

Are you allergic to any medications? Yes _____ No _____

Medication: _____ Reaction: _____

Are you taking any medications? Yes _____ No _____

Medication: _____ Dose: _____ Frequency: _____

Do you use Tobacco? Yes _____ No _____ #Packs/day _____

Do you use Alcohol? Yes _____ No _____ #Drinks/wk _____

Have you ever used drugs? Yes _____ No _____

Do you use a hot tub or wear tight underwear? Yes _____ No _____ #Times/wk _____

Weight: _____ Height: _____

Have you (♂) had any of the following tests or procedures?

Test/ Procedure	Date	Result	Comment
Male Blood Tests			
FSH			
LH			
Testosterone			
TSH			
Prolactin			
DQ Alpha or HLA			
Semen Culture			
Surgery			
Vasectomy			
Vasectomy Reversal			
Testicular Biopsy			
Varicocele Surgery			
Hernia Repair			
Undescended Testicle			
Removal of Testicle (s)			
TESE or MESA			
Other			

PREVIOUS INFERTILITY EVALUATION:

Have you (♀) ever had any of the following tests or procedures? Please enter all that apply.

Test/ Procedure	Date	Result
Female Blood Tests		
FSH (Cycle day 3)		
Estradiol (Cycle day 3)		
Anti-Mullerian Hormone (AMH)		
Inhibin B level		
LH (Cycle day 3)		
Progesterone (7 days after ovulation)		
TSH		

Prolactin		
DHEAS		
Testosterone		
17 Hydroxy-Progesterone		
Blood type and Rh status		
Rubella/Varicella Titers		
HIV		
Hepatitis B surface antigen		
Hepatitis C antibody		
RPR/ VDRL (Syphilis)		
Blood tests (Immunologic)		
Anti-Nuclear Antibodies (ANA)		
Anti-Phospholipid Antibodies (APA)		
Anti-Paternal Leukocyte Antibodies (APLA)		
Natural Killer (NK) cell assay		
Immunophenotype		
DQ Alpha or HLA testing		
Anti-Thyroglobulin Antibodies (ATA)		
Anti-Microsomal Antibodies (AMA, TPO)		
Anti-Sperm Antibodies		
IgA level		
Thrombophilia work up (clotting disorders)		
Cervical/Vaginal Cultures		
Chlamydia/Gonorrhea		
Ureaplasma/Mycoplasma		
General Assessment		
Gynecological exam		
Mammogram		
Physical exam		
Basal Body Temperature Chart (BBT)		
Ovulation Predictor Kits (OPK or LH kit)		
Endometrial biopsy		
Pelvic exam		
Vaginal ultrasound		
Hysterosalpingogram (HSG) (Dye Test)		
Fluid ultrasound (Hydrosonography)		
Hysteroscopy (Camera to look inside uterus)		
Laparoscopy (Camera to look inside abdomen)		
Laparotomy (Open abdominal surgery)		
Other		

PREVIOUS INFERTILITY TREATMENT

Have you ever used any of the following medications or treatments?

Medication	Date	Dose	# Cycles	Comment
Clomiphene Citrate (Oral) or Femara (Oral)				
Gonal F, Follistim, Repronex, Menopur, Bravelle, Luveris (Injectible Medications)				
HCG (Profasi, Ovidrel)				
Progesterone				
Aspirin				
Heparin or Lovenox				
Prednisilone (Medrol)				
Prednisone				
Dexamethasone				
Intravenous Immunoglobulin (IVIG) or Intralipid				
Leukocyte Immunization Therapy (LIT)				
Treatment				
Timed Intercourse				
Intrauterine Insemination (IUI)				
In Vitro Fertilization (IVF) 1. 2. 3. 4.				
Ovum Donation (OD)				
Gestational Surrogacy (SUR)				
OD + SUR				
Gamete Intrafallopian Tube Transfer (GIFT)				
Zygote Intrafallopian Tube Transfer (ZIFT)				
Other				