LA IVF® - CLINICAL QUESTIONNAIRE

Tel: 310-286-2800 or 626-744-3288 Fax: 310-691-1116 or 626-744-3266
Email: info@laivfclinic.com

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.

Patient: Last Name: _____ First Name: _____

Biological Gender - Please circle one: Female / Male Marital Status - Please circle one: Married / Single

Birth Date: Month _____ Day: _____ Year: _____ Age: _____

Partner: Last Name: _____ First Name: _____

Biological Gender - Please circle one: Female / Male

Birth Date: Month _____ Day: _____ Year: _____ Age: _____

Address: _____

City: _____ State/Country: _____ Zip Code: _____

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

(Cell) _____ Email Address: _____

Social Security Number: _____ Partner's SS Number: _____

Medical Insurance (Please provide a copy of the front and back of your insurance card): Yes___ No: ____

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

Bing _____ Seminar ____ Ob-Gyn _____ Other _____

Referring Physician (Name and phone number):_____

OBSTETRICAL HISTORY: How long have you tried 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 _____
Do you have pain with ovulation? Yes_____ No_____
Do you experience pain with sexual intercourse? Yes _____ No _____
Are you experiencing a vaginal discharge? 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 or pelvic inflammatory disease (PID)?
(i.e. Chlamydia, Gonorrhea, Syphilis, Herpes) Yes _____ No _____
When? _____Was it treated? 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 _____
Have you ever used <u>any</u> type contraception? Yes _____ No _____

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		
Attention Deficit Hyperactivity Disorder (ADHD or ADD)		
Frequent Bladder Infection		
Bleeding Tendency or Intestinal Bleeding		
Clot Formation in Legs or Lung		
Diabetes		
Depression/Psychiatric Problems		
Heart Disease/High blood pressure		
Hepatitis		
High Blood Pressure		
Kidney Disease/Infection/Stones		
Lung Disease/Pneumonia History		
Migraine		
Neurological or Psychiatric Disorders		
Problems with Anesthesia		
Rheumatic Fever or Rheumatoid Arthritis		

Systemic Lupus Erythematosus		
Stomach Problems/Gastritis/Acid Reflux		
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 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		
Diabetes or Insulin Resistance		
Early Menopause or Ovarian Failure		
Heart Disease or High Blood Pressure		
Infertility/ Polycystic Ovary Syndrome		
Twins or Triplets		
Recurrent Miscarriages		
Rheumatoid Arthritis or Lupus		
Thyroid Disease		
Any Medical Disorders/Other Issues		

SOCIAL HISTORY:

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

BACKGROUND INFORMATION: (Please check all that apply)
Ashkenazi Jewish ___ Caucasian (Non-Hispanic) ___ Hispanic___ African American ___
Asian American _____ Mixed/Other (Please specify) _____

I acknowledge that I received a copy of the Notice of Privacy Practices for LA IVF as required by The Federal Health Insurance Portability and Accountability Act. **Please check one:** Yes _____ No _____

May we leave messages, such as lab results, appointments or other medical information on an answering machine or with another person who answers the phone at that number or in case of an emergency? **Please check one:** Yes _____ No _____

Emergency Contact Person's Full Name: _____

Phone Number: _____

The undersigned declares that the above information is true and accurate:

_____ _____
Signature Date

COMMENTS: Please describe the nature of your problem.

_____

_____

_____

_____

_____

PARTNER HISTORY: Gender - Please circle one: Female / Male

Occupation: _____
Do you have any medical problems? Yes _____ No _____
Have you ever had any surgeries? Yes _____ No _____
(Examples: Testicular biopsy, vasectomy or reversal, hernia repair, testicular surgery, other)
Any family history of any major illnesses? Yes _____ No _____
(You may refer to Page 3 for illnesses) _____
Have you initiated any pregnancies? Yes ____ No ____ Number with current partner? _____
Have you been evaluated by a Urologist? (If applicable/male partner) Yes _____ No _____
Diagnosis: _____
Have you ever had a semen analysis?(If applicable/male partner) Yes _____ No _____
Result: Date: _____
Volume (ml or cc): _____ Count (million/ml): _____
Motility (% moving sperm): _____ Morphology (% normal forms): _____
Have you ever had sperm DNA testing? (If applicable/male partner)
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/week _____
Have you ever used drugs? Yes _____ No _____
Do you use a hot tub or wear tight underwear? Yes _____ No _____ #Times/week _____
Weight: _____ Height: _____

Have you (♂) had any of the following tests or procedures? **For male partner only.**

Test/ Procedure	Date	Result
Male Blood Tests		
FSH/LH/TSH/Prolactin		
Testosterone		
Semen Culture/Other		

PREVIOUS INFERTILITY EVALUATION: For Female Patient only.

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

Test/ Procedure	Date	Result
Female Blood Tests		
FSH/Estradiol/AMH		
TSH		
Prolactin		
Testosterone		
Blood type and Rh status		
Infectious Disease Testing/Chlamydia/Gonorrhea		
Thrombophilia work up (clotting disorders)		
Antral Follicle Count		
Ovulation Predictor Kits (OPK or LH kit)		
Endometrial biopsy		
Hysterosalpingogram (HSG) (Dye Test)		
Fluid ultrasound (Hydrosonography)		
Hysteroscopy (Camera to look inside uterus)		
Laparoscopy (Camera to look inside abdomen)		
Laparotomy (Open abdominal surgery)		
Vaginal ultrasound / Other		

PREVIOUS INFERTILITY TREATMENT: Have you ever received any of these treatments?

Medication	Date	Dose	# Cycles	Comment
Clomid or Femara				
Gonal F, Follistim, Menopur,				
HCG (Novarel, Pregnyl)				
Progesterone				
Heparin or Lovenox or Aspirin				
Prednisilone				
Prednisone/Dexamethasone				
IVIG/Intralipid/LIT/Other				
Treatment				
Intrauterine Insemination (IUI)				
In Vitro Fertilization (IVF) 1. 2. 3.				