COASTAL FERTILITY Medical Center | RSMC Irvine
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Patient Infertility History Questionnaire

(Important: Please complete and return 5-7 Business days prior to your appointment)

PART I: CONTACT INFORMATION - Primary Patient

First Name _____ **Middle Initial** ____ **Last Name** _____ Age: _____

Date of Birth (MM/DD/YY) _____/_____/_____ Occupation _____
Home Street Address _____
City _____ State_____ Zip/Postal Code_____ Country _____
Indicate which number to call or leave messages;

☐ Home_____ ☐ Work_____ ☐ Cell_____

Email Address:_____

Are you married? ☐ Yes ☐ No ☐ Divorced ☐ Other _____

Spouse/Partner: ☐ Not Applicable

First Name _____ **Middle Initial** ___ **Last Name** _____ Age: _____

Date of Birth (MM/DD/YY) _____/_____/_____ Occupation _____
Home Street Address _____
City _____ State_____ Zip/Postal Code_____ Country _____
Indicate which number to call or leave messages:

☐ Home_____ ☐ Work_____ ☐ Cell_____

Email Address:_____

By whom were you referred?
☐ Physician
Name _____ Phone ( ) _____

Address _____

☐ Former Patient/Friend/Relative _____
☐ Web Site _____
☐ Insurance (Name of Insurance)_____

Who is your Ob/Gyn?
Name _____ Phone ( ) _____

Address _____

Who is your Primary Care Physician?
Name _____ Phone ( ) _____

Address _____

Physician Notes
(for office use only)

Name_____ DOB _____

* Have you been evaluated by a urologist? ☐ Yes ☐ No
* Have you previously conceived with another woman? ☐ Yes: How many times?_____ No: Birth control used? Yes☐ No☐
* Have you had a semen analysis? ☐ Yes ☐ No ☐
* Do you have difficulty with erections? ☐ Yes ☐ No
* Do you have retrograde ejaculation of sperm into the bladder? ☐ Yes ☐ No
* Have you had any of the following sexually transmitted diseases or pelvic infections?
  ☐ Yes (check all that apply) ☐ No

☐ Chlamydia - date_____	☐ Gonorrhea - date_____	☐ Herpes - date_____	☐ Genital warts/HPV - date_____
☐ Syphilis - date _____	☐ HIV/AIDS - date_____	☐ Hepatitis - date_____	☐ Other_____

* Have you had a history of undescended testicles? ☐ Yes - One side☐ Both☐ ☐ No
* Do you have scrotal or testicular pain? ☐ Yes ☐ No
* Did you have the mumps after puberty? ☐ Yes ☐ No
* Have you had prior injury to your testicles requiring hospitalization? ☐ Yes ☐ No

* Have you been diagnosed with any of the following diseases?
  ☐ Diabetes Mellitus - Yes☐ No☐ ☐ Cancer - Yes☐ No☐
  ☐ Multiple Sclerosis - Yes☐ No☐ ☐ Other neurologic problems - Yes☐ No☐
  ☐ Prostatic infections - Yes☐ No☐ ☐ Urinary infections - Yes☐ No☐
  ☐ High Blood Pressure - Yes☐ No☐ If yes, any medications?_____

* Have you had any fever in the last 3 months? ☐ Yes ☐ No
* Have you had a vasectomy? ☐ Yes (date_____) ☐ No If yes, have you had a vasectomy reversal? ☐ Yes (date_____) ☐ No
* Have you had surgery for varicocele repair? ☐ Yes ☐ No
* Have you had hernia surgery? ☐ Yes ☐ No
* Did you undergo any bladder or penis surgery as a child? ☐ Yes ☐ No
* Are you exposed to prolonged heat in the workplace? ☐ Yes ☐ No
* Are you exposed to any radiation or harmful chemicals in the workplace? ☐ Yes ☐ No
* Have you had chemotherapy for cancer? ☐ Yes ☐ No
* Are you allergic to any medications? ☐ No ☐ Yes (Please list and describe reactions) _____

List your current medications: _____
_____
List any current medical problem(s):_____
_____
_____

* How many caffeinated beverages (coffee, tea, soda) do you drink per day?_____ ☐ None
* Do you smoke cigarettes? ☐ No ☐ Yes How many/day? ____ How many years? ____ ☐ Quit - when?
* Do you drink alcohol? ☐ No ☐ Yes
  ☐ Beer - # per week ____ ☐ Wine - # per week ____ ☐ Liquor - # per week _____
* Do you use marijuana, cocaine, or any other similar drug? ☐ No ☐ Yes (describe_____)
* Do you exercise? ☐ No ☐ Yes (describe_____)
* Are you aware of any radiation exposures other than X-rays? ☐ No ☐ Yes (describe_____)

Physician Notes (for office use only)

Disorders in Your Family

Living	Relationship to You		
* Cystic Fibrosis	☐ Yes _____	☐ No	☐ Don't Know
* Tay-Sachs disease	☐ Yes _____	☐ No	☐ Don't Know
* Canavan disease	☐ Yes _____	☐ No	☐ Don't Know
* Bloom syndrome	☐ Yes _____	☐ No	☐ Don't Know
* Gaucher disease	☐ Yes _____	☐ No	☐ Don't Know
* Neimann-Pick disease	☐ Yes _____	☐ No	☐ Don't Know
* Fanconi Anemia	☐ Yes _____	☐ No	☐ Don't Know
* Familiar Dysautonia	☐ Yes _____	☐ No	☐ Don't Know
* Muscular Dystrophy	☐ Yes _____	☐ No	☐ Don't Know
* Paternal Grandmother	☐ Yes _____	☐ No	☐ Don't Know
* Paternal Grandfather	☐ Yes _____	☐ No	☐ Don't Know
* Neurologic brain/spine	☐ Yes _____	☐ No	☐ Don't Know
* Neural Tube Defects	☐ Yes _____	☐ No	☐ Don't Know
* Neural Tube Defects	☐ Yes _____	☐ No	☐ Don't Know
* Bone/Skeletal Defects	☐ Yes _____	☐ No	☐ Don't Know
* Dwarfism	☐ Yes _____	☐ No	☐ Don't Know
* Developmental Delay	☐ Yes _____	☐ No	☐ Don't Know
* Learning problems	☐ Yes _____	☐ No	☐ Don't Know
* Polycystic kidney disease	☐ Yes _____	☐ No	☐ Don't Know
* Heart defect from birth	☐ Yes _____	☐ No	☐ Don't Know
* Down syndrome	☐ Yes _____	☐ No	☐ Don't Know
* Other chrom. defects	☐ Yes _____	☐ No	☐ Don't Know
* Marfan syndrome	☐ Yes _____	☐ No	☐ Don't Know
* Hemophilia	☐ Yes _____	☐ No	☐ Don't Know
* Sickle Cell Anemia	☐ Yes _____	☐ No	☐ Don't Know
* Thalassemia	☐ Yes _____	☐ No	☐ Don't Know
* Galactosemia	☐ Yes _____	☐ No	☐ Don't Know
* Deafness/Blindness	☐ Yes _____	☐ No	☐ Don't Know
* Hemochromatosis	☐ Yes _____	☐ No	☐ Don't Know
* None of the above	☐ Other (specify)_____		

What is your Ancestry?

- ☐ African - American
- ☐ American. Indian/NativeAmer.
- ☐ Ashkenazi Jewish
- ☐ Asian-American
- ☐ Cajun/French Canadian
- ☐ Caucasian
- ☐ Eastern European
- ☐ Hispanic - American
- ☐ Northern European
- ☐ Southern European
- ☐ Other- (specify) (_____)

Would you like to be screened for:

- ☐ Cystic Fibrosis: ☐Y ☐N
- ☐ Sickle Cell Anemia: ☐Y ☐N
- ☐ Tay-Sachs Disease: ☐Y ☐N
- ☐ Thalasemia: ☐Y ☐N

_____

SPOUSE/MALE PARTNER'S SIGNATURE:_____ **DATE**_____

I confirm that I have reviewed the information above.

PHYSICIAN'S SIGNATURE:_____ **DATE**_____

Physician Notes (for office use only)