COASTAL FERTILITY Medical Center | RSMC Irvine
Medical Director: Lawrence B. Werlin M.D.

15500 Sand Canyon Ave. Suite 100
Irvine, CA 92618
Tel: 949.726.0600
Fax: 949.726.0601
Email: info@coastalfertility.com
Web: www.coastalfertility.com

Patient Infertility History Questionnaire

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

PART I: CONTACT INFORMATION - Primary Patient (Female)

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 _____

PART II: FEMALE MEDICAL HISTORY AND INFORMATION (Primary Patient)

Reason for Visit: ☐ Infertility Evaluation ☐ Sperm Insemination ☐ Other _____

What are your expectations for this visit?_____

Any questions you wish to address:_____
_____

Do you have any personal, ethical, or relations objections to any of our tests or treatments such as insemination, in vitro fertilization, egg donation, sperm donation, masturbation to collect a semen sample, etc.? ☐ No ☐ Yes_____

How many months have you been having intercourse without using any form of birth control?_____

Pregnancy History

* Number of ALL Pregnancies:_____
* Number of Miscarriages (less than 20 weeks): _____
* Number of Ectopic / Tubal Pregnancies _____
* Number of Elective Terminations (Abortions):_____
* Number of Full Term Deliveries: _____ Of these, how many were live births?____ How many were stillborn?_____
* Number of Premature (less than 37 weeks) Deliveries: _____ Of these, how many were live births? ____ How many were stillborn? _____
* Any Pregnancies with Birth Defects? ☐ No ☐ Yes - explain_____

Date Pregnancy Ended or delivered	Months to Conception	Treatments to Conceive	Deliver Type/D&C Complications	Current Partner?
1.				☐ Y ☐ N
2.				☐ Y ☐ N
3.				☐ Y ☐ N
4.				☐ Y ☐ N
5.				☐ Y ☐ N
6.				☐ Y ☐ N

Menstrual Cycle History

* Menstrual cycle pattern (check all that apply): ☐ Regular periods ☐ Irregular periods ☐ Spotting before periods ☐ No periods ☐ Heavy periods ☐ Light periods ☐ Bleeding between periods

* Number of days between the start of one period to the start of the next period: _____days
* How many days of bleeding do you have? _____ days
* Dates of the 1st day of your last 2 menstrual periods: _____/ _____/ _____: _____/ _____/_____
* Age when you had your first period: _____ years old
* Age when you first noticed: Breast development:_____years old Pubic hair:_____years old Underarm hair:_____years old
* How many periods do you have per year?_____
* Do you need medication to bring on a period? [ ] Yes - what type?_____ ☐ No
* If you do not have periods, at what age did you stop having them?_____ years old
* Do you have server cramping or pelvic pain with your periods? ☐ Yes:☐Always ☐ Sometimes ☐ Recently ☐In the past ☐ No

Contraceptive Methods (History)

☐ None ☐ Condoms - dates of use _____ ☐ Diaphragm - dates of use _____ ☐ IUD -Dates of use _____
☐ Birth control pills - dates of use _____ - complications?_____ ☐ Never used birth control pills
☐ Inject able contraception (Depo-Provera, Lunelle (TM), etc.) - dates of use _____- Complications? _____
☐ Skin patch - dates of use _____- complications? _____ ☐ Foam or Jelly
☐ Tubal sterilization procedure (tubes tied) - date (month/year) _____/_____ ☐ Tubes untied - date (month/year) _____/_____
*Did your mother take DES when she was pregnant with you? ☐ Yes ☐ No ☐ Don't know

Sexual History

* How many times do you have intercourse per week? ____times per week ☐ None ☐ Not applicable
* Have you used over-the-counter ovulation kits to time intercourse ☐ Yes ☐ No
* Do you have pain with intercourse? ☐ Yes ☐ No
* Do you use lubricants (K-Y Jelly*, etc.) during intercourse? ☐ Yes - what types? _____ ☐ 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

Name_____ DOB _____

Pap Smear Medical History

* When was your last pap smear (month end year) ? _____/_____ ☐ Normal ☐ Abnormal
* When was your last abnormal pap smear? _____/_____ ☐ Not applicable

Have you undergone any procedures as a result of an abnormal pap smear?

☐ Yes (check all that apply) ☐ No

☐ Colposcopy ☐ Cryosurgery (Freezing) ☐ Laser treatment ☐ Conization ☐ LEEP procedure

Breast Screening History

Have you ever had a mammogram? ☐ No ☐ Yes - date_____ Result: ☐ normal ☐ abnormal - explain _____

Do you perform self breast exams? ☐ Yes ☐ No

Medical History

* Are you allergic to any medications? ☐ No ☐ Yes (Please list and describe reactions) _____

_____

_____

* Are you allergic to any foods (peanuts, eggs, etc.)? ☐ No ☐ Yes (Please list and describe reactions) _____

_____

* List any medications you are currently taking, including over the counter medicines . _____

_____

* Do you take any herbal medicines/vitamins or health food store supplements? ☐ No ☐ Yes (Please list) _____

* Do you have any medical problem(s)? ☐ No ☐ Yes (Please list type, dates, and treatments.)

(1)_____

(2)_____

(3)_____

(4)_____

(5)_____

* Did you have either of these childhood illnesses? ☐ Chickenpox (Varicella) ☐ German Measles (Rubella) ☐ Don't know

Other childhood diseases:_____

Vaccinations

Social History

* Chickenpox (Varicella):	☐ No	☐ Yes (dates_____)	☐ Don't know
* MMR - Measles, Mumps, and Rubella (German Measles):	☐ No	☐ Yes (dates_____)	☐ Don't know
* BCG (Tuberculosis):	☐ No	☐ Yes (dates_____)	☐ Don't know
* Hepatitis B:	☐ No	☐ Yes (dates_____)	☐ Don't know
* Polio:	☐ No	☐ Yes (dates_____)	☐ Don't know
* Influenza:	☐ No	☐ Yes (dates_____)	☐ Don't know

* 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)_____

_____

_____

Name_____ DOB _____

Surgical History

Have you had any surgeries ☐ No ☐ Yes (List all surgeries in chronologic order)

Year	Reason and Type of Surgery
_____	(1) _____
_____	(2) _____
_____	(3) _____
_____	(4) _____
_____	(5) _____
_____	(6) _____
_____	(7) _____

*Did you have any anesthesia problems? ☐ No ☐ Yes (describe) _____

Physical Symptoms

General
- ☐ Diabetes ☐ Hair loss
- ☐ Anorexia/Bulimia
- ☐ Lack of energy
- ☐ Fever/chills
- ☐ Other _____

_____

☐ None

Head, Eyes, Ears, Nose, and Throat
- ☐ Dizziness ☐ Loss of sense of smell
- ☐ Headaches ☐ Chronic nasal congestion
- ☐ Blurred vision ☐ Ringing ears
- ☐ Hearing loss/deafness
- ☐ Other _____

☐ None

Respiratory
- ☐ Shortness of breath
- ☐ Asthma ☐ Bronchitis
- ☐ Pneumonia ☐ Tuberculosis
- ☐ Bloody cough
- ☐ Other

☐ None

Endocrine/Hormonal:
- ☐ Recent weight gain or loss
- ☐ Thyroid gland problems
- ☐ Rapid weight gain or loss
- ☐ Excessive hunger/thirst
- ☐ Temperature intolerance- hot flashes or feeling cold
- ☐ Other _____
- ☐ None

Breasts:
- ☐ Discharge (Clear? _____Bloody? ____ Milky?____)
- ☐ Lumps ☐ Pain ☐ Cancer
- ☐ Abnormal mammogram
- ☐ Reduction
- ☐ Augmentation/Breast Implants (saline? _____ silicone? _____)
- ☐ Other _____
- ☐ None

Neurological Problems:
- ☐ Weakness/Loss of balance
- ☐ Seizures/Epilepsy
- ☐ Headaches
- ☐ Migraine headaches
- ☐ Numbness
- ☐ Memory Loss
- ☐ Other _____]
- ☐ None

Gastrointestinal
- ☐ Nausea/Vomiting ☐ Ulcers
- ☐ Hepatitis ☐ Diarrhea
- ☐ Blood in your stools
- ☐ Irritable Bowel Syndrome
- ☐ Change in bowel habits
- ☐ Colitis (ulcerative or Cohn's)
- ☐ Other _____
- ☐ None

Genito-Urinary:
- ☐ Bladder infections
- ☐ Kidney infections
- ☐ Vaginal infections
- ☐ Frequent urination ☐ Leaking Urine
- ☐ Blood in the urine
- ☐ Herpes
- ☐ Other _____
- ☐ None

Skin/Extremities:
- ☐ Unexplained rash/inflammation
- ☐ Acne
- ☐ Skin caner
- ☐ Burn injury
- ☐ Moles changing in appearance
- ☐ Excess hair growth
- ☐ Other _____
- ☐ None

Musculoskeletal:
- ☐ Unusual muscle weakness
- ☐ Decreased energy/stamina
- ☐ Rheumatoid arthritis
- ☐ Lupus Erythematosus
- ☐ Myasthenia gravis
- ☐ Other _____
- ☐ None

Hematologic:
- ☐ Blood clotting disorder/Blood clot
- ☐ Sickle Cell Anemia ☐ Thrombophlebitis
- ☐ Easy bruising
- ☐ Swollen glands/lymph nodes
- ☐ Blood transfusions (dates/reasons_____)
- ☐ Other _____
- ☐ None

Cardiovascular:
- ☐ Palpitations/Skipped beats
- ☐ Chest pain ☐ Heart attack
- ☐ Stroke ☐ Murmurs
- ☐ High blood pressure
- ☐ Rheumatic fever
- ☐ Mitral valve prolapse (need antibiotics before dental procedures? ☐ Yes ☐ No
- ☐ Other _____
- ☐ None

Mental Health Problems:
- ☐ Depression ☐ Anxiety disorder
- ☐ Schizophrenia
- ☐ Other
- ☐ None

Physician Notes (for _____

_____

_____

_____

Name_____ DOB _____

Family History

	Living	Cause of Death/Age at Death
* Mother	☐ Yes - age ☐ No	_____
* Father	☐ Yes - age ☐ No	_____
* Brother (s)	☐ Yes - age ☐ No	_____
	☐ Yes - age ☐ No	_____
	☐ Yes - age ☐ No	_____
* Sister (s)	☐ Yes - age ☐ No	_____
	☐ Yes - age ☐ No	_____
* Maternal Grandmother	☐ Yes - age ☐ No	_____
* Maternal Grandfather	☐ Yes - age ☐ No	_____
* Paternal Grandmother	☐ Yes - age ☐ No	_____
* Paternal Grandfather	☐ Yes - age ☐ No	_____

What is your Ancestry?

- ☐ African - American
- ☐ Amer.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: ☐ Yes ☐ No
- ☐ Sickle Cell Anemia: ☐ Yes ☐ No
- ☐ Tay-Sachs Disease ☐ Yes ☐ No
- ☐ Thalasemia: ☐ Yes ☐ No

Disorders in Your Family

Relationship to You

* Breast cancer	☐ Yes _____	☐ No	☐ Don't Know
* Ovarian cancer	☐ Yes _____	☐ No	☐ Don't Know
* Ovarian cancer	☐ Yes _____	☐ No	☐ Don't Know
* Other cancer_____	☐ Yes _____	☐ No	☐ Don't Know
* Diabetes	☐ Yes _____	☐ No	☐ Don't Know
*Thyroid Problems	☐ Yes _____	☐ No	☐ Don't Know
* Heart Disease	☐ Yes _____	☐ No	☐ Don't Know
* Blood Clots	☐ Yes _____	☐ No	☐ Don't Know
* Obesity	☐ Yes _____	☐ No	☐ Don't Know
* Psychiatric problems	☐ Yes _____	☐ No	☐ Don't Know
* Tuberculosis	☐ Yes _____	☐ No	☐ Don't Know
* Endometriosis	☐ Yes _____	☐ No	☐ Don't Know
* Infertility	☐ Yes _____	☐ No	☐ Don't Know
* Menopause before age 40	☐ Yes _____	☐ No	☐ Don't Know
* Birth Defects	☐ Yes _____	☐ No	☐ Don't Know
* 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
* Neurologic brain/spine	☐ 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
* 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
* Color/Blindness	☐ Yes _____	☐ No	☐ Don't Know
* Hemochromatosis	☐ Yes _____	☐ No	☐ Don't Know
* None of the above	☐ Other (specify)_____		

Name_____ DOB _____

PRIOR INFERTILITY TESTING AND TREATMENT

* Have you had prior infertility testing or treatment elsewhere? ☐ Yes ☐ No

Prior Tests (check all that apply): ☐ Basal body temperature chart (date_____/results_____)
☐ Thyroid test (date____/results _____) ☐ Ovulation test (date____/results_____)
☐ Day 3 blood test for FSH level (date____/results _____) ☐ Hysterosalpingogram (HSG) (date____/results_____)
☐ Laparoscopy (date____/results _____) ☐ Hysteroscopy surgery (date____/results_____)
☐ Progesterone blood test (date____/results _____) ☐ Prolactin blood test kit (date____/results_____)

Prior Treatment (Check all that apply):

	# of cycles	Dates (mo/year) (mo/year)	Outcome
☐ Intrauterine insemination:	_____	**From** ___/___ **to**___/___	☐Pregnant: ☐delivered --Ectopic ☐Miscarriage ☐Not Pregnant
☐ Clomiphene citrate with timed intercourse Maximum # tablets per day? _____	____	**From** ___/___ **to**___/___	☐Pregnant: ☐delivered --Ectopic ☐Miscarriage ☐Not Pregnant
☐ Clomiphene citrate with insemination Maximum # tablets per day? _____	_____	**From** ___/___ **to**___/___	☐Pregnant: ☐delivered --Ectopic ☐Miscarriage ☐Not Pregnant
☐ Daily fertility drug injections with insemination: Maximum # vials per day? _____	_____	**From** ___/___ **to**___/___	☐Pregnant: ☐delivered --Ectopic ☐Miscarriage ☐Not Pregnant
☐ Completed in vitro fertilization cycle(s): 1. # eggs___ #embryos transferred ___ #frozen___ 2. # eggs___ #embryos transferred ___ #frozen___ 3. # eggs___ #embryos transferred ___ #frozen___ 4. # eggs___ #embryos transferred ___ #frozen___	_____	_____/_____ _____/_____ _____/_____ _____/_____	☐Pregnant: ☐delivered --Ectopic ☐Miscarriage ☐Not Pregnant ☐Pregnant: ☐delivered --Ectopic ☐Miscarriage ☐Not Pregnant ☐Pregnant: ☐delivered --Ectopic ☐Miscarriage ☐Not Pregnant ☐Pregnant: ☐delivered --Ectopic ☐Miscarriage ☐Not Pregnant
☐ Frozen embryo transfers): 1. # eggs___ #embryos transferred___ #frozen___ 2. # eggs___ #embryos transferred___ #frozen___ 3. # eggs___ #embryos transferred __ #frozen 4. # eggs___ #embryos transferred___ #frozen___	_____	_____/_____ _____/_____ _____/_____ _____/_____	☐Pregnant: ☐delivered --Ectopic ☐Miscarriage ☐Not Pregnant ☐Pregnant: ☐delivered --Ectopic ☐Miscarriage ☐Not Pregnant ☐Pregnant: ☐delivered --Ectopic ☐Miscarriage ☐Not Pregnant ☐Pregnant: ☐delivered --Ectopic ☐Miscarriage ☐Not Pregnant
Canceled in vitro fertilization attempts (s)	____		
☐ **Any other prior treatment (describe)** _____			

* Additional Information/Complications:_____

EMOTIONAL STATUS

* On a scale of 1-10 (10 being the worst), estimate the level of stress you feel due to infertility and other pressures. _____
* Do you see a counselor? ☐ No ☐ Yes - for how long _____ How often?_____
* List any anti-depressant/anti - anxiety medications you are currently taking?_____
* Describe any emotional, marital, or sexual problems caused by your infertility._____

PATIENT'S SIGNATURE_____**DATE**_____

I confirm that I have reviewed the information above:
PHYSICIAN'S
SIGNATURE_____**DATE**_____