Rocky Mountain
CENTER FOR REPRODUCTIVE MEDICINE PC
Creating a spark of life®

PATIENT INFORMATION *(i.e. person desiring pregnancy)* (Please Print and fill out COMPLETELY)

Any numbers listed below will be used to facilitate communication regarding your healthcare.

Last Name	First Name	Marital Status	DOB	Age	Social Security Number
Street/Mailing Address		City/State/Zip			Home Phone #
Patient's Employer		Occupation (Indicate if Student)			Business Phone #
Employers Address		City/State/Zip			Cell Phone #
		Email Address			
Family Physician		City/State/Zip			Phone #
OBGYN		City/State/Zip			Phone #
Emergency Contact	Relationship	City/State/Zip			Phone #
How were you referred to our office? Physician Friend/Patient Other Please specify:_______________					
Insurance Name		Claims mailing address			
Phone # for benefits & eligibility		Employer that insurance is with			
Identification #		Group #		Insured person (owner of policy)	
If insurance requires a referral, do you have it with you? No Yes Not applicable Do you have secondary insurance? No Yes Primary:_____________________ Secondary:______________________					

Spouse/Partner Information (Please Print and fill out COMPLETELY)

Spouse/Partner Last Name First Name		DOB	Social Security Number
Street/Mailing Address	City/State/Zip		Home Phone #
Employer	Occupation		Business Phone #
Employer's Address	City/State/Zip		Cell Phone #
	Email Address		
Insurance Name	Claims mailing address		
Phone # for benefits & eligibility	Identification #		Group #

PLEASE COMPLETE AND RETURN PRIOR TO APPOINTMENT

FEMALE MEDICAL HISTORY AND INFORMATION

HEIGHT_______ **WEIGHT**________

Reason for Visit: Infertility Evaluation Infertility treatment Other___________________________________

What are you expectations for this visit? ____

What questions do you want answered at this visit? ____

____

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

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

Pregnancy Summary

- Total 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 (greater than 37 weeks) Deliveries: __ Of these, how many were live birth? __ How many stillborn? __
- Number of Premature (less than 37 weeks) Deliveries:_____
- Any Pregnancies with Birth Defects? Yes-explain____ No

Date Pregnancy Ended or Delivered	Months to Conception	Treatments to Conceive	Delivery 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 History

- Menstrual cycle pattern (check all that apply): Regular periods Irregular periods No periods
  Spotting before periods: x___days 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 severe cramping or pelvic pain with periods? Yes No
- Did your mother take DES when she was pregnant with you? Yes No Don't know

Contraceptive History

None Condoms Diaphragm Foam or Jelly

Birth Control pills – dates of use__________________ Complications/side effects? _______________________

Injectable contraception (Depo-Provera®, Lunelle™, etc.) – dates of use _________________________

Skin patch – dates of use _______________________ IUD – dates of use ___________________

Tubal sterilization procedure (tubes tied)–date)mo/yr) _____/_____ Tubes untied–date (mo/yr) _____/_____

Sexual History

- Are you sexually active? Yes No Is your partner Male Female
- How many times do you have intercourse per week? _____ times per week
- 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 Gonorrhea Herpes Genital warts/
Syphilis HIV/AIDS Hepatitis HPV Other:

Pap Smear History

- When was your last pap smear (month and 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 Screen History

Have you ever had a mammogram? Yes – Result: Normal Abnormal – explain No
Do you perform breast self-exams? Yes No Are you currently breastfeeding? Yes No

Medical History

- Are you allergic to any medications? Yes No
  If yes, please is and describe reactions:
- Are you allergic to any foods (peanuts, eggs, etc.)? Yes No
  If yes, please list and describe reactions:
- List any medications you are currently taking, including over-the-counter medicines:
- List any herbal medicines/vitamins or health food store supplements:
- Do you have any medical problems, past or present, for which you take medication or receive treatment?
  1. ____
  2. ____
  3. ____
  4. ____
  5. ____

Surgical History

- Have you had any surgeries? Yes (list all surgery in chronologic order) No

	Year	Reason and Type of Surgery
1.	________	____________________________________
2.	________	____________________________________
3.	________	____________________________________
4.	________	____________________________________
5.	________	____________________________________

- Did you have any problems with anesthesia? Yes – describe:_________________________________ No
- Have you had either of these childhood illnesses? Chickenpox (Varicella) German Measles (Rubella)
  Don't know Other childhood diseases:____

Social History

How many caffeinated beverages (coffee, tea, soda) do you drink per day? _____ None
Do you smoke cigarettes? Yes - How many/day? ___ How many years?___ Quit-when?_____ No
Do you drink alcohol? Yes No
If yes, how many drinks per week?____
Have you used marijuana, cocaine, or any other similar drugs? Yes – describe_______________ No
Do you exercise? Yes - describe____ No
Are you aware of any radiation exposure other than X-rays? Yes – describe________________________ No
Do you feel safe in your own home? Yes No – describe____

Review of Physical Symptoms -- check if no physical symptoms listed below are present

General:
- Recent weight gain or loss
- Anorexia/Bulimia
- Lack of energy
- Fever/Chills

Endocrine/Hormonal:
- Hair loss
- Rapid weight gain or loss
- Excessive hunger/thirst
- Temperature intolerance - hot flashes or feeling cold

Gastrointestinal:
- Nausea/Vomiting
- Blood in stools
- Ulcers
- Constipation
- Diarrhea
- Recent change in bowel habits

Musculoskeletal:
- Unusual muscle weakness
- Decreased energy/stamina

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

Breasts:
- Discharge (clear___ bloody___ milky___)
- Lumps
- Pain

Genito-Urinary:
- Bladder infections
- Kidney infections
- Vaginal infections
- Frequent urination
- Blood in urine

Hematologic:
- Blood clot or disorder
- Thrombophlebitis
- Easy bruising
- Swollen glands/lymph nodes
- Blood transfusion

Respiratory:
- Shortness of breath
- Pneumonia
- Bloody Cough

Neurological Problems:
- Weakness/Loss of balance
- Seizures/Epilepsy Headaches
- Migraine headaches
- Numbness
- Memory loss

Skin/Extremities:
- Unexplained rash/inflammation
- Acne
- Burn injury
- Moles changing in appearance
- Excess hair growth

Cardiovascular:
- Palpitations/Skipped beats
- Chest pain
- Heart attack
- Murmur

Mental Health Problems:
- Depression
- Anxiety

PRIOR INFERTILITY TESTING AND TREATMENT

Have you had prior inFertility testing or treatment elsewhere? Yes No

Prior Tests (check all that apply):

- Labwork:
  - Thyroid Testing
  - Prolactin
  - Day 3 FSH/estradiol
  - Mid-Luteal Progesterone
  - Anti Mullerian Hormone (AMH)
- Hysterosalpingogram (HSG)
- Hysteroscopy
- Laparoscopy
- Ovulation Test Kit
- Basal Body Temperature

Prior Treatment (check all that apply):

- Intrauterine insemination (without medication)
- Clomiphene citrate with timed intercourse
  - Dosing:
    - 50mg (1 tab) 100mg (2 tabs) 150mg (3 tabs)
- Clomiphene citrate with intrauterine insemination
  - Dosing:
    - 50mg (1 tab) 100mg (2 tabs) 150mg (3 tabs)
- Daily fertility drug injections with intrauterine insemination
- Completed in vitro fertilization cycle(s)
  - Cycle #1: # eggs # embryos transferred #frozen
  - Cycle #2: # eggs # embryos transferred #frozen
- Frozen embryo transfer(s)
  - # Embryo(s) Transferred
  - # Embryo(s) Transferred

Family History

	Living - Current Age	Age at Death/Cause of Death
• Mother		
• Father		
• Brother(s)		
• Sister(s)		
• Maternal Grandmother		
• Maternal Grandfather		
• Paternal Grandmother		
• Paternal Grandfather		

What is your Ancestry?
American Indian or Alaskan Native
Asian or Pacific Islander
Black, no of Hispanic Origin
Hispanic
White, not of Hispanic Origin
Other (specify_________________)

Disorders in You/Your Family: **PLEASE LIST AFFECTED INDIVIDUAL AND SPECIFIC DETAILS IF KNOWN.**

Birth Defects
Blood Clots
Bloom Syndrome
Bone/Skeletal Defects
Canavan Disease
Cancer (specify type)
Color blindness
Cystic Fibrosis
Deafness/Blindness
Developmental Delay
Diabetes
Down Syndrome
Dwarfism
Endometriosis
Familial Dysautonia
Fanconi Anemia
Galactosemia
Gaucher Disease
Heart Defect from Birth

Hemochromatosis
Hemophilia
Infertility
Learning Problems
Marfan Syndrome
Menopause before age 40
Muscular Dystrophy
Neural Tube Defects
Neurologic (Brain/Spine)
Niemann-Pick DIsease
Obesity
Polycystic Kidney Disease
Psychiatric Problems
Sickle Cell Anemia
Tay-Sachs Disease
Thalassemia
Thyroid Problems
Tuberculosis

MALE MEDICAL HISTORY AND INFORMATION (Complete with your male partner if applicable.)

Have you been evaluated by a urologist? Yes No

Have you previously conceived with another woman? Yes: How many times? No

Have you had a semen analysis? No Yes -- please request this result be sent to our clinic for review

Date	Volume	Count	Motility	Morphology
1.	ml	M/ml	%	%
2.	ml	M/ml	%	%
3.	ml	M/ml	%	%

Do you have difficulty with erections? Yes No

Are you able to ejaculate inside your partner's vagina? Yes No

Do you have retrograde ejaculation of sperm into the bladder? Yes No

Have you had any of the following sexually transmitted diseases? (Check all that apply)

Chlamydia Gonorrhea Herpes Genital warts/HPV

Syphilis HIV/AIDS Hepatitis Other___________________

Have you had a history of undescended testicles? Yes – One side___ Both___ No

Have you ever had torsion/twisting of the testicles? Yes No

Did you have mumps after puberty? Yes No

Have you had injury to your testicles requiring an ER visit or hospitalization? Yes No

Check if any of the following have been diagnosed for you:

Diabetes mellitus

Multiple sclerosis

Prostate infections

High blood pressure --> If yes, any medication(s)?

Cancer

Other neurologic problems

Urinary infections

Have you had fever (>101°F) in the last 3 months? Yes No

Have you had a vasectomy? Yes (date _______) No

Have you had a vasectomy reversal? Yes (date_____) No

Have you had varicocele surgery? Yes No

Have you had hernia surgery? Yes No

Have you had other surgery to the scrotum or groin area? 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 or radiation for cancer? Yes No

Are you allergic to any medications? Yes No

If yes, please list and describe reactions:

List your current medications:

Use of anabolic steroids or testosterone?

List any current medical problem(s):

Social History

How many caffeinated beverages (coffee, tea, soda) do you drink per day? _____ None

Do you smoke cigarettes? Yes - How many/day? ___ How many years?___ Quit-when?_____ No

Do you drink alcohol? Yes No

If yes, how many drinks per week?____

Have you used marijuana, cocaine, or any other similar drugs? Yes – describe_______________ No

Do you exercise? Yes - describe____ No

Are you aware of any exposure to solvents/toxic materials? Yes – describe_________________________ No

Do you use hot tubs regularly? Yes No – describe____

Did your mother take DES during pregnancy to prevent miscarriage? Yes No Don't know

Have any of your immediate family members had difficulty conceiving a child? Yes No

If yes, please describe:

Family History

	Living - Current Age	Age at Death/Cause of Death
Mother		
Father		
Brother(s)		
Sister(s)		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		

What is your Ancestry?
- American Indian or Alaskan Native
- Asian or Pacific Islander
- Black, no of Hispanic Origin
- Hispanic
- White, not of Hispanic Origin
- Other (specify_________________)

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Bone/Skeletal Defects
Canavan Disease
Cancer (specify type)
Color blindness
Cystic Fibrosis
Deafness/Blindness
Developmental Delay
Diabetes
Down Syndrome
Dwarfism
Endometriosis
Familial Dysautonia
Fanconi Anemia
Galactosemia
Gaucher Disease
Heart Defect from Birth
Hemochromatosis
Hemophilia
Infertility
Learning Problems
Marfan Syndrome
Menopause before age 40
Muscular Dystrophy
Neural Tube Defects
Neurologic (Brain/Spine)
Niemann-Pick DIsease
Obesity
Polycystic Kidney Disease
Psychiatric Problems
Sickle Cell Anemia
Tay-Sachs Disease
Thalassemia
Thyroid Problems
Tuberculosis