West Coast Fertility Centers
New Patient Intake Form

	OFFICE STAFF USE			
	B/P :	____________	GRAV :	____________
	LMP :	____________	PARA :	____________
	CD :	____________	SAB :	____________
	Wt :	____________	TAB :	____________
	BMI :	____________	ECTOPIC :	____________

PATIENT HISTORY

FEMALE NAME: ____

AGE: ____________ HEIGHT: ____________ ETHNICITY: ____________________

LIST ANY MEDICATIONS YOU HAVE ALLERGIES TO & YOUR REACTIONS: ____________________

____

____

LIST ALL MEDICATIONS YOU ARE TAKING CURRENTLY: ____________________

____

____

YEARS WITH PARTNER? ________ YEARS OF UNPROTECTED SEX? ________ PROVEN? Present Partner Previous Partner

LIST ANY COMPLICATIONS DURING PREGNANCIES OR DELIVERY: ____________________

____

____

GYNECOLOGIC HISTORY

ONSET OF MOST RECENT MENSTRUAL PERIOD? ____________

HOW MANY DAYS DO PERIODS LAST? ____________

HOW MANY DAYS FROM THE START OF ONE PERIOD TO THE NEXT? ____________

LEVEL OF PAIN (0 - 10): ____________

IS IT PAINFUL DURING INTERCOURSE? ____________

LAST PAP SMEAR (Date / Result): ____________________

MEDICAL HISTORY

PLEASE EXPLAIN ANY MEDICAL CONDITIONS YOU HAVE: ____________________

____

____

PLEASE LIST AND DATE ALL PAST SURGERIES AND/OR PROCEDURES (Major & Minor): ____________________

____

____

OCCUPATION: ____________________ STRESS LEVEL: ____________________

EXERCISE (Type / How Often): ____________________

DO YOU SMOKE? __________ IF YOU SMOKE, HOW MANY CIGARETTES PER DAY? __________

DO YOU DRINK? __________ IF YOU DRINK, HOW MANY ALCOHOLIC DRINKS PER DAY? __________

FAMILY HISTORY

HOW MANY BROTHERS DO YOU HAVE? __________

HOW MANY SISTERS DO YOU HAVE? __________

DO YOUR SIBLINGS HAVE CHILDREN? __________

MOTHER'S AGE AND HEALTH STATUS: ____________________

FATHER'S AGE AND HEALTH STATUS: ____________________

FAMILY HISTORY OF CANCER: ____________________

____

____

EXPLAIN FAMILY HISTORY OF GENETIC OR BIRTH DEFECTS: ____________________

____

____

PREVIOUS INFERTILITY TESTS / TREATMENTS

STATE CAUSE OF INFERTILITY & FERTILITY TREATMENTS (Dates / Type of Procedure / Results): ____________________

____

____

HYSTEROSCOPY (Date / Result): ____________________

HYSTEROSALPINGOGRAM (Date / Result): ____________________

CYCLE DAY 3 **HORMONES**: DATE __________ FSH __________ LH __________ E2 __________ TSH __________

PARTNER'S HISTORY

MALE NAME: ____________________

AGE: __________ ETHNICITY: __________

LIST ANY MEDICATIONS YOU HAVE ALLERGIES TO & YOUR REACTIONS: ____________________

____

____

PREGNANCIES INITIATED WITH CURRENT PARTNER: ______ PAST PARTNER? ______

PROVEN? Present Partner Previous Partner

MEDICAL HISTORY

PLEASE EXPLAIN ANY MEDICAL CONDITIONS YOU HAVE: ____________________

____

____

PLEASE LIST AND DATE ALL PAST SURGERIES AND/OR PROCEDURES (Major & Minor): ____________________

____

____

OCCUPATION: __________ STRESS LEVEL: __________

DO YOU USE A JACUZZI? __________

EXERCISE (Type / How Often): ____________________

DO YOU SMOKE? __________ IF YOU SMOKE, HOW MANY CIGARETTES PER DAY? __________

DO YOU DRINK? __________ IF YOU DRINK, HOW MANY ALCOHOLIC DRINKS PER DAY? __________

FAMILY HISTORY

HOW MANY BROTHERS DO YOU HAVE? __________

HOW MANY SISTERS DO YOU HAVE? __________

DO YOUR SIBLINGS HAVE CHILDREN? __________

MOTHER'S AGE AND HEALTH STATUS: ____________________

FATHER'S AGE AND HEALTH STATUS: ____________________

EXPLAIN FAMILY HISTORY OF GENETIC OR BIRTH DEFECTS: ____________________

____

____

SEMEN ANALYSIS DATE: ________________

CONCENTRATION: ________________________________

MOTILITY: ______________________________________

MORPHOLOGY: __________________________________

PROGRESSION: ________________ VOL: ________________

INTAKE BY: ______________________________________

PHYSICAL EXAMINATION

HABITUS: ____

____

____

____

____

SKIN:	WNL	________	OTHER	____________________________________
THYROID:	WNL	________	OTHER	____________________________________
ABD:	WNL	________	OTHER	____________________________________
PELVIC:	BUS - WNL	________	OTHER	____________________________________
MANUAL:	WNL	________	OTHER	____________________________________

ULTRASOUND: ____

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IMPRESSION: ____

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____

PLAN: ____

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