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www.haveababy.com
www.lasvegasfertilityclinic.com

Phone 702-892-9696
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Welcome to SIRM Fertility Center

We are pleased that you have chosen us to provide your medical care. Our mission is to help infertile couples complete their journey to joyful parenthood. Through the expertise of our staff, we commit to:

- Providing our patients with the highest quality of medical care in a sensitive, compassionate and caring environment.
- Being accessible and available to our patients at all times.

Date Completed:______________

CLINICAL QUESTIONNAIRE

Please fill out the following questionnaire as accurately as possible. If you have difficulty completing it, please call our office and we will assist you. We very much look forward to your upcoming consultation.

Patient Legal Name: *Preferred Name:*	DOB – MM/DD/YY:	Age: ________ M / F
Partner Legal Name: *Preferred Name:*	DOB – MM/DD/YY:	Age: ________ M / F
Address:		

Telephone: (Patient Cell)	(Patient Work)	(Partner Cell)

Patient Email Address:	Partner Email Address:
Patient Social Security Number:	Partner Social Security Number:

How were you referred to SIRM Fertility Center?

□ Friend	□ Relative	□ Seminar	□ Internet	□ Other

OB/GYN:

Date of Consultation:	Seeing Dr.:

INSURANCE INFORMATION **Please fill out insurance information and make sure to send us a copy of both the front and back of your insurance cards. If you have an HMO insurance: You must obtain a referral from your insurance company, and/or your OBGYN prior to your initial consultation. The only HMO insurance we are a provider for is Health Plan of Nevada.

Primary Insurance		Secondary Insurance	
Subscriber Name		Subscriber Name	
Insurance ID #		Insurance ID #	
Group #		Group #	
Customer Service #		Customer Service #	
HMO or PPO		HMO or PPO	

SIRM
LAS VEGAS

Height (in)		Weight (lbs)	
Ethnicity:			

OBSTETRICAL HISTORY

How long have you been trying to have a baby? Years

Have you ever been pregnant before?	☐ Yes	☐ No

Date	Current/ Prior Partner	Live Birth (Y/N)	Miscarriage/ Abortion Ectopic	Wks	Fetal Heart (Y/N)	D&C (Y/N)	Mode of Delivery	Sex	Wt.	Complications/ Comments

GYNECOLOGIC HISTORY

When was the first day of your last period?

Are your periods regular?		☐ Yes	☐ No
Do you have heavy or prolonged bleeding (more than 5 days duration)?		☐ Yes	☐ No
Have you ever needed medication to bring on your period?		☐ Yes	☐ No
Pain with menstruation?		☐ Yes	☐ No
Degree of Pain?	☐ Mild	☐ Moderate	☐ Severe
Pain relieved by over the counter medications?		☐ Yes	☐ No
Begins a few days prior to the onset of bleeding?		☐ Yes	☐ No
Persists more than 48 hours?		☐ Yes	☐ No
Do you experience pain with ovulation		☐ Yes	☐ No
Do you experience pain with sexual intercourse?		☐ Yes	☐ No

When was your last pap smear?

Have you ever had an abnormal pap smear?	☐ Yes	☐ No

Do you have any vaginal discharge: a) non irritant b) itching/burning	□ Yes □ Yes □ Yes	□ No □ No □ No
Have you ever had a sexually transmitted disease? (i.e. Chlamydia, Gonorrhea, Syphilis, Herpes) Was it treated?	□ Yes □ Yes	□ No □ No
Have you ever had Pelvic Inflammatory Disease (PID)? Was it treated: When?	□ Yes □ Yes Month:____	□ No □ No Year____
Do you experience milk or discharge from your breasts?	□ Yes	□ No

PREVIOUS SURGERIES

Have you ever had surgery?

Procedure	Date	Indication	Outcome

MEDICAL CONDITIONS

Do you have a history of any of the following conditions?

Condition	Yes/No	Comments
Migraine		
Thyroid problems		
Asthma		
Heart Murmur		
Rheumatic fever		
High blood pressure		
Gastric/duodenal ulcer		
Bleeding tendency		
Problems with anesthesia		
Diabetes		
Kidney stones		
Kidney infection		
Rheumatoid arthritis		
Other forms of arthritis		
Lupus Erythematosus		
Neurologic disorders		
Thrombophlebitis		
Sickle cell disease		
Thalassemia		
Cancer		
Other		

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DRUG ALLERGIES

Are you allergic to or have a sensitivity to Latex?	□ Yes	□ No
Are you allergic to any medications?	□ Yes	□ No
If yes, please explain below:		

Medication	Reaction

CURRENT MEDICATIONS

Are you currently taking any medications?	□ Yes	□ No

Medication	Dose	Frequency

FAMILY HISTORY

Is there a history of any of the following conditions in your family?

Condition	Yes/No	Comments
Diabetes		
Heart disease		
High blood pressure		
Birth defects		
Inherited diseases		
Thyroid disease		
Breast cancer		
Ovarian cancer		
Uterine cancer		
Rheumatoid arthritis		
Lupus Erythematosus		
Other		

FEMALE SOCIAL HISTORY

Occupation:

Have you ever smoked?	□ Yes □ No	If yes, what is your approximate daily intake over last 3 months? (Number of cigarettes per day)
Do you use alcohol?	□ Yes □ No	#Drinks/week
Are you currently married?	□ Yes □ No	

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COMMENTS

Please describe the nature of your problem

MALE HISTORY

Occupation:

Have you initiated any pregnancies in the past?	□ Yes	□ No
Number of pregnancies?		
Number with current partner?		
When was the most recent pregnancy?		
Have you been evaluated by an Urologist?	□ Yes	□ No
Diagnosis?		
Have you ever had a semen analysis?	□ Yes	□ No

Result:	Date	
	Count (Million cell/ml)	
	Motility (%)	
	Morphology (% normal forms)	
	Volume	

Are you allergic to any medications?	□ Yes	□ No
Are you taking any medications?	□ Yes	□ No

Do you use alcohol?	□ Yes □ No	#Drinks/week
Have you ever smoked?	□ Yes □ No	If yes, what is your approximate daily intake over last 3 months? (Number of cigarettes per day)

MALE INFERTILITY TESTING Have you had any of the following tests or procedures?			
Test/Procedure	Date	Result	Comment
FSH			
LH			
Testosterone			
TSH			
Anti-sperm antibodies			
DQ Alpha/HLA			
Surgery			
Vasectomy			
Vasectomy reversal			
Testicular biopsy			
Varicocele surgery			
Hernia repair			
Undescended testes			
Surgical removal of testes			
Other			

PREVIOUS FEMALE INFERTILITY EVALUATION Have you had or used any of the following tests or procedures?		
Test/Procedure	Date	Result
FSH (Cycle day 3)		
Estradiol (Cycle day 3)		
LH (Cycle day 3)		
AMH		
Progesterone (7 days after ovulation)		
TSH		
Prolactin		
DHEAS		
Testosterone		
17 Hydroxy-Progesterone		
Blood type and Rh- status		
Rubella		
HIV		
Hepatitis B surface antigen		
Hepatitis C antibody		
RPR/ VDRL (Syphilis)		
Antiphospholipid antibodies panel (APA)		
Natural Killer (NK) cell assay (K-562 test)		
DQ Alpha/HLA		
Antithyroid antibodies		

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PELVIC ASSESSMENT:	DATE	RESULT
Vaginal Ultrasound		
Hysterosalpingogram (HSG)(Dye Test)		
Fluid Ultrasound (Sonohysterogram)		
Hysteroscopy		

PREVIOUS INFERTILITY TREATMENT

Have you ever used any of the following medications?

Medication	Date	Dose	# Cycles	Comment
Clomiphene Citrate (Oral)				
Letrazole				
Follistim/Gonal F/ Menopur/Luveris				
hCG				
Progesterone				
Heparin/Lovenox				
IVIG				
LIT				
Intralipid (IL)				
Treatment				
Intrauterine Insemination				
In Vitro Fertilization (IVF)				
Ovum Donation (OD)				
Gestational surrogacy (GS) or egg donation (OD)				

IF YOU HAVE UNDERGONE IVF, ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY. MEDICAL RECORDS CAN BE ORDERED AT A LATER DATE:

General Questions:	Response:
1. How many fresh IVF stimulation cycles have you undergone using your own eggs and/or donor eggs?	Own eggs: ________ Donor eggs: ________
2. How many frozen embryo transfers (FETs) have you undergone?	
3. When did each cycle (using fresh or frozen embryos) take place?	(Mo/Yr)1. ___/___ 2. ___/___ 3. ___/___ 4. ___/___ 5. ___/___ 6. ___/___
4. Outcomes in each Cycle: ❖ Negative pregnancy test; ❖ Chemical Pregnancy (positive pregnancy test without ultrasound confirmation) ❖ Clinical pregnancy (ultrasound confirmation) ❖ Miscarriage; ❖ Molar pregnancy ❖ Live birth ❖ Still born	1. 2. 3. 4. 5. 6. 7. 8. 9.

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QUESTIONS PERTAINING TO YOUR MOST RECENT FRESH IVF ATTEMPT	
General Questions	Response
1. When did you undergo your most recent IVF?	(Month/Year)
2. Did you use oral contraceptive pills prior to cycle?	
3. Did you use (Lupron) (long/short) or Antagonists (Ganirelix/Cetrotide)?	
4. How many International Units of gonadotropins (e.g., Follistim, Gonal F and Menopur) were injected on the 1st, 2nd, and 3rd day of the cycle treatment?	IU/ day 1________ IU/day 2________ IU/day 3________
5. How many follicles were observed by ultrasound examination?	
6. What was the peak plasma E2 level on the day of hCG?	
7. What was the maximal endometrial thickness?	________mm
8. What form and dosage of hCG did you receive as a “trigger” before the egg retrieval?	1.Profasi ____Units 2.Pregnyl ___ Units 3.Novarel____Units 4.Ovidrel____ Micrograms
9. How many eggs were harvested?	
10. Was ICSI used to fertilize the eggs?	
11. How many embryos were produced?	
12. Were cleaved embryos transferred on day 2 or 3?	
13. Were blastocysts transferred on Day 5 or 6?	
14. How many embryos/blastocysts were transferred at ET?	
15. What was the quality (i.e. cell/grade) of each transferred embryo/blastocyst?	1. _____2._____ 3. _____4._____
16. Were any embryos/blastocysts frozen?	□ Yes □ No
17. Do you have any frozen embryos left?	□ Yes □ No
18. Did you have any of the following immunotherapies? ❖ Heparin ❖ Lovenox/Clexane ❖ Aspirin ❖ Medrol ❖ Dexamethasone ❖ Prednisone ❖ Intralipid (IL) ❖ IVIG, LIT, Intralipid	