WASHINGTON FERTILITY CENTER

Physician: P. Asmar, MD

Date of Visit: ________________

Demographic Information

Name: ____ Age: _____________ Date of Birth: __________________

Your occupation & employer: ____

Ethinicity:
- ☐ American Indian
- ☐ Native Hawaiian
- ☐ Hispanic / Latino
- ☐ Alaska Native
- ☐ Other Pacific Islander
- ☐ Asian
- ☐ Black / African American
- ☐ Caucasian
- ☐ ____________________

Spouse/Partner's Name: __________________________________ Age: _____________ Date of Birth: __________________

Spouse/Partner's Occupation & employer:____

Ethinicity:
- ☐ American Indian
- ☐ Native Hawaiian
- ☐ Hispanic / Latino
- ☐ Alaska Native
- ☐ Other Pacific Islander
- ☐ Asian
- ☐ Black / African American
- ☐ Caucasian
- ☐ ____________________

If referred by another physician please list name and address: ____

History of Present Illness

Reason for your visit:

____

____

Describe as thoroughly as possible the background of your present problem.

____

____

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____

Physician Notes:

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☐ All records from outside source reviewed with patient.

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Past Medical History

Allergies and Medications:

Do you have any allergies or sensitivity to any of the following?

Medications: ☐ No ☐ Yes If yes, list: ______________________________

Iodine / Dyes / Shellfish: ☐ No ☐ Yes

Latex: ☐ No ☐ Yes

List current medications: State the name of the drug, reason you are taking it, and for how long.

Medication	Reason	Dates/Duration/Last time taken
1. ____________	____________	____________
2. ____________	____________	____________
3. ____________	____________	____________
4. ____________	____________	____________
5. ____________	____________	____________

Medical History:

Present Height: ____________ Present Weight: ____________

Have you ever been hospitalized for reasons other than pregnancy or surgery? If so, please list date, reason, duration of stay, name of hospital. ☐ No ☐ Yes______________________________

Have you ever been exposed to chemicals, toxic substances, or radiation? ☐ No ☐ Yes______________

Have you ever been in a serious accident? ☐ No ☐ Yes -- Details ______________________

Have you ever received a blood transfusion? ☐ No ☐ Yes -- Details ______________________

Have you had any of the following? Place a check (√) by all that apply.

Condition		Condition	
Measles, German Measles (Rubella), Mumps		Burning on urination or recurrent urinary infections	
Chicken Pox		Discharge from Nipples	
Other Childhood Diseases:		Sexually Trasmitted Disease or PID (Pelvic Infection	
Hear/Vascular Disease, Mitral Valve Prolapse		Stomach or Intestinal Problems, Ulcers	
Lung Disease, Chronic Bronchitis or Asthma		Kidney Disease or Kidney Stones	
Chronic/Migraine Headaches		Anemia or Blood Clotting Disorders	
Head Trauma		Chronic or Serious Disease	
Seizures		Cancer	
Diabetes Mellitus (High Blood Sugar)		Psychiatric Disorder (Depression, anxiety…)	
Hypoglycemia (Low Blood Sugar)		Multiple Miscarriages	
High or Low Blood Pressure (please circle)		Baby with Defects, Retardation, or genetic abnormality	
Thyroid Disorder		Poor Sense of Smell	
Obesity		Hepatitis/Liver Disease	
Other: ______________________________			

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Surgical History (Please include D+C's and surgery on cervix)

Date(s)	Type of Surgery	Name of surgeon & Hospital
1. ______________	______________________	____
2. ______________	______________________	____
3. ______________	______________________	____
4. ______________	______________________	____
5. ______________	______________________	____

Review of Systems

Please mark any of the following disorders **YOU** currently have or have a history of:

☐ ROS: All Negative

Constitutional:

- ☐ Increase or decrease in appetite (please circle)
- ☐ Weight gain or loss (please circle)
- ☐ Difficulty concentrating
- ☐ Hot flashes/Night sweats
- ☐ Fatigue

Central Nervous System:

- ☐ Dizziness
- ☐ Other:

EENT:

- ☐ Problems with head, eyes, ears, nose or throat
- ☐ Visual problems
- ☐ Other___________________________

Endocrine

- ☐ Excessive hair growth
- ☐ Heat or cold intolerance (Circle)
- ☐ Unexplained rash
- ☐ Excessive thirst or hunger
- ☐ Other___________________________

Genitourinary:

- ☐ Bladder infections (cystitis)
- ☐ Kidney infections
- ☐ Other kidney or bladder problems

____

Musculo-Skeletal:

- ☐ Lupus erythematous
- ☐ Tremors
- ☐ Rheumatoid arthritis/joint pain
- ☐ Auto-immune disorder
- ☐ Problems w/ smell
- ☐ Other

Hematological

- ☐ Anemia
- ☐ Blood clotting disorder / bleeding tendency
- ☐ Sickle cell anemia or trait
- ☐ Other___________________________

Cardiovascular

- ☐ High / low blood pressure
- ☐ Mitral Valve prolapse
- ☐ Rheumatic fever
- ☐ Other___________________________

Any other pertinent information not already asked?

____

____

____

____

____

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Family History

Diabetes		Cystic Fibrosis	
Cancer (Breast, ovary, colon, other)		Muscular Dystrophy	
Thyroid Disorder		Spinal Disorders (anencephaly, neural tube defect, hydrocephalus	
Blood clotting disorders / Hemophilia		Mental Retardation	
High Blood Pressure / Stroke		Down's Syndrome (Trisomy 21)	
Heart / Vascular Disease		Tay Sach's Dz. (Jewish Descent)	
Seizures		Sickle Cell Dz. Or Trait (African American Descent)	
Birth Defects		Thalassemia (Italian, Greek, Med. Oriental Descent, Fr. Canadian)	
Osteopenia Osteoporosis		Huntington Chorea	
Tuberculosis		Other Inherited or Chromosomal Disorders	
Psychiatric Disorder (Specify)			
Other ______________________________			

Social History

Are you (check ALL that apply): ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Remarried ☐ Single ☐ Single in a committed relationship

Have you ever had an eating disorder such as anorexia or bulimia? ☐ No ☐ Yes
If yes -- Describe ______________________________

Do you exercise regularly? ☐ No ☐ Yes
If yes --Describe ______________________________

How much caffeine do you drink per day? __________ cups

How many cigarettes do you smoke per day? ________ cigarettes / ________ packs (Circle).
For how long? ________ years / ________ months

How much alcohol do you drink per week? ________ glass(es)

Have you used any street drugs in the past 5 years? ☐ No ☐ Yes
If yes -- What & how much ______________________________

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GYNECOLOGICAL HISTORY

Age of onset of periods ____________

Date of (LMP) last menstrual period ________________ Are your cycles regular? ☐ No ☐ Yes

Length of menstrual cycle ____________ days (interval from 1st day of bleeding until day before bleeding of next cycle).

Menstrual flow lasts ____________ days Menstrual flow is: ☐ Light ☐ Heavy

Do you have pain around time of your period? ☐ No ☐ Yes
Do you have pain around the time of ovulation? ☐ No ☐ Yes
Do you bleed between periods? ☐ No ☐ Yes
Do you have symptoms of bloating, breast tenderness, cramping, or mood changes prior to period? ☐ No ☐ Yes

Date of last gynecologic exam ______________ Date and result of last Pap's Smear ______________
Any history or abnormal Pap? ______________

Date and result of last mammogram (if applicable)____

Any history of:
Chlamydia ☐ No ☐ Yes – Date:______________ Pelvic or tubal infection ☐ No ☐ Yes – Date:________________
Gonorrhea ☐ No ☐ Yes – Date:______________ DES exposure ☐ No ☐ Yes – Date:________________

Have you previously been told by another physician that you have:

Endometriosis: ☐ No ☐ Yes Fibroids: ☐ No ☐ Yes

OBSTETRICAL HISTORY: ☐ Not Applicable (Never Pregnant)

Pregnancy	Year	Delivered liveborn (Vag or C/S) Premie or Full Term? (Weeks)	Miscarriage or Induced Abortion	Ectopic pregnancy	Time to conceive? (Months or Years)	Infertility therapy to conceive? (Y / N) What type.	Is current partner the father? (Y / N)
1							
2							
3							
4							
5							
6							

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INFERTILITY HISTORY:

How long have you been trying to get pregnant? ________years ________months
Length of time not employing contraception: ________years ________months
Length of time with current partner? ____________________ Number of children with current partner_______
Any children from a previous partner? ☐ No ☐ Yes -- # ________ Number of times married: ________

Sexual History:

Frequency of intercourse ________ per week. Do you use lubricant: ☐ No ☐ Yes

Pain with intercourse? ☐ No ☐ Yes— (Circle) superficial / deep : occasional / frequent

Do you bleed during or after intercourse? ☐ No ☐ Yes ☐ Not applicable

Sex drive: ☐ Decreased ☐ Normal ☐ Increased

Orgasm: ☐ Always ☐ Usually ☐ Rarely ☐ Never

Contraceptive History: (check ALL that apply) ☐ Not applicable

☐ Birth control pill ☐ IUD ☐ Diaphragm ☐ Condom ☐ Rhythm
☐ Surgical Sterilization ______Male ______Female ____
☐ Other ____

Have you experience any of the following? (check ALL that apply)

☐ Menstrual irregularity
☐ Primary amenorrhea *(never had a period)*
☐ Oligomenorrhea *(very few periods)*
☐ Hirsutism *(excessive hair growth)*
☐ Galactorrhea *(milky breast discharge)*
☐ Visual disturbances/headaches

SPOUSE / PARTNER HISTORY

Birth date of spouse / partner __________________ Present Age __________________

Duration of present marriage / relationship ____

Has husband / partner initiated pregnancy in a previous relationship? ☐ No ☐ Yes
If yes, please give dates and outcome of pregnancy ____

Has husband / partner had a previous relationship where pregnancy did not occur, even though no contraception used?
☐ No ☐ Yes—How long a period was involved? ____

Any history of possible reproductive tract problem? Provide dates for all positives.

☐ Prostatitis ☐ Epididymitis ☐ Orchitis ☐ Previous vasectomy
☐ Testicular tumor ☐ Injury to testes ☐ Undescended testicles
☐ Radiation or Chemotherapy

Any history of sexually transmissible disease?

☐ Gonorrhea ☐ Chlamydia ☐ Syphillis ☐ Nonspecific urethritis

Any history of reproductive tract surgery? ☐ No ☐ Yes—Procedure & Date__________________
Any difficulty achieving or maintaining erection? ☐ No ☐ Yes
Any difficulty with ejaculation (e.g. retrograde, premature) ☐ No ☐ Yes __________________________

Any history of discharge from penis? ☐ No ☐ Yes __________________________
Any history of cancer? ☐ No ☐ Yes __________________________

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Spouse / Partner Medical History

Present Weight __________________ Height __________________

General Health ____

Any recent illnesses or change in health? ☐ No ☐ Yes—Describe ______________________________

ALLERGIES to medications, latex, or iodine? ☐ No ☐ Yes—____

List all significant medical illness which husband / partner has experienced requiring treatment, including dates and name of physician / hospital.

____

____

List all surgical procedures which your husband / partner has undergone

____

____

List current medications: State the name of the drug, reason husband / partner is taking it, and for how long.

Medication	Reason	Dates/Duration/Last time taken
1. ______________	______________________	____
2. ______________	______________________	____
3. ______________	______________________	____
4. ______________	______________________	____
5. ______________	______________________	____

How many cigarettes does your husband / partner smoke per day? ________ cigarettes / ________ packs.
For how long? ________ years / ________ months

How much alcohol does your husband / partner drink per week? ________ glass(es)

Has husband/ partner used any street drugs in the past 5 years? ☐ No ☐ Yes
If yes -- What & how much____

Has husband / Partner been exposed to high temperatures (work, hot tubs, etc.)? ☐ No ☐ Yes
☐ Radiation ☐ Chemicals ☐ Toxic Substances

Past Infertility Evaluation for Couple

Previous Testing: (give dates and results for all positives)

Test	No	Yes
Semen Analysis:	☐ No	☐ Yes ________________________________
BBT Charts	☐ No	☐ Yes ________________________________
Post Coital Test	☐ No	☐ Yes ________________________________
Endometrial Biopsy	☐ No	☐ Yes ________________________________
HSG (X-ray of tubes)	☐ No	☐ Yes ________________________________
Sonohysterogram	☐ No	☐ Yes ________________________________
Ovulation Predictor	☐ No	☐ Yes ________________________________
Laparoscopy	☐ No	☐ Yes ________________________________
Hysteroscopy	☐ No	☐ Yes ________________________________
Testicular Biopsy	☐ No	☐ Yes ________________________________

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Hormonal Tests:

Test			
Prolactin	☐ No	☐ Yes	______
Thyroid (TSH, T4)	☐ No	☐ Yes	______
Day 3 FSH, Estradiol, LH	☐ No	☐ Yes	______
Serum Progesterone	☐ No	☐ Yes	______
DHEAS	☐ No	☐ Yes	______
Testosterone	☐ No	☐ Yes	______

Previous Treatments:

	Dose Type	Dates
☐ Clomiphene (Clomid)	______	______
☐ Injectable Gonadotropins	______	______
☐ Intrauterine Insemination (IUI)	______	______
☐ In Vitro Fertilization (IVF)	______	______
☐ Intracytoplasmic Spermi Injection (ICSI)	______	______
☐ Tubal Reconstructive Surgery	______	______
☐ Estrogens	______	______
☐ Progestins (oral or vaginal)	______	______
☐ Surgical removal of adhesions or endometriosis	______	______
☐ Other	______	______

STOP HERE

We thank you and appreciate the time you dedicated to completing this form.

IMPRESSION:

______

PLAN: ☐ Briefly discussed risks, benefits, alternatives of Clomid+IUI, FSH+IUI, IVF

______

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TESTING:

☐ Day 2-3 Baseline Sonogram
☐ Blood test: CD#2-3 FSH, E2, LH ☐ Clomid Challenge Test ☐ Serum B-hCG
☐ HSG (Abx: ☐ No ☐ Yes ___Doxy 100mg BID x5d or ___ Levoquin 500mg BID x10d)
☐ Sonohysterogram ☐ Physical exam/Cultures ☐ Pap Smear
☐ Diagnostic Hysteroscopy ☐ Trial Transfer
☐ Diagnostic Laparoscopy
☐ Endometrial Biopsy
☐ Bloods:
☐ TSH, Free T4 ☐ Day 21 P4 Level
☐ Prolactin ☐ CBC w/ plt
☐ Bld Grp / Rh status / Indirect Coomb's ☐ AST, ALT, Alk Phos, T Bili, D Bili
☐ Rubella Titers
☐ Hiv ☐ Hep BsAg ☐ Hep C Ab ☐ RPR

☐ Lupus Anticoagulant ☐ Anticardiolipin Abs ☐ Phosphatidylserine Abs
☐ Factor V Leiden ☐ MTHFR ☐ Protein C & S activity
☐ Karyotype

☐ Free Testost, DHEAS, 17OH Prog ☐ Androstenedione ☐ Cortisol (am) ☐ __________
☐ Fasting Glucose & Insulin ☐ 2 hr GTT with Insulin ☐ UFC ☐ __________

Genetic Screening implications offered and discussed: ☐ Desires testing ☐ Declines testing
☐ Cystic Fibrosis (Cauc) ☐ Sickle Cell (AA) ☐ Thal (MED/SE Asia) ☐ Tay Sachs (Jewish, Fr Can)

Male Testing and Treatment
☐ Semen Analysis___x1___x2 (two weeks apart) ☐ Serum & Sperm Ab (IBT) testing
☐ Y (DAZ) Karyotype ☐ Male STDs (HIV, RPR, Hep B & C) + Blood type
☐ RX for Clomid 50mg qD x3 mos ☐ Karyotype

Medications Rx'd:
☐ PNV________(sample given) ☐ Abx for HSG (___Doxy ___ Levoquin)
☐ Folate 1mg / 4mg ☐ ASA 81mg ☐ Glucophage 1000mg / 15000mg / 2000mg
☐ Provera 10mg x10d ☐ _______________ ☐ __________________

Teaching Info sheets needed / given:
☐ Sonohyst ☐ HSG ☐ IUI ☐ IVF ☐ ICSI ☐ Donor Egg
☐ Fibroids ☐ Unexpl. Infertility ☐ _____________

Referral Appts:
☐ Urology consult
☐ MFM consult
☐ Primary care
☐ Mammogram

☐ **Records Request Form:**____

Billing based upon:
Consultation only: ☐ 15min (99243) ☐ 25min (99244) ☐ 40min (99245) ☐ of _____mins
New patient visit: ☐ 15min (99243) ☐ 25min (99244) ☐ 40min (99245) ☐ of _____mins

☐ Letter to referring Physician dictated____

☐ CC to: ____