

REGISTRATION

Date _____ Home Phone _____

Patient _____
Last Name First Name Initial

Street Address _____

City _____ State _____ Zip _____

Sex M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced

Social Security # _____ Driver's License # _____

Insured's Name _____
Last Name First Name Initial

Relationship To Insured Self Spouse Child Other Condition Related to Illness Employment Auto Other

EMPLOYER	Company Name _____ Occupation _____ Address _____ Phone _____ City _____ State _____ Zip _____		
SPOUSE	Name _____ <small style="display: inline-block; width: 30%; text-align: center;">Last Name</small> <small style="display: inline-block; width: 40%; text-align: center;">First Name</small> <small style="display: inline-block; width: 30%; text-align: center;">Initial</small> Birthdate _____ Social Security # _____ Employer Name _____ Occupation _____ Address _____ Phone _____ City _____ State _____ Zip _____		
PATIENT INSURANCE INFORMATION	Please <input checked="" type="checkbox"/> any and all insurance coverage you or your spouse has applicable in this case. <input type="checkbox"/> MEDICARE <input type="checkbox"/> BLUE SHIELD <input type="checkbox"/> AUTO ACCIDENT <input type="checkbox"/> MEDICAID <input type="checkbox"/> MAJOR MEDICAL <input type="checkbox"/> UNION PLAN <input type="checkbox"/> BLUE CROSS <input type="checkbox"/> WORKER'S COMPENSATION <input type="checkbox"/> OTHER BCBS I.D. # _____ MEDICARE/MEDICAID I.D. # _____ MAJOR MEDICAL OR AUTO INSURANCE Date of accident _____ Insurance Company Name _____ Adjuster _____ Address/Phone _____ Claim # _____ Policy # _____ Effective Date _____		
SPOUSE CO-INSURANCE INFORMATION	MAJOR MEDICAL ONLY Insurance Company Name _____ Address/Phone _____ Policy # _____ Effective Date _____		
MEDICAL AND LEGAL INFORMATION	<table style="width: 100%; border: none;"> <tr> <td style="width: 65%; border: none;"> Referred by _____ Present Complaint _____ Known Medical Problems _____ </td> <td style="width: 35%; border: none; vertical-align: top;"> Attorney _____ Address _____ Phone _____ </td> </tr> </table> Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No Family Physician _____ Person to contact in emergency (Name and Phone #) _____	Referred by _____ Present Complaint _____ Known Medical Problems _____	Attorney _____ Address _____ Phone _____
Referred by _____ Present Complaint _____ Known Medical Problems _____	Attorney _____ Address _____ Phone _____		
PATIENT AGREEMENT	ASSIGNMENT AND RELEASE I, the undersigned, have insurance coverage with _____ <small style="display: inline-block; width: 60%; text-align: center;">Name of Insurance Company</small> and assign directly to Dr. _____ all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. _____ <small style="display: inline-block; width: 60%; text-align: center;">Signature of Insured/Guardian</small> <small style="display: inline-block; width: 40%; text-align: center;">Date</small>		

FERTILITY QUESTIONNAIRE

NAME: _____

AGE _____

DATE: _____

FEMALE HISTORY

PRENATAL & CHILDHOOD HISTORY

Exposure to DES as a fetus: yes no. Exposure to any other toxins as a child? yes no

Did your mother or any siblings have any problems getting pregnant or miscarriage? yes no.

How were you born? Check all that apply: vaginal cesarean forceps vacuum
 full-term premature hospital home birth center don't know

Did you experience any physical trauma as a child? automobile accident sports injury
 falls broken bones other (explain) _____

Did you experience emotional trauma as a child? physical abuse emotional abuse death
 divorce sexual abuse depression other (explain) _____

Were you vaccinated? yes no. Were you sick alot as a kid? yes no. If yes, explain _____

Were there any problems with your development as a child? yes no. If yes, explain _____

MENSTRUAL & SEXUAL HISTORY

At what age did you begin your menses? _____ Do you have any problems yes no.
If yes, explain _____

When was your last menstrual period? _____ Are your periods regular? yes no.
If no, explain _____ Do you get cramps? yes no.

How long do your periods last? less than 3 days 3 days 4-5 days other _____

What is the character of your menstrual flow? scant regular heavy very heavy

Do you have any premenstrual symptoms? water retention irritable cravings

At what age did you begin to have sex? _____ Do you experience any problems? yes no.
If yes, please explain _____

History of sexually transmitted diseases? genital warts herpes chlamydia gonorrhea
 syphilis Have you been pregnant? yes no. If yes, how many times? miscarriage abortion

Any pregnancies with your current partner? yes no.

How often do you currently have sex? _____ Do you use lubricants? yes no.

How would you rate your libido? excellent good poor non-existent

What types of birth control have you used? oral contraceptives condom diaphragm IUD

MEDICAL HISTORY

Check any condition you have had: diabetes lupus arthritis high fevers asthma
 endometriosis high blood pressure yeast infections pelvic inflammatory disease
 polycystic ovaries luteinized unruptured follicle syndrome (LUFS) hypothyroid other

Do you take antihistamines decongestants aspirin advil/aleve antibiotics antidepressants
 other (list) _____

TOXIC EXPOSURE

Have you been exposed to any chemicals or radiation? yes no. If yes, explain _____

Do you use pesticides or herbicides at your home or work? yes no. If so what _____

Do you smoke? yes no. If so, how much _____ for how long _____

Do you drink alcohol? yes no. If so how much _____ for how long _____

Do you do recreational drugs? yes no. If so, what drugs _____
how much _____ for how long _____

Check if you have QUIT smoking alcohol recreational drugs _____ mos/yrs ago

DIETARY & SUPPLEMENT HISTORY

Do you eat animal products? red meat chicken fish shellfish dairy eggs

Do you consume organic products? as much as possible occasionally rarely never

How much per day do you consume diet soda regular soda chips fried foods tea coffee
 fast food sugar water Do you microwave with or in plastic? yes no.

Do you take vitamins or supplements? yes no. If so, what _____

What is your height _____ weight _____ Do you have a history of anorexia
 bulimia overweight underweight suddenweight change

LIFESTYLE HISTORY

What is your current occupation? _____

How often do you exercise? daily 5-6 times per week 3-4 times per week 1-2 times per week
 never. What do you do? _____

What are your hobbies? _____

Rate your stress level for EACH of these areas, on a scale of 1-10, 10 being the most stress.
 family work fertility money time other _____

What do you do to relieve your stress? hobbies exercise yoga breathe meditate eat

CHIROPRACTIC HISTORY

Have you ever received any chiropractic care? yes no. If yes, when and for what reason _____

Did you have a good chiropractic experience? yes no. If no, why not? _____

If you haven't had any care, what have you heard about chiropractic? _____

TRAUMA HISTORY

Did you experience any physical trauma as an adult? automobile accident sports injury
 falls broken bones other (explain) _____

Do you have any pain in your head neck midback lowback hips
 shoulders/elbows/hands knees/ankles/feet other (explain) _____

Did you experience emotional trauma as an adult? physical abuse emotional abuse death
 divorce sexual abuse depression other (explain) _____

FERTILITY HISTORY

How long have you been trying to get pregnant? less than 6 months 6-12 months
 12-18 months 18-14 months 2-3 years more than 3 years

Are you seeing a reproductive specialist? yes no. If yes, who? _____

What procedures have you had (list dates of all that apply?) _____ pelvic exam _____ hormonal blood tests
_____ postcoital test _____ ultrasound _____ sonohysterography (SHG) _____ endometrial biopsy
_____ hysterosalpingogram (HSG) _____ laparoscopy _____ hysteroscopy _____ chromosomal analysis

Have you been charting your fertility (temperature, cervical mucus & opening)? yes no

Have you had any pelvic surgery? yes no. If yes, why? _____

What medical procedures have you attempted in trying to get pregnant? (check all that apply)

Drugs: clomid perganol humegon fertinex urofollitropin
 human chorionic gonadotroin (hCG) metrodin lupron danazol prednisone
 estrogen progesterone other (please list) _____

List dates of Assisted Reproductive Techniques attempted: _____ IUI _____ IVF _____ GIFT
_____ ZIFT _____ microimplantation _____ other (explain) _____

What other treatments have you tried? (check all that apply) acupuncture accupressure herbs
 nutritionist massage chinese medicine other (list) _____

MALE HISTORY

PRENATAL & CHILDHOOD HISTORY

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Were you vaccinated? yes no. Were you sick alot as a kid? yes no. If yes, explain _____

Were there any problems with your development as a child? yes no. If yes, explain _____

MEDICAL HISTORY

Check any condition you have had: diabetes mumps high fevers prostatitis
 genitourinary infections high blood pressure cancer hemochromatosis
 liver cirrhosis hernia repair undescended testicles testicular abnormalities
 varicoceles chron's disease gout ulcers other (explain) _____

Do you take medication for any of the above conditions? yes no. If yes, what are you taking? _____

Check any of the medications you have taken. Circle the ones you are currently taking: aspirin
 antibiotics antidepressants high blood pressure medication anabolic steroids epilepsy drugs
 other (list) _____

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FERTILITY HISTORY

What procedures have you had (list dates of all that apply?) _____ physical exam _____ hormonal bloodtest
_____ semen culture _____ sperm penetration assay _____ urinalysis _____ testicular biopsy
_____ sperm antibody test _____ vasography _____ ultrasonography _____ other

Have you had a semen analysis? yes no. If yes, when? _____

Was the sperm count normal (> 20 million)? yes no. If no, what was the count? _____ million sperm/ml.

Was the morphology (shape and size) normal (50-60%)? yes no. If no, what was the percentage? _____ %

Was the motility normal (50-80%)? yes no. If no, what was the percentage? _____ %

Was the volume normal (1-5 ml)? yes no. If no, what was the volume? _____ ml.

IF the results of the semen analysis were abnormal, did you have a retest? yes no. If yes, when? _____

Were the results of the retest normal? yes no. If no, what were the values of the results?
_____ sperm count _____ morphology _____ motility _____ volume

Have you had any pelvic surgery? yes no. If yes, why? _____

What other treatments have you tried? (check all that apply) acupuncture accupressure herbs
 nutritionist massage chinese medicine other (list) _____

Use the space below to list any other information you think is pertinent.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of her staff responsible for any errors or omissions I may have made in the completion of this form.

Patient Signature

Date