Office Only
Location: _________
Physician: __________

***Please tell us how you heard about PRC*:** ______________________________

Patient Information

First Name: ______________ Initial: ______ Last Name: ______________

Address: ______________ City: ______ ST: ____ Zip ______

Preferred Contact Number: ______________ Alternative: ______________

Email: ______________ Social Security: ______________

Occupation: ______________ Employer: ______________

Age: ______ Birthdate: ______ Height: ______ Weight: ______

Primary MD: ______________ OB-GYN: ______________

Partner Information

First Name: ______________ Initial: ______ Last Name: ______________

Address: ______________ City: ______ ST: ____ Zip ______

Preferred Contact Number: ______________ Alternative: ______________

Email: ______________ Social Security: ______________

Occupation: ______________ Employer: ______________

Age: ______ Birthdate: ______ Height: ______ Weight: ______

Primary Insurance – Please provide your card as we will need a copy (front/back) for your chart.

Company: ______________ Subscriber: ______________ Birthdate: ______

Group #: ______ Policy/Member ID: ______ Partner covered? □ No □ Yes

□ PPO □ HMO □ POS □ EPO Medical Group (if applicable): ______________

Secondary/Partner Insurance – Please provide your card as we will need a copy (front/back) for your chart.

Company: ______________ Subscriber: ______________ Birthdate: ______

Group #: ______ Policy/Member ID: ______ Partner covered? □ No □ Yes

□ PPO □ HMO □ POS □ EPO Medical Group (if applicable): ______________

Emergency Contact: ______________ Contact #: ______________ Relationship: ______

I hereby authorize Pacific Reproductive Center, INC., to release any medical information necessary to process my insurance claims (if applicable), and to release medical benefit reimbursement directly to PRC for professional services. I fully understand that I am responsible for all charges incurred for services provided.

______________ ______ ______________ ______
Patient Signature Date Partner Signature Date

Patient Name: ___________________________

Female Medical History & Information

Reason for your visit: **□ Fertility Evaluation** **□ Fertility Preservation** **□ Fertility Treatment**

Pregnancy History

Year you conceived?	How long to conceive?	Vaginal , C-section, D&C, Abortion, Miscarriage	Current Partner	Fertility treatment used?

Prior Fertility Treatment

Have you had prior fertility testing or treatment? □ No □ Yes - If yes check all that apply:

□ Clomiphene with natural intercourse □ Clomiphene with insemination (IUI)

□ Injectable medications with natural intercourse □ Injectable medications with intrauterine insemination (IUI)

□ In vitro fertilization (IVF) □ Frozen Embyro Transfer (FET)

□ Donor or Recipient □ Surrogacy

Menstrual History

How old were you when you had your first period: _______________

Are your periods (check all that apply): □ Absent □ Regular □ Light □ Heavy

□ Spotting before periods □ Spotting between periods

□ Irregular How many periods do you have yearly? ________________________

What medication have you used to start a period? ___________________

Number of days between periods: ____________________ Number of days of bleeding: ________________

Do you have severe cramping or pelvic pain with your period? □ No □Yes __Always __Sometimes __ Recently __ Past

Sexual History

Have you used over-the-counter ovulation kits to time intercourse? □ No □ Yes

How often do you have intercourse? # of times per week: ________ # of times per month: ________ Not applicable: ______

Do you have pain with intercourse: □ No □ Yes

Do you use lubricants (KY Jelly, etc.) during intercourse? □ No □ Yes – What type: ____________________________

Have you ever used contraceptives: □ No □ Yes – What type: ____

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

□ Chlamydia □ Gonorrhea □ Syphilis □ Genital Warts/HPV □ Hepatitis □ Herpes

□ HIV/AIDS □ PID □ Other: ____

Patient Name: ______________________________

Medical History

Do you have any current, chronic medical conditions (IE: diabetes, cholesterol, etc.)?

□ No □Yes – What type: ______________________________

Are you currently taking any prescribed medications?

□ No □ Yes – What type: ______________________________

Are you currently taking any over-the-counter or herbal medications?

□ No □ Yes – What type: ______________________________

Are you allergic to any medications? □ No □ Yes – What type: ______________________________

Additional information you would like to share: ______________________________

____

Surgical History

Year of surgery?	Physician?	What type of surgery?	Complications?

Do you have any problems with anesthesia? □ No □ Yes – Describe: ______________________________

Social History

Do you smoke cigarettes? □ No □ Yes – How many per day: _________ How many years: _________

Do you drink alcohol? □ No □ Yes – Beer: # per week: ________ Wine: # per week: ________ Liquor: # per week: _______

Do you use marijuana, cocaine, or other similar drug? □ No □ Yes – Describe: ______________________________

Do you exercise? □ No □ Yes – Describe: ______________________________

Additional information you would like to share: ______________________________

____

Family Ancestry

What is your ancestry? □ African-American □ American Indian/Native American □ Ashkenazi Jewish

□ Asian-American □ Cajun/French Canadian □ Caucasian □ Eastern European □ Hispanic/Latino

□ Northern European □ Southern European □ Other: ______________________________

Patient Name: ______________________________

Does anyone in your immediate family have a history of a medical condition (IE: Diabetes, Cancer, High Blood Pressure, Autism etc.)?

☐ Mother ____

☐ Father ____

☐ Brother(s) ____

☐ Sister(s) ____

☐ Maternal Grandmother: ____________________________________

☐ Maternal Grandfather: ____________________________________

☐ Paternal Grandmother: ____________________________________

☐ Paternal Grandfather: ____________________________________

Would you like to be screened for: ☐ Cystic Fibrosis ☐ Sickle Cell ☐ Tay Sachs ☐ Thalasemia

Additional information you would like to share: ____

____

Continued on next page….

Patient Name: ____________________________

Male Medical History & Information

Medical History

Have you been evaluated by an urologist?: □ No □ Yes

Have you had a semen analysis? □ No □ Yes Do you have difficulty with erections? □ No □ Yes

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

Have you had a vasectomy? □ No □ Yes – Date: ______________ Reversal? □ No □ Yes – Date: ______________

Have you been exposed to radiation or harmful chemicals? □ No □ Yes – Describe: ______________________________

Have you been diagnosed with cancer? □ No □ Yes – Describe: ______________________________

Have you had chemotherapy for cancer? □ No □ Yes

Do you have any current, chronic medical conditions (IE: diabetes, cholesterol, etc.)?

□ No □Yes – What type: ______________________________

Are you currently taking any prescribed medications?

□ No □ Yes – What type: ______________________________

Are you currently taking any over-the-counter or herbal medications?

□ No □ Yes – What type: ______________________________

Are you allergic to any medications? □ No □ Yes – What type: ______________________________

Additional information you would like to share: ______________________________

____

Sexual History

Have you previously conceived with another woman? □ No Birth control used? □ No □ Yes
□ Yes How many children?: ________ Age of youngest child? ____

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

□ Chlamydia □ Gonorrhea □ Syphilis □ Genital Warts/HPV □ Hepatitis □ Herpes

□ HIV/AIDS □ Other: ______________________________

Social History

Do you smoke cigarettes? □ No □ Yes – How many per day: ________ How many years: ________

Do you drink alcohol? □ No □ Yes – Beer: # per week: ________ Wine: # per week: ________ Liquor: # per week: ______

Do you use marijuana, cocaine, or other similar drug? □ No □ Yes – Describe: ______________________________

Do you exercise? □ No □ Yes – Describe: ______________________________

Additional information you would like to share: ______________________________

____

Family Ancestry

What is your ancestry? □ African-American □ American Indian/Native American □ Ashkenazi Jewish

□ Asian-American □ Cajun/French Canadian □ Caucasian □ Eastern European □ Hispanic/Latino

□ Northern European □ Southern European □ Other: ______________________________

Would you like to be screened for: □ Cystic Fibrosis □ Sickle Cell □ Tay Sachs □ Thalasemia