Pacific Reproductive Center
Helping Create Families Every Day

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