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_____
Last Name First Name Initial

Birthdate_____ Social Security #_____

Employer Name_____ Occupation_____

Address_____ Phone_____

City_____ State_____ Zip_____

PATIENT INSURANCE INFORMATION

Please ✓ any and all insurance coverage you or your spouse has applicable in this case.

☐ MEDICARE ☐ BLUE SHIELD ☐ AUTO ACCIDENT
☐ MEDICAID ☐ MAJOR MEDICAL ☐ UNION PLAN
☐ BLUE CROSS ☐ WORKER'S COMPENSATION ☐ 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

Referred by_____

Present Complaint _____

Known Medical Problems_____

_____

Attorney_____

Address_____

_____

Phone_____

Pregnant ☐ Yes ☐ No Pacemaker ☐ Yes ☐ No Family Physician_____

Person to contact in emergency (Name and Phone #)_____

PATIENT AGREEMENT

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with_____
Name of Insurance Company

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.

_____ _____
Signature of Insured/Guardian Date

#20142 – Medical Arts Press 1-800-328-2179

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 __ syphillis 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 contaceptives __ condom __ diaphram __ IUD

MEDICAL HISTORY

Check any condition you have had: __ diabletes __ lupus __ arthritis __ high fevers __ asthma __ endometriosis __ high blood pressure __ yeast infections __ pelvic inflammatory disease __ polysystic 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 hebicides 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
__ bulemia __ 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 speciatist? __ 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

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 _____

MEDICAL HISTORY

Check any condition you have had: __ diabletes __ 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) _____

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

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 _____ motiltiy _____ 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