Troché Fertility Centers

PATIENT INFORMATION *PLEASE PRINT*

Patient Full Name: First MI Last	**DOB:** **AGE:**
Address: Street Apt#	**Marital Status:**
City State Zip	**Gender:** F M
BEST DAYTIME CONTACT #: ( )	**Social Security #** _____ - _____ - _____
Patient Email Contact:	**Preferred Language:**

Partner's Full Name: First MI Last	**DOB:** **AGE:**
Address: ☐same as above Street Apt#	**Marital Status:**
City State Zip	**Gender:** F M
BEST DAYTIME CONTACT # ( )	**Social Security #** _____ - _____ - _____
Partner Email Contact:	**Preferred Language:**

Name of your Referring Physician? **Phone:** ( )
Please tell us how you heard about our facility.....
Doctor/Nurse *Friend/Family* *Internet* *Insurance Co.* *Donor Egg Agency* *Other*

Financial and Insurance Information	
PRIMARY insurance:	**Subscriber:** **DOB:**
Policy #:	**Group #:**
SECONDARY Insurance:	**Subscriber:** **DOB:**
Policy #:	**Group #:**

Emergency Contact:	**Phone:** ( )

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to my physician and authorize the release of any information required to process my claims. I understand that if my account goes to a collection agency that I will be responsible for any and all fees in connection with such agency or legal counsel. I also understand that regardless of my insurance that I will be financially responsible for all services rendered.

SIGNED: _____ **RELATIONSHIP:** _____ **DATE:** _____

For Office Use Only: Troche _____ ***Ann*** ___ ***ART Lab*** _____

Patient's Name: _____ Date: _____

Gynecological and Fertility Histories

Menstrual History

- Menstrual cycle pattern (check all that apply): □ Regular periods □ Irregular periods □ Spotting before periods
- Age of first period _____ □ Light flow □ Heavy flow □ Bleeding between cycles
- Number of days between the start of one period to the start of another: _____
- How many days of bleeding do you have? _____
- When was your last period? _____
- Do you pass clots? □ No □ Yes -- every cycle? □ No □ Yes
- Do you have cramps? □ No □ Yes -- every cycle? □ No □ Yes
- Can you tell when you ovulate? □ No □ Yes How? □ BBT □ LH Kits □ Other
- What medications do you use for pain relief? _____
- Did your mother take DES when she was pregnant with you? □ No □ Yes □ Don't know

Sexual History

- How many times per week do you have intercourse? _____ □ None □ Not applicable
- Do you have pain with intercourse? □ No □ Yes
  If yes, describe the pain _____
- Do you use lubricants? □ No □ Yes If yes, which type? _____
- Have you had any of the following sexually transmitted or pelvic infection? (Check all that apply)
  □ Chlamydia □ Gonorrhea □ Herpes □ Genital warts □ Syphilis □ HIV/AIDS
  □ Hepatitis

Contraceptive History

□ None
□ Condoms
□ IUD
□ Birth Control Pills
□ Skin patch
□ Injectable contraception
□ Complications? _____
□ Tubal sterilization ("tubes tied") When? _____

Pap Smear History

- When was your last PAP Smear? (month and year) _____ □ Normal □ Abnormal
- When was your last abnormal PAP Smear? (month and year) _____ □ Not applicable
- Have you undergone any of the following procedures as a result of an abnormal PAP Smear? (Check all that apply)
  □ Colposcopy □ Cryosurgery (freezing) □ Conization □ Laser □ LEEP

Breast Screening History

Have you ever had a mammogram? □ No □ Yes Date: _____ Result: □ Normal □ Abnormal
Do you perform breast self-exams? □ No □ Yes

Pregnancy Summary

- Total Number of ALL pregnancies: _____
- Number of Full Term Deliveries: _____
- Number of Miscarriages: _____
- Number of Elective Terminations: _____
- Number of Ectopic/Tubal pregnancies: _____
- Number of Preterm Deliveries: (less than 37 weeks): ____
- Any pregnancies with birth defects? □ No □ Yes Please explain:

_____

Previous Infertility Testing and Treatment:

Have you had prior infertility testing or treatment elsewhere? □ Yes □ No

Previous Infertility Testing:
Length of time currently attempting pregnancy _____ Years _____ Months
Length of time not using contraceptives _____

Patient's Name: _____ Date: _____

Prior Testing:

	Yes	No	Year	Normal	Abnormal
Temperature charts	□	□	_____	□	□
Hysterosalpingogram (x-ray of tubes and uterus)	□	□	_____	□	□
Hysteroscopy (looking inside uterus)	□	□	_____	□	□
Endometrial biopsy (taking tissue from inside uterus)	□	□	_____	□	□
Post-coital test (to test sperm in cervical mucus)	□	□	_____	□	□
Semen Analysis	□	□	_____	□	□
Laparoscopy (looking inside the abdomen)	□	□	_____	□	□
Hormone Tests					
Day 3 FSH ____	□	□	_____	□	□
Day 3 Estradiol	□	□	_____	□	□
AMH Level	□	□	_____	□	
Clomid Challenge Test	□	□	_____	□	□
Thyroid tests	□	□	_____	□	□
Chromosome tests	□	□	_____	□	□

Prior Treatments:

Ovulation Induction	**With Intrauterine Inseminations?**	**# of cycles**	**Month/Year**	**Outcome**
Clomiphene citrate (Clomid) Maximum number of tablets per day _____ Letrozole (Femara) Maximum number of tablets per day _____				
Daily fertility Injections Maximum # of vials per day _____ Name of drug used_____				
Other (describe) _____ _____				

Prior IVF Cycles (Please include frozen embryo transfers and cancelled cycles):

DATES	**Medications Used and Total Dose (IU)**	**Peak Estradiol**	**# Oocytes Obtained**	**# Mature Oocytes**	**# Fertilized (2 PN)**	**ICSI? Yes or No**	**# Embryos Transferred**	**Embryo Grades**	**Outcome (Biochemical, Miscarriage, Delivery)**
1.									
2.									
3.									
4.									

Patient's Name: _____ Date: _____

Past Medical History

Do you have any medical problems? □ No □ Yes (please list type, dates and treatment)

1. _____
2. _____
3. _____
4. _____

Surgical History

Have you had any surgeries? □ No □ Yes (Please list in chronological order)

Year	Reason and Type of Surgery
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Did you have any anesthesia problems? □ No □ Yes

Review of Systems

General:
□ Weight loss or gain
□ Anorexia/ Bulimia
□ Lack of energy
□ Fever/ Chills

Skin/Extremities:
□ Acne
□ Skin cancer
□ Burn injuries
□ Excess hair growth

Head/Eyes/Ears/Nose/Throat:
□ Dizziness
□ Headaches
□ Blurred vision
□ Hearing loss
□ Loss of sense of smell
□ Chronic nasal congestion
□ Ringing ears

Respiratory:
□ Shortness of breath
□ Asthma
□ Pneumonia
□ Bloody cough

Breast:
□ Discharge (clear, bloody or milky?)
□ Lumps □ Pain □ Cancer
□ Abnormal mammogram
□ Reduction
□ Augmentation (saline or silicone)

Cardiovascular:
□ Palpitations
□ Chest pain
□ Stroke
□ High blood pressure
□ Mitral valve prolapse

Gastrointestinal:
□ Nausea/vomiting
□ Hepatitis
□ Blood in your stools
□ Diarrhea/ constipation
□ Irritable bowel syndrome
□ Ulcers

Genito/Urinary:
□ Bladder infections
□ Kidney infections
□ Vaginal infections
□ Frequent urination
□ Blood in urine

Musculoskeletal:
□ Unusual muscle weakness
□ Rheumatoid arthritis
□ Lupus erythematosus
□ Myasthenia gravis

Neurological:
□ Weakness
□ Seizures
□ Headaches
□ Numbness
□ Memory loss

Psychiatric:
□ Depression
□ Anxiety disorder

Endocrine/Hormonal:
□ Diabetes
□ Thyroid gland problems
□ Rapid weight gain or loss
□ Excessive hunger/thirst
□ Temperature intolerance
□ Hair loss

Hematologic:
□ Blood clotting disorder
□ Sickle cell anemia
□ Easy bruising
□ Swollen glands/lymph nodes

Patient's Name: _____ Date: _____

Occupation/Habits/Leisure History

		Dates/Comments
Exposed to chemical or x-rays in work or hobby	□ No □ Yes	_____

Please list		Amount per day or week
Caffeine	□ No □ Yes	_____
Smoking	□ No □ Yes	_____
Alcohol	□ No □ Yes	_____
Marijuana	□ No □ Yes	_____
Nutritional supplements, herbs, etc.	□ No □ Yes	_____
Drugs	□ No □ Yes	_____

Please describe recreation/sports activities (frequency, length of time, etc.) _____
_____

Family History

□ Breast cancer	□ Endometriosis	□ Neimann-Pick disease	□ Heart defect from birth
□ Ovarian cancer	□ Infertility	□ Fanconi anemia	□ Down syndrome
□ Colon cancer	□ Menopause before age 40	□ Familia Dysautonia	□ Other chromosomal problems
□ Diabetes	□ Birth defects	□ Neurologic (brain/spine)	□ Marfan syndrome
□ Thyroid problems	□ Cystic fibrosis	□ Neural tube defect	□ Hemophilia
□ Heart disease	□ Tay-Sachs disease	□ Bone/skeletal defects	□ Sickle cell anemia
□ Blood clots	□ Canavan disease	□ Dwarfism	□ Thalassemia
□ Obesity	□ Bloom syndrome	□ Developmental delay	□ Galactosemia
□ Psychiatric problems	□ Gaucher disease	□ Learning problems	□ Deafness/Blindness
□ Tuberculosis	□ Hemochromatosis	□ Polycystic kidney disease	□ Color blindness

What is Your Ancestry?

□ African American	□ American Indian	□ Ashkenazi
□ Asian American	□ Cajun/French	□ Caucasian
□ Eastern European	□ Hispanic/Caribbean	□ Northern European
□ Southern European	□ Other Specify	

9/2015

Patient's Name: _____ Date: _____

Male Medical History

Please complete with your male partner, if applicable.

- Have you ever been evaluated by a urologist? □ No □ Yes
- Have you had any previous pregnancies? □ No □ Yes If so, □ Previous Partner □ Present Partner □ Both. How many times? _____
- Have you had a semen analysis? □ No □ Yes
- Have you had any of the following sexually transmitted diseases or pelvic infections?

□ Chlamydia □ Gonorrhea □ Herpes □ Genital warts □ Syphilis □ HIV/AIDS □ Hepatitis □ Other

Have you ever been diagnosed with any of the following diseases?

□ Diabetes
□ Multiple sclerosis
□ High blood pressure
□ Prostatic Infections
□ Cancer _____
□ Urinary Infections _____
If yes, any medications? _____

Have you had any of the following? If so, please explain.

□ Yes □ No	Retrograde ejaculation of sperm into the bladder
□ Yes □ No	History of mumps
□ Yes □ No	Difficulty with erections
□ Yes □ No	Difficulty with ejaculation
□ Yes □ No	History of undescended testicles
□ Yes □ No	Fever in the last three months
□ Yes □ No	Hernia Repair
□ Yes □ No	Surgery for Varicocele
□ Yes □ No	Bladder or penis surgery as a child
□ Yes □ No	Exposure to prolonged heat at the workplace
□ Yes □ No	Chemotherapy for cancer
□ Yes □ No	Exposure to radiation or chemicals at the workplace

- Are you allergic to any medications? □ No □ Yes If so, please list: _____
- List any medical problems:
  _____
- List any medications you have taken within the last three months: _____
  _____

Occupation/Habits/Leisure History

		Dates/Comments
Exposed to chemical or x-rays in work or hobby	□ No □ Yes	_____
Please list		**Amount per day or week**
Caffeine	□ No □ Yes	_____
Smoking	□ No □ Yes	_____
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