Welcome to STL Fertility!

We are thrilled that you have chosen us to support you on your fertility journey. Our mission is to help everyone complete their journey to joyful parenthood. Through the expertise of our staff, we commit to:

- Science: providing cutting edge, evidence-based fertility care
- Success: delivering the best care and clinical outcomes in the region
- Support: fostering a sensitive, compassionate, and supportive environment

Clinical Questionnaire

It is very important that we receive your paperwork prior to your appointment.
Please fill out the following questionnaire as accurately as possible.
If you have difficultly completing it, please call our office for assistance at 314-983-9000.

Patient Information		
Name:	DOB:	
Address:		
Telephone:		
Email Address:		
Social Security Number:	Height:	Weight:
Occupation:		
Do you use tobacco? ☐ Yes ☐ No If yes, how many packs per day?		
Do you use alcohol? ☐ Yes ☐ No If yes, how many drinks per week?		
OB/GYN:		
How were you referred to us? ☐ OB/GYN ☐ Friend ☐ Internet ☐ Other: Comments:		
Pharmacy Information Name and Location: Phone Number:		

Patient Drug Allergies	
Are you allergic or have a sensitivity to Latex? ☐ Yes ☐ No	
Are you allergic to contrast dye? ☐ Yes ☐ No	
Are you allergic to Betadine or shellfish? ☐ Yes ☐ No	
Medication	Reaction

Patient Current Medications		
Medication	Dose	Frequency

Patient Previous Surgeries	
Procedure	Date

Patient Medical Conditions			
Condition	Yes / No	Condition	Yes / No
Migraine		Kidney Infection	
Thyroid Problems		Rheumatoid Arthritis	
Asthma		Other forms of Arthritis	
Heart Murmur		Lupus Erythematosis	
Rheumatic Fever		Neurologic Disorders	
High Blood Pressure		Thrombophlebitis	
Gastric/duodenal Ulcer		Sickle Cell Disease	
Bleeding tendency		Thalassemia	
Problems with Anesthesia		Cancer	
Diabetes		Blood Clots (DVTs)	
Kidney Stones		Other:	
Comments on any conditions answered “yes.”			

Patient Family History			
Condition	Yes / No	Condition	Yes / No
Diabetes		Thyroid Disease	
Blood Clots		Breast Cancer	
Heart Disease		Ovarian Cancer	
High Blood Pressure		Uterine Cancer	
Birth Defects		Rheumatoid Arthritis	
Inherited Diseases		Lupus Erythematosis	
Endometriosis		Recurrent Pregnancy Loss	
Early Menopause			
Comments on any conditions answered "yes."			

Patient Gynecologic History
When was the first day of your last period?
Are your periods regular? ☐ Yes ☐ No How many days apart? How many days do you have menses?
Do you have heavy or prolonged bleeding (more than 5 days)?
Pain with menstruation? ☐ Yes ☐ No Comments:
Do you experience pain with ovulation? ☐ Yes ☐ No Comments:
Do you experience pain with sexual intercourse? ☐ Yes ☐ No Comments:
When was your last pap smear?
Have you ever had an abnormal pap smear? ☐ Yes ☐ No Comments:
Do you have discharge? ☐ Yes ☐ No Comments:
Have you ever had a sexually transmitted disease? (i.e. Chlamydia, Gonorrhea, Syphilis, Herpes) ☐ Yes ☐ No When? Was it treated?
Have you ever had Pelvic Inflammatory Disease (PID)? ☐ Yes ☐ No When? Was it treated?

Patient Obstetrical History

How long have you been trying to have a baby?

_____years _____months

Have you ever been pregnant before? Yes / No If yes, please complete the table below.

Date	Current /Prior Partner	Live Birth (Y/N)	Miscarriage/ Abortion/ Ectopic	Wks.	D&C (Yes/No)	Mode of Delivery	Complications/ Comments

Have you had any previous fertility treatments? (i.e. Clomid, IUI, IVF, FET) ☐ Yes ☐ No

If yes, please provide physician name and date and type of treatment.

Partner Information

Name:	DOB:
Gender Identity:	
Telephone:	
Email Address:	
Social Security Number:	Have you ever taken Testosterone? Yes / No
Occupation:	
Do you use tobacco? ☐ Yes ☐ No If yes, how many packs per day?	
Do you use alcohol? ☐ Yes ☐ No If yes, how many drinks per week?	

Have you been evaluated by a Urologist, if applicable? ☐ Yes ☐ No If yes, please provide physician name and date of treatment.
Have you ever had a semen analysis, if applicable? ☐ Yes ☐ No If yes, please provide physician name and date of treatment.

Partner Drug Allergies	
Are you allergic or have a sensitivity to Latex? ☐ Yes ☐ No	
Medication	Reaction

Partner Current Medications		
Medication	Dose	Frequency

In your own words please describe your fertility journey.

Signature _____ Date _____