## 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

Please fill out the following questionnaire as accurately as possible.
Include a front and back copy of your insurance card(s) when returning this document.
If you have difficultly completing it, please call our office for assistance at 314-983-9000.
It is **important** that we receive your paperwork within 48 hours of **creating** your appointment.
**Failure to do so will result in cancellation of your appointment.**

| Patient Information | | |
|---|---|---|
| Name: | DOB: | Age: |
| Address: | | |
| Telephone: | Email Address: | |
| Social Security Number: | Height: | Weight: |
| Ethnicity: ☐American Indian or Alaska Native ☐Asian ☐Black or African American<br>☐Hispanic or Latino ☐Native Hawaiian or Other Pacific ☐White or Caucasian<br>☐Prefer not to answer ☐Other: _____ ☐Unknown | | |
| 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:<br>Comments: | | |
| Pharmacy Information<br>Name and Location:<br>Phone Number: | | |

| Patient Insurance | |
|---|---|
| Primary Insurance | Secondary Insurance, if applicable. |
| Insurance Name: | |
| ID#: | |
| Group#: | |
| Insurance Phone #: | |

| 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 |
| | |
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| | |

| Patient Current Medications | | |
|---|---|---|
| Medication | Dose | Frequency |
| | | |
| | | |
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| Patient Previous Surgeries | |
|---|---|
| Procedure | Date |
| | |
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| Patient Medical Conditions | | | |
|---|---|---|---|
| Condition | Yes / No | Condition | Yes / No |
| Migraine | Please choose | Kidney Infection | Please choose |
| Thyroid Problems | Please choose | Rheumatoid Arthritis | Please choose |
| Asthma | Please choose | Other forms of Arthritis | Please choose |
| Heart Murmur | Please choose | Lupus Erythematosis | Please choose |
| Rheumatic Fever | Please choose | Neurologic Disorders | Please choose |
| High Blood Pressure | Please choose | Thrombophlebitis | Please choose |
| Gastric/duodenal Ulcer | Please choose | Sickle Cell Disease | Please choose |
| Bleeding tendency | Please choose | Thalassemia | Please choose |
| Problems with Anesthesia | Please choose | Cancer | Please choose |
| Diabetes | Please choose | Blood Clots (DVTs) | Please choose |
| Kidney Stones | Please choose | Other: | |
| Comments on any conditions answered "yes." | | | |

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

| Patient Gynecologic History |
|---|
| When was the first day of your last period? |
| Are your periods regular? ◯Yes ◯No<br>How many days apart?<br>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 you 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<br>When?<br>Was it treated? |
| Have you ever had Pelvic Inflammatory Disease (PID)? ◯Yes ◯No<br>When?<br>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 |
|---|---|---|---|---|---|---|---|
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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: | Age: |
| Gender Identity: | | |
| Telephone: | Email Address: | |
| Social Security Number: | Have you ever taken Testosterone? ◯Yes ◯No | |
| Ethnicity: ☐American Indian or Alaska Native ☐Asian ☐Black or African American<br>☐Hispanic or Latino ☐Native Hawaiian or Other Pacific ☐White or Caucasian<br>☐Prefer not to answer ☐Other: _____ ☐ Unknown | | |
| 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<br>If yes, please provide physician name and date of treatment. | | |
| Have you ever had a semen analysis, if applicable? ◯Yes ◯No<br>If yes, please provide physician name and date of treatment. | | |

| Partner Insurance | |
|---|---|
| Primary Insurance | Secondary Insurance, if applicable. |
| Insurance Name: | |
| ID#: | |
| Group#: | |
| Insurance Phone #: | |

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

| Partner Current Medications | | |
|---|---|---|
| Medication | Dose | Frequency |
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| In your own words please describe your fertility journey. |
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**Cancellations made 48 hours or less before an appointment will be subject to a $40 rescheduling fee.**

Signature _____ Date _____

555 North New Ballas Rd. Suite 150, St. Louis, MO 63141
Tel: 314.983.9000, M-F 8am to 4pm Fax: 314.983.9023