Acacio Fertility Center, Inc.
Brian Acacio, MD
Mission Viejo • Laguna Niguel • Bakersfield

CLINICAL QUESTIONNAIRE

Please complete this questionnaire as accurately as possible. Feel free to keep a copy for your records. We very much look forward to your upcoming consultation.

Name of Patient _____ DOB _____ Age _____

SSN (required) _____ Race/Ethnicity: _____

Name of Partner _____ DOB _____ Age _____

SSN (required) _____ Race/Ethnicity: _____

Address: _____
Street

_____
City State Zip Code

Patient's Cell: Patient's Email: _____

Partner's Cell: Partner's Email: _____

Emergency Contact Name: _____

Cell and Email : _____

How were you referred to the Acacio Fertility Center, Inc?

Friend _____ Relative _____ Internet _____ Other _____

Physician: _____

Date of Consultation with Dr. Acacio: _____ Location: LN MV BK

OBSTETRICAL HISTORY

How long have you been trying to have a baby? _____ years
Have you ever been pregnant before? Yes _____ No ___
If recently delivered, are you still breastfeeding? Yes _____ No ___

Date	Current/ Prior Partner	Live Birth (Y/N)	Miscarriage/ Abortion/ Ectopic	Wks	Fetal Heart (Y/N)	D&C (Y/N)	Mode of Delivery	Sex	Wt	Complications/ Comments

When was the first day of your last period? _____ (mm/dd)

Are your periods regular? Yes _____ No _____

Age at first period? _____ # of days between periods? _____ # of days bleeding _____

Amount of bleeding: Light _____ Medium _____ Heavy _____

Have you ever needed medication to bring on your period? Yes _____ No _____

Pain with menstruation? Yes _____ No _____

Degree of pain: Mild _____ Moderate _____ Severe _____

Pain relieved by over the counter medications? Yes _____ No _____

Starts with the onset of bleeding? Yes _____ No _____

Begins a few days prior to the onset of bleeding? Yes _____ No _____

Persists more than 48 hours? Yes _____ No _____

Do you have pain with ovulation? Yes _____ No _____

Do you experience pain with sexual intercourse? Yes _____ No _____

Pain is mostly on the exterior Yes _____ No _____

Pain is mostly internal (deep penetration)? Yes _____ No _____

Do you experience painful ovulation? Yes _____ No _____

Are you experiencing a vaginal discharge? Yes _____ No _____

Associated with itching or burning? Yes _____ No _____

Associated with an unusual odor? Yes _____ No _____

Do you have a Gynecologist? Yes _____ No _____

When was your last Pap Smear? _____ Results _____

Have you ever had an abnormal Pap Smear? Yes _____ No _____

If yes, what follow up was needed? _____

Have you ever had a Mammogram? Yes _____ No _____

Have you ever had a sexually transmitted disease? Yes _____ No _____

(i.e. Chlamydia, Gonorrhea, Syphilis, Herpes)

When? _____ Was it treated? _____

Have you ever had Pelvic Inflammatory Disease (PID) Yes _____ No _____

When? _____ Were you hospitalized? _____

Do you experience milk or discharge from your breasts? Yes _____ No _____

Have you ever used an IUD? Yes _____ No _____

Have you ever used the Oral Contraceptive Pill? Yes _____ No

How many years? _____ When did you last use it? _____

PREVIOUS SURGERIES

Have you ever had surgery? Yes _____ No _____

Procedure	Date	Indication	Outcome

MEDICAL CONDITIONS

Do you have a history of any of the following conditions? Yes _____ No _____

Condition	Yes	No	Comments
German Measles (Rubella)			
Migraine			
Prolonged Dizziness			
Glasses/ Contact Lenses			
Thyroid Problems			
Pneumonia			
Tuberculosis			
Asthma			
Bronchitis			
Other Lung Conditions			
Heart Attack			
Heart Murmur			
Rheumatic Fever			
Other Heart Conditions			
High Blood Pressure			
Gastric/Duodenal Ulcer			
Hepatitis			
Cirrhosis			
Intestinal Bleeding			
Bleeding Tendency			
Problems with anesthesia			
Diabetes			
Kidney Stones			
Kidney Infection			
Other Kidney Disorders			
Bladder Infection			
Rheumatoid Arthritis			
Other forms of Arthritis			
Lupus Erythematosis			
Paralysis			
Neurologic Disorders			
Thrombophlebitis			
Varicose Veins			
Breast Tumor (benign)			
Breast Cancer			
Ovarian Cancer			

Uterine Cancer			
Genetic Disorder			
Other Cancer			
Other			

DRUG ALLERGIES

Are you allergic to any medications that you know of? Yes _____ No _____

Medication	Reaction

CURRENT MEDICATIONS

Are you currently taking any medications? Yes _____ No _____

Medication	Dose	Frequency

FAMILY HISTORY

Is there a history of any of the following conditions in the family? Yes _____ No _____

Condition	Yes	No	Comments
Diabetes			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Multiple Births			
Mental Retardation			
Birth Defects			
Inherited Diseases			
Rheumatoid Arthritis			
Thyroid Disease			
Lupus Erythematosis			
Blood Disorders			
Breast Cancer			
Ovarian Cancer			
Uterine Cancer			
Other Cancer			

Sickle Cell Disease			
Cystic Fibrosis			
Tay Sachs			
Thalassemia			
Other			

SOCIAL HISTORY

Occupation: _____

Do you use tobacco? Yes _____ No _____ Pack/day _____

Do you use alcohol? Yes _____ No _____ Drinks/wk _____

Are you currently married? Yes _____ No _____

How long? _____ Month/Year

Have you been married before? Yes _____ No _____

Problems conceiving in that relationship? Yes _____ No _____

How frequently do you have intercourse? _____ Per week/month

Do you use a lubricant? Yes _____ No _____

COMMENTS

Please describe the nature of your problem in details:

MALE HISTORY

Occupation: _____

Have you initiated any pregnancies in the past? Yes _____ No _____

Number of pregnancies? _____

Number with current partners? _____

When was the most recent pregnancy? _____

Have you been evaluated by an Urologist? Yes _____ No _____

Result: _____

Have you ever had a semen analysis? Yes _____ No _____

Result: Date _____

Count (Million-cell/ml) _____

Motility (%) _____

Morphology (% normal forms) _____

Additional Male Factor Testing _____

Other _____

Do you use Tobacco? _____ Yes _____ No _____ #Pack/day _____

Do you use Alcohol _____ Yes _____ No _____ #Drinks/wk _____

Do you use a hot tub? _____ Yes _____ No _____ #Times/wk _____

DRUG ALLERGIES

Are you allergic to any medications that you know of? Yes _____ No _____

Medication	Reaction

CURRENT MEDICATIONS

Are you currently taking any medications? Yes _____ No _____

Medication	Dose	Frequency

MALE TEST/PROCEDURE

Have you had any of the following tests or procedures? Yes _____ No _____

Blood Tests	Date	Result	Comment
FSH			
LH			
Testosterone			
TSH			
Estradiol			
Proluctin			
Semen Tests			
Sperm DNA Fragmentation Test (SCSA, etc)			
Semen culture			
Surgery			
Vasectomy			
Vasectomy reversal			
Testicular biopsy			
Varicocele ligation			
Hernia repair			
Undescended testicle			
Removal of testicle(s)			
Other			

PREVIOUS INFERTILITY EVALUATION

Have you had or used any of the following tests or procedures?

Female Test/ Procedure	Date	Result
Blood Tests (Non immunologic)		
Anti-Mullerian Hormone (AMH)		
FSH (Cycle day 3)		
Estradiol (Cycle day 3)		
LH (Cycle day 3)		
Progesterone (7 days after ovulation)		
TSH		
Prolactin		
DHEAS		
Testosterone		
17 Hydroxy-Progesterone		
Blood type and Rh status		
Rubella		
HIV		
Hepatitis B surface antigen		
Hepatitis C antibody		
RPR/ VDRL (Syphilis)		

Blood tests (Immunologic)	**Date**	**Result**
Antinuclear antibodies (ANA)		
Antiphospholipid antibodies (APA)		
Natural Killer (NK) cell assay		
DQ Alpha		
Antithyrogobulin antibodies (ATA)		
Antimicrosomal antibodies (AMA, TPO)		
Other		
Thrombophilia		
Factor V		
MTHFR		
Prothrombin		
Protein C		
Protein S		
LAC		
ACA		
Homocysteine		
Other		
Cervical Cultures		
Chlamydia		
Gonorrhea		
Ureaplasma/ Mycoplasma		
Routine aerobic/ anaerobic		
General Assessment		
Pap smear		
Mammogram		
Physical exam		
Basal Body Temperature chart (BBT)		
Urine Ovulation predictor (LH kit)		
Post coital test (PCT)		
Endometrial biopsy		
Additional Testing:		
Pelvic Assessment	**Date**	**Result**
Pelvic exam		
Vaginal ultrasound		
Femvue		
Hysterosalpingogram (HSG) (Dye Test)		
Fluid ultrasound		
Hysteroscopy		
Laparoscopy		
Laparotomy		
Other		

PREVIOUS INFERTILITY TREATMENT

Have you ever used any of the following medications or treatment? Yes _____ No _____

Medication	Date	Dose	# Cycles	Comment
Letrozole, Clomiphene Citrate (Oral)				
Bravelle, Menopur, Gonal F, Follistim (Injectable), Lupron, Cetrotide, Antagon				
HCG (Profasi), Lupron Trigger				
Progesterone				
Aspirin				
Heparin				
Prednisone				
Dexamethasone				
Intralipids				
Intravenous Immunoglobulin (IVIG)				
Leukocyte Immunization Therapy (LIT)				
Treatment				
Timed Intercourse				
Intrauterine Insemination				
In Vitro Fertilization (IVF)				
Gamete Intrafallopian Tube Transfer (GIFT)				
Ovum Donation (OD)				
Gestational Surrogacy (SUR)				
OD + SUR				
Other				

IF YOU HAVE UNDERGONE IVF, ANSWER THE FOLLOWING QUESTIONS:

GENERAL QUESTIONS:	**RESPONSE**	
1. What date were the most recent cycle day three (CD-3) blood tests for FSH, plasma estradiol (E2) level or AMH and what were the respective values?	*Date:*	
	Values : *FSH:* _____ *U/ml* *E2:* _____ *Pg/ml* *AMH:* *Mg/ml*	
2. How many IVF cycles, using your own eggs vs. an egg donor have you undergone?	*Own eggs:*	
	Donor eggs:	

3. How many frozen embryo transfers (FETs) have you undergone?	

4. Did you do genetic testing of the embryos? Day 3 or Trophectoderm biopsy (Day 5 or Day 6)? How many embryos were tested? Results?	Genetic Testing	*Yes*		*No*		
	Day 3 or Trophectoderm					
	Embryos					
	Results:					
5. When did each cycle (using fresh or frozen embryos) take place?	*(Mo/Yr)*	*1.*		*2.*		
		3.		*4.*		
		6.		*7.*		
6. What were the outcomes in each case (negative pregnancy test; positive pregnancy test but no ultrasound confirmation of a gestational sac [i.e., chemical pregnancy]; ultrasound confirmation of a gestational sac [i.e., clinical pregnancy]; ectopic pregnancy; miscarriage; live birth or perinatal death)?	1.					
	2.					
	3.					
	4.					
	5.					
	6.					
7. Which were single and which were multiple pregnancies (when applicable)? (use the number in 5- above to designate The cycle concerned)	*1.*					
	2.					
	3.					
	4.					
	5.					
	6.					

QUESTIONS PERTAINING TO YOUR MOST RECENT FRESH IVF ATTEMPT	**RESPONSE**	
1. When did you undergo your most recent IVF?		*(Month/Year*
2. How many units of gonadotropins (e.g.,Brauelle, Menopur; Follistim; Gonal F or Repronex) were injected on the 1st, 2nd and 3rd day of the cycle of treatment?	*Amps Day 1*	
	Amps Day 2	
	Amps Day 3	
3. Did you use your own eggs or that of an egg donor?		
4. Did you use a gestational surrogate?		
5. How many follicles were observed by ultrasound examination?		
6. What was the peak plasma E2 level on the day of HCG/ Lupron Trigger administration (whether given to you or to the ovum donor)?		
7. What was the thickness of the endometrial lining prior to egg retrieval?		mm
8. For how many days were gonadotropins administered?		days

9. Did you hyperstimulate (OHSS)?	Yes		No	
Hospitalization?	Yes		No	
10. Was GnRH agonist (e.g., lupron) started five (5) or more days before initiating gonadotropin therapy (i.e., the "long protocol") or less than three (3) days prior to gonadotropin administration (i.e., "flare protocol")				
11. How many eggs were harvested?				
12. Was intracytoplasmic sperm injections (ICSI) used to fertilize the eggs?				
13. How many embryos were produced?				
14. Were embryos/blastocysts transferred three (3) days or (5) days following egg retrieval?				
15. Was genetic testing (PGD/PGS) performed? If so, how many embryos biopsied? How many "normal" embryos?				
16. How many fresh ,Day-3 embryos Vs Day-5 embryos (blastocysts) were transferred at ET?				
17. How many times had each transferred embryo divided (number of cells) at the time of ET? Grading of Blastocysts? _____	*1.*		*2.*	
	3.		*4.*	
	5.		*6.*	
18. What was the embryological assessment of the quality of each fresh embryo transferred (poor, average, or good)?				
19. What was the outcome of the IVF cycle (negative pregnancy test; positive pregnancy test but no ultrasound confirmation of a gestational sac (i.e., chemical pregnancy); ultrasound confirmation of a gestational sac (i.e., clinical pregnancy; ectopic pregnancy; healthy pregnancy, still ongoing; miscarriage; live birth or perinatal death)?				
20. If a clinical pregnancy occurred, was it a single pregnancy, twin pregnancy or a higher multiple than twins?				
21. Do you have an Advance Directive?				

* Only applies to embyros transferred three (3) days following ET