**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 _____

Name of Partner _____ DOB _____ Age _____

Address: _____
Street

_____
City State Zip Code

Telephone: (H) _____ (W) _____ (F) _____

(Cell) _____ Email Address: _____

Skype ID or Alternate Email: _____

Partners: _____

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 Culture**s | | |
| 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*<br>*E2:* _____ *Pg/ml*<br>*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?<br>If so, how many embryos biopsied?<br>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?<br>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