GREEN VALLEY
FERTILITY PARTNERS

NEW PATIENT DATA SHEET

Please complete as best you can. It is not necessary to have all the information before speaking with a doctor.

PATIENT INFORMATION

PATIENT NAME		DOB	AGE
PARTNER NAME		DOB	AGE
STREET	CITY	STATE/COUNTRY	ZIP
PATIENT EMAIL	PARTNER EMAIL		
PHONE	PHONE		
HOW WERE YOU REFERRED TO GREEN VALLEY FERTILITY PARTNERS?			
ARE YOU A PREVIOUS PATIENT OF DR FISCH?			
WERE YOU REFERRED BY A PREVIOUS PATIENT OF DR.FISCH			
HAVE YOU CONSULTED A FERTILITY SPECIALIST BEFORE?			
DO YOU HAVE AN OB/GYN?			
OB/GYN CONTACT NUMBER			

2950 W. Horizon Ridge Parkway, Henderson, NV 89052
(702) 722-BABY (2229) | Fax: (702) 778-7672
greenvalleyfertility.com

INSURANCE INFORMATION

PRIMARY INSURANCE		**SECONDARY INSURANCE**	
SUBSCRIBER NAME		SUBSCRIBER NAME	
SUBSCRIBER DOB		SUBSCRIBER DOB	
RELATIONSHIP TO PATIENT		RELATIONSHIP TO PATIENT	
INSURANCE ID #		INSURANCE ID #	
GROUP ID #		GROUP ID #	
CUSTOMER SERVICE #		CUSTOMER SERVICE #	
HMO OR PPO		HMO OR PPO	
PATIENT SS #		PARTNER SS #	

CLINICIAL QUESTIONNAIRE

I. OBSTETRICAL HISTORY									
How long have you been trying to conceive?									
Have you ever been pregnant before?									
Date	Current Partner Y/N	Live Birth Y/N	Mode of Delivery Vaginal/ C-Section	# of Wks.	Fetal Heartbeat Y/N	D+C	Sex	Birth Weight	Complications/ Comments

II. GYNECOLOGIC HISTORY		
When was the first day (full flow) of your last menstrual period?		
Height	Weight	BMI
Are your periods regular (between 25-35 days)		
If not regular, how many periods do you have a year?		/12
Have you ever taken Provera to bring on a period? If yes, did it bring on a period?		
Do you have acne or unwanted hair growth?		
Are you or have you been a heavy exerciser, runner or gymnast?		
Have you ever struggled with an eating disorder? (Anorexia / Bulemia)		
Do you experience pain with your period? (Mild / Moderate/ Severe)		
If yes, is pain relieved by medication? (Over-The-Counter / Prescription)		
If yes, does pain begin prior to bleeding, last more than 48 hrs. or interfere with daily activity?		
Do you experience pain with intercourse? (Insertion / Deep penetration)		
Have you been diagnosed or treated for Endometriosis?		
Have you been diagnosed or treated for Uterine Fibroids?		
Date of last PAP smear/ breast exam?		
Have you ever had an abnormal PAP smear/ breast exam?		
If yes, what follow up was necessary?		
Have you ever had a sexually transmitted infection? (Chlamydia / Gonorrhea / Syphilis / Herpes)		
If yes, was it treated?	When?	
Have you ever had Pelvic inflammatory Disease (PID)?		
If yes, were you treated with antibiotics and/ or hospitalized?	When?	
Do you experience discharge from your breasts?		

If yes, have you had an MRI?	Taking Parlodel?	If yes, dosage?

CLINICIAL QUESTIONNAIRE

III. ALLERGIES: Do you have any known allergies to medications? If yes, please indicate allergies below:

MEDICATION ALLERGIES	KNOWN REACTION THAT OCCURS:

IV. CURRENT MEDICATIONS: Please list all medications you are currently taking

MEDICATION	DOSAGE/FREQUENCY

V. SURGICAL HISTORY: Please list all previous surgical procedures.

PROCEDURE	DATE	INDICATION	OUTCOME

VI. MEDICAL HISTORY:
Do you (P), your spouse/ partner (S) or your family (F) have any of the following medical conditions? (Yes / No)

CONDITION	WHO AFFECTED?			WHEN DIAGNOSED	TREATING PHYSICIAN	COMMENTS
	P	S	F			
Diabetes						
Hypertension						
Thyroid Disease						
Blood Clotting Disorders						
Migraine Headaches						
Heart Disease						
Asthma						
Gastrointestinal Disorders						
Kidney Disease						
Urinary Disorders						
Neurologic Disorders						
Cancer						
Other						

CLINICIAL QUESTIONNAIRE

VII. MALE HISTORY	
Do you have any children?	
If yes, number of children with current partner	
Have you caused any pregnancies in the past?	
Have you been evaluated by a Urologist? If yes, who?	
Diagnosis	
Have you had a semen analysis? In your office	
Date:	
Volume:	
Count (Million/mL)	
Motility (%)	
Morphology (% normal forms)	
Do you have any known allergies to medications?	
Are you taking any medications?	
Do you have any medical or surgical problems?	
Have you had a vasectomy or vasectomy reversal?	
Have you had a hernia repair, varicocele ligation or testicular biopsy?	
Have you ever used anabolic steriods?	
Do you have problems achieving an erection or ejaculating?	

VIII. IMMUNIZATION Indicate if and when you have had the following immunizations:	**Patient** Y / N	**Date** Month & Year	**Partner** Y / N	**Date** Month & Year
Flu Shot				
COVID Vaccination				
Rubella				
Varicella				

IX. SOCIAL HISTORY	Patient	Partner
Occupation		
Tobacco use; if yes, packs/day		
Alcohol use; if yes, drinks/week		
Exercise; if yes, hours/week		

X. BRIEFLY DESCRIBE YOUR GOALS AND ISSUES

CLINICIAL QUESTIONNAIRE

XI. PREVIOUS FERTILITY EVALUATION

PARTNER	TEST	DATE	RESULT	COMMENTS
MALE	FSH			
	LH			
	TESTOSTERONE			
	TSH			
	PROLACTIN			
	ANTISPERM AB			
	SPERM DNA INTEGRITY			
	HIV AB			
	HEPATITIS B s Ag			
	HEPATITIS C AB			
	RPR (SYPHILIS)			
FEMALE	FSH			
	AMH			
	ESTRADIOL			
	LH			
	TSH			
	PROLACTIN			
	PROGESTERONE			
	TESTOSTERONE			
	170HP			
	DHEA-S			
	PELVIC US			
	HSG			
	SONOHYSTEROGRAM			
	BLOOD TYPE/RH			
	RUBELLA AB			
	VARICELA AB			
	HIV AB			
	HEPATITIS B s Ag			
	HEPATITIS C AB			
	RPR (SYPHILIS)			
	NK CELL ACTIVITY			

XII. PREVIOUS FERTILITY TREATMENT (NON IVF)

TREATMENT	DATE	NUMBER OF CYCLES	DOSE	COMMENTS
Timed Intercourse				
Clomiphene (oral)				
FSH (injectable)				
Insemination (IUI)				

CLINICIAL QUESTIONNAIRE

XIII. IVF TREATMENT

PROCEDURE	NUMBER	DATES
How many IVF egg retrievals have you had?		
How many fresh Embryo Transfers have you had?		
How many Frozen Embryo Transfers have you had?		
How many Third Party Parenting (OD/GS) cycles have you had?		
Do you have frozen embryos at another facility? Yes / No		Where?

XIV. REGARDING YOUR MOST RECENT FRESH IV CYCLE

Medical records can provide missing details. Not all questions may be applicable to your case.

When did the cycle occur?	
Did you use Oral Contraceptive Pills prior to cycle?	
Did you use Lupron?	
If yes, did it start before or after your period?	
Did you use GnRH Antagonist (Ganarelix/Cetrotide)?	
If yes, did it start with FSH or later in the cycle?	
Did you use FSH or HMG (Follistim/ Gonal-f/ Menopur)? Starting dose?	
Did you use Estrogen Priming?	
Did you use Human Growth Hormone (Saizen/ Omnitrope)	
How many days of stimulation did you need?	
How many total follicles were counted on hCG day?	
How many mature follicles (>15mm) were counted on hCG day?	
What was your Estradiol (E2) level on hCG day?	
What was your endometrial thickness on hCG day?	
How many total eggs were recovered?	
How many mature eggs (MII) were recovered?	
How many normally fertilized embryos (2PN) did you have?	
Was ICSI used?	
Was Assisted Hatching used?	
Was Preimplantation Genetic Diagnosis (PGD) used?	
What as the embryo quality on day 3?	
Were embryos transferred on Day 3 or Day 5?	
How many embryos were transferred?	
What was the quality of the transferred embryos?	
Were any embryos frozen?	
Did you experience Ovarian Hyper-Stimulation Syndrome (OHSS)?	
If yes, did you need to have fluid drained? Were you hospitalized?	
Was your pregnancy test positive? bHCG level?	
If yes did the bhCG level rise appropriately?	
yes, was a gestational sac seen on ultrasound?	
Did you use immunotherapy? (Heparin/ Lovenox/ Intralipid/ IVIG)?	