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ASSISTED REPRODUCTIVE TECHNOLOGY (ART) CLIENT INFORMATION FORM

Your Name: _____ **Age**: _____
First Middle Last

Today's Date: _____ **Date of Birth:** _____ **SSN:** _____
(Last Four Digits)

Home Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Name of Employer: _____

Address of Employer: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____ **Email:** _____

Calls will be discreet, but please indicate any restrictions: _____

_____

Referred by: _____

Person(s) to notify in case of any emergency: _____
name phone#

Name of REI Physician: _____

Phone number: _____ **Email Address:** _____

Address: _____

What type of fertility treatment are you considering (please check all that apply)?

Intrauterine insemination (IUI) ___ In vitro fertilization (IVF) ____ Ovarian stimulation (Clomid) ____

Donor egg ____ Donor sperm ____ Donor embryo ____ Intracytoplasmic sperm injection (ICSI) ____

Please briefly describe any questions or concerns about utilizing assisted reproductive technology (ART) or donor gametes:

_____

_____

_____

_____

** The following information on this form will help me get to know you. Please try to fill out as much as you are comfortable disclosing.*

MEDICAL/PHYSICAL HEALTH HISTORY

Please explain any current medical problems, symptoms, or illnesses: _____

_____

_____

_____

Current Medications:

Name	Dosage	Purpose	Name of Prescribing Physician

Previous medical hospitalizations, surgeries, illnesses or injuries (please include approximate dates):

_____

_____

_____

Height: _____ Weight:_____

Briefly describe your nutritional and exercise/physical activity patterns:

_____

_____

_____

How many hours of sleep do you get per night (on average)? _____

Describe any persistent problems with sleep (falling asleep, staying asleep, waking too early, etc.): _____

_____

_____

Do you smoke or use tobacco? YES NO If YES, how much per day?_____

Do you consume caffeine? YES NO If YES, how much per day?_____

Do you drink alcohol? YES NO If YES, how much per day?_____

Do you use any non-prescription, recreational or club drugs? YES NO

If YES, what kinds and how often?_____

Have you experimented with or regularly used any recreational substances in the past? YES NO

If YES, what kinds and how often? _____

Have any of your friends or family members voiced concern about your substance use? YES NO

Have you ever been in trouble or in risky situations due to your substance use? YES NO

If YES, please describe:

_____

Have you ever had problems with addiction to prescription medications/painkillers or have you routinely needed to take more than prescribed to manage pain? YES NO

If YES, please describe:

_____

Have you ever met with a psychiatrist, psychologist, or other mental health professional? YES NO

If YES, please list approximate dates and reasons:

_____

_____

_____

Previous inpatient psychiatric hospitalizations (please include approximate dates and reasons):

_____

_____

_____

Please briefly describe any history of abuse (physical, sexual or emotional), neglect and/or trauma:

_____

_____

_____

_____

FAMILY

Are your parents still married to each other/together? YES NO

If NO, how old were you when they divorced or when the relationship ended? _____

What effect did this have on you? _____

Are either of your parents deceased?_____

How would you describe your relationship with your parents? _____

_____

_____

Name any other significant caregivers you had: _____

Please list your siblings' names and ages:

_____

How would you describe your relationship(s) with your sibling(s)?_____

_____

Do you have any concerns about discussing assisted reproduction treatments with family, friends, or with the child born from that treatment? _____

_____

_____

RELATIONSHIPS, SOCIAL SUPPORT & SELF-CARE

I identify my gender as: _____ Preferred pronoun(s): _____

Sexual Orientation/Identity: Heterosexual ____ Lesbian ____ Gay____ Bisexual ____ Queer ____

Questioning ____ Asexual ____ Polyamorous ____ Other_____

Married/Long-term Partnered? YES NO For how long? _____

Previously Married/Life-Partnered? YES NO For how long? _____

Currently in a relationship? YES NO For how long? _____

Name of Spouse/Partner/Girlfriend/Boyfriend: _____

Relationship Satisfaction: Poor 1 2 3 4 5 6 7 Excellent

Do you have children? YES NO If YES, please list their names and ages: _____

_____

Describe any concerns about your children: _____

_____

List the names and ages of any others living in your household:

_____

_____

Please name any significant friends or close confidants: _____

Current level of satisfaction with your social support/friends: Poor 1 2 3 4 5 6 7 Excellent

Please briefly describe how you cope with stress and recharge yourself:

_____

_____

_____

Do you have a cultural, national, ethnic or religious heritage that is important to you? YES NO

If YES, please describe:

_____

EARLY LIFE, EDUCATION & CAREER

Where did you grow up? _____

How long have you lived in Atlanta? _____

High School/GED ___ Vocational Degree ____ College Degree ____ Graduate Degree (or Higher)____

Name of College, University and/or Vocational School: _____

Type of degree: _____ Major: _____

What is your current employment status/job title? _____

Current level of satisfaction with your employment situation: Poor 1 2 3 4 5 6 7 Excellent

Any past career positions that you feel are relevant: _____

_____

What do you consider to be your greatest strengths?

_____

_____

_____

Additional information you would like to include: _____

_____

_____

_____

_____

_____

_____

_____

_____

PLEASE CHECK ALL THAT APPLY & CIRCLE YOUR MAIN CONCERN(S):

Difficulty with	Now	Past		Difficulty with	Now	Past		Difficulty with	Now	Past
Anxiety				People in General				Abdominal Distress		
Depression				Parents				Fainting		
Anger or Temper				Children				Dizziness		
Panic				Marriage/Partnership				Diarrhea		
Fears				Friend(s)				Shortness of Breath		
Irritability				Co-Worker(s)				Chest Pain		
Concentration				Employer				Lump in Throat		
Headaches				Finances				Sweating		
Memory Loss				Legal Problems				Heart Palpitations		
Excessive Worry				Sexual Concerns				Muscle Tension		
Trusting Others				Hx of Child Abuse				Pain in Joints		
Communication				Hx of Sexual Abuse				Allergies		
Drugs				Domestic Violence				Making Careless Mistakes		
Alcohol				Thoughts of Self Harm				Frequent Fidgeting		
Caffeine				Thoughts of Hurting Others				Speaking without Thinking		
Frequent Vomiting				Self Harm				Patience		
Eating Problems				Thoughts of Suicide				Paying Attention		
Severe Weight Gain				Sleeping too much				Easily Distracted		
Severe Weight Loss				Sleeping too little				Hyperactivity		
Blackouts				Getting sleep				Chills or Hot Flashes		
Feeling Manic				Waking too early				Completing Tasks		
Head Injury				Nightmares				Nausea		

Family History of (check all that apply):
Drug/Alcohol Problems ___ Physical Abuse ___ Depression ___ Legal Trouble ___ Anxiety ___
Sexual Abuse ___ Domestic Violence ___ Hyperactivity ___ Psychiatric Hospitalization ___
Suicide ___ Learning Disabilities ___ "Nervous Breakdown" ___