CHA FERTILITY CENTER
LOS ANGELES

5455 Wilshire Blvd. Suite 1904, Los Angeles, CA 90036, Tel 323-525-3377 Fax 323-525-3376 chaivf.com

First Name (名字)		**Last Name** (姓氏)			
Date of birth (生日)		**Phone Number** (联系电话)			
Address (地址)					
City （城市）		**State**	（省份）	**Zip Code** （邮编）	
Spouse/Partner First Name (伴侣/名字)		**Spouse/Partner Last Name** (伴侣姓氏)			
Spouse/Partner Date of birth (伴侣生日)		**Spouse/Partner Phone Number** (伴侣联系电话)			

Authorization to Release Medical Information

（病历授权）

Contact via Voicemail/Email Authorization （语音留言/电子邮件）

During the course of your treatment, we will need to contact you periodically with test results, embryo status reports, appointment dates/times and other pertinent information. In an effort to respect your privacy, please indicate your preferences from the selections below.
（在您的治疗过程中，我们需要联系您，以告知您预约时间，检查结果，以及胚胎情况。考虑到尊重客人隐私，请选择以下：）

☐ **Yes, leave a voicemail message on my home phone, mobile phone, or send an email.**
(是的，在我电话上留言，或者发电子邮件给我)
Wechat ID (微信)： ______ phone # （联系电话）： ______
Send me an email at （邮箱地址）： ______

☐ **No, I do not authorize any voicemails or emails. I will call the office for my results.**
(不，我不授权通过任何语音留言或者电子邮件联系我。我会主动打电话给诊所来询问我的检查报告。)

Consent to Share Information (授权共享信息)

Infertility involves treatments with both male and female partners, please select and authorize your preference.
（不孕治疗同时针对男性和女性，请选择以下一项：）

☐ **Yes, I authorize CHA Fertility Center to leave confidential information such as test results, embryo status reports, and/or treatment and appointment information directly with my spouse/partner or on my spouse/partner's voicemail whenever I am not available unless I request otherwise.**
（是的，我授权 CHA 生殖中心在联系不到我本人的情况下，将我的检查报告，胚胎情况，治疗项目和预约时间等个人信息直接或语音留言告知我的丈夫。除非我有其他要求。）

☐ **No, I do not authorize any information whatsoever regarding my personal medical treatment and/or any results to my partner.** (不，我不同意授权 CHA 生育中心将我的任何医疗信息告知我的丈夫。)

I understand that my treatment medical records will be maintained jointly with my spouse/partner throughout my infertility care at CHA Fertility Center. ______ (Initial)
（我理解在 CHA 治疗的过程中，我的医疗信息会和我丈夫的信息共同保存。）

____
Print First and Last Name **Signature** **Date**

____
Print First and Last Name (spouse/partner) **Signature** **Date**
（名字，姓氏 拼音填写） （签字） （日期 月 / 日 / 年）

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NEW PATIENT CONSULTATION CLINICAL QUESTION@AIRE
病史问卷

Please complete this questionnaire and bring to your appointment. Feel free to retain a copy for your records. Please let us know if you have any questions or require translation assistance. Thank you! (请完整填写，如需要您可以保存一份复印件。如果您有任何疑问，请及时联系我们，谢谢！)

I confirm that I will read and complete this questionnaire in its entirety and will provide information truthfully and accurately to the best of my knowledge. （在我的认知范围内我会完整的填写我真实的病史。）

Patient's Full Name: （病人姓名，正楷和拼音）________________________

Patient's Signature: （病人签字 中/英）________________ Date （日期）: ________

Your Partner's Full Name（您伴侣的全名， 正楷和拼音）: ____________________

Reason for Visit: (问诊原因)

☐ Infertility Evaluation (不孕不育评估)
☐ Egg Freezing/Fertility Preservation (冻卵)
☐ Gynecology Evaluation (妇科检查)
☐ Male Infertility (男性不孕不育)
☐ Gender Selection (性别选择)
☐ Other（其他）________________

Your Ob/Gyn's Name (您妇产科医生的名字): ________________ Phone (电话): __________

Address (地址): ________________________________

When was the last time you visited your Ob/Gyn（您上一次看妇产科医生是什么时候）? __________

Your Primary Care Physician's Name (您的主治医生姓名): ______________ Phone(电话): __________

Address (地址): ________________________________

When was the last time you visited your Primary Care Physician? ________________

How did you first hear about CHA Fertility Center - Los Angeles? (您是怎么了解到 CHA 生殖生育中心的？)

☐ My doctor. Name and location of doctor（我的医生。姓名和地址）: ________________
☐ My family/relative. Specify relation （我的家人/亲戚。 与您的关系）: ________________
☐ Friends/Colleagues/Patients. Full Name (optional)（朋友/同事/之前的客人）全名（自愿填写）: __________
☐ Donor/Surrogacy Agency. Specify name of agent or agency: 捐卵/代孕/中介 ________________
☐ Internet Search. Please mark all that apply（网络渠道，多选）:

☐ Google ☐ Healthgrades.com ☐ YouTube
☐ Yelp ☐ Vitals.com ☐ Twitter
☐ Facebook ☐ Zocdoc ☐ Other (其它). Specify: ____________

☐ Newspaper/Magazine（报刊/杂志）Specify name of publication / language（具体名字/语言）: __________
☐ Television（电视）. Specify TV program name / language（具体电视节目名称/语言）: __________
☐ Radio（广播）. Specify radio channel / language（调频/语言）: ________________
☐ Other. Specify（其他，请说明）: ________________________

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FEMALE - GYNECOLOGIC HISTORY (女性－妇科历史)

What is your ancestry / ethnic background? (您的籍贯/ 种族？) ______________________________

Are you currently trying to have a baby (您现在正在尝试怀孕吗)? ☐ Yes ☐ No

How long have you been trying to have a baby(您尝试怀孕多久了)? ____________________________

When was the first day of your last period (您上一次例假第一天日期)? __________________________

How old were you when you started your period(您第一次来例假年龄)? _________________________

Are your periods regular or irregular(您的经期正常吗)? ☐ Regular （正常） ☐ Irregular（不正常）

How often do you get your periods (您多久来一次例假)? _______________________________________

How many days of bleeding do you experience (每次来例假出血多少天)? ________________________

Have there been recent changes in your menstrual patterns (您最近例假有变化吗)? ☐ Yes ☐ No

Do you have pain with menstruation (您有痛经症状吗)? ☐ Yes ☐ No

Do you experience pain with sexual intercourse (性交的时候有疼痛感吗)? ☐ Yes ☐ No

Do you experience pain with ovulation (排卵期有疼痛感吗)? ☐ Yes ☐ No

Have you experienced abnormal hair growth on your face, chin, chest or abdomen

(是否有异常毛发：脸上、下巴、胸口、腹部)? ☐ Yes ☐ No

Date of your last Pap smear (上一次做宫颈抹片检查日期)？ _______________

Have you ever had an abnormal Pap smear? ☐ Yes ☐ No If yes, when? ______________
(您有过不正常的宫颈抹片结果吗?)

Have you ever had a sexually transmitted disease? ☐ Yes ☐ No If yes, when? ____________
(您曾经有过性传染疾病吗?)

Have you ever had Pelvic Inflammatory Disease (PID)? ☐ Yes ☐ No If yes, when? __________
(你有过盆腔炎吗？)

Have you ever used an IUD (您用过子宫环吗) ? ☐ Yes ☐ No

Have you ever used Oral Contraceptive Pills (您用过口服避孕药吗) ? ☐ Yes ☐ No

What type / brand（药品名称）? ____

Did you have any side effects / reactions （您有副作用 / 不良反应）? ☐ Yes ☐ No

How many years （几年）? ____________________

When did you last use the pills （您最近一次服用避孕药的日期） _____________________

Date of last Mammogram (最近一次乳房 x 光片)_______________

Result （检查结果）: ____

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PREVIOUS FERTILITY WORKUP AND TREATMENT （生育历史和治疗）

Please specify if you have had any of the following tests before (如果您做过以下任何一项检查，请填写)

Female Assessment （女性项目）	Date（日期）	Result（结果）
Vaginal Ultrasound （阴道超声波）		
HSG Hysterosalpingogram (Dye test) （子宫输卵管造影/染色检查）		
Fluid Ultrasound/Sonohysterogram 液体超声 / 子宫声学造影		
Day 3 FSH （经期第三天卵泡刺激素）		
Anti-Mullerian Hormone （抗缪勒氏管激素）		
Other Blood Tests （其他血检）		

Has your partner ever had a semen analysis?
（您的伴侣做过精子分析吗？） ☐ Yes ☐ No If yes, when（日期）? __________

Results (结果):

Coun (cell/ml) __________ Motility (%) _________ Morphology (% normal) __________

Have you ever received fertility treatments before (您之前接受过生育治疗吗？) ☐ Yes ☐ No

If yes, please specify types of treatments and other information (请说明):

Treatment （治疗项目）	Date （日期）	# of attempt （尝试次数）	Outcome （结果）
Clomid and Intercourse (克罗米芬+性交)			
Clomid and IUI （克罗米芬+单精子注射）			
Gonadotropins injections and intercourse（促性腺激素注射+性交）			
Gonadotropin Injections and IUI （促性腺激素注射+ 单精子注射）			
Other（其他）			

Have you had an IVF cycle in the past (你之前做过试管周期吗) ☐ Yes ☐ No

If yes, please provide the following: (如有，请填写：)

Date of IVF Cycle （IVF 周期日期）	# of Eggs （卵子数量）	# of Embryos （胚胎数量）	Outcome （结果）

Did you ever use an egg donor (您接受过捐卵吗)? ☐ Yes ☐ No

Did you ever use a sperm donor (您接受过捐精)? ☐ Yes ☐ No

Did you ever use a gestational surrogate (您接受过代孕服务吗)? ☐ Yes ☐ No

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MEDICAL HISTORY （病历）

Please indicate if you and/or your partner have or have had any of the following conditions:
（如您或您的另一半符合以下任何一项， 请填写）

Condition （病症）	Yes	No	Comments （说明）
Anemia 贫血			
Bleeding disorders 出血性疾病			
Blood clots in lungs or veins 肺部或血管血栓			
Thalassemia 地中海贫血			
Asthma 哮喘			
Pneumonia / Lung Disease 肺炎/肺病			
Liver Disease / Hepatitis 肝病/肝炎			
Acid Reflux / Heartburn 胃酸反流/胃灼烧			
Heart Disease 心脏病			
High Blood Pressure 高血压			
Kidney Disease 肾病			
Migraines / Headaches 偏头痛/头痛			
Multiple Births 多胎生产			
Birth Defects 畸形胎			
Inherited / Genetic Disease 先天/基因疾病			
Carrier of a Genetic Disease 基因疾病携带者			
Fragile X Syndrome / Pre-mutation 脆弱性 X 染色体综合症/基因前突变			
Diabetes 糖尿病			
Thyroid Disease 甲状腺疾病			
Other Hormonal Conditions 其他激素症状			
Lupus 狼疮			
Rheumatoid Arthritis 风湿性关节炎			
Uterine Cancer 子宫癌			
Cystic Fibrosis 囊泡性纤维症			
Tay Sachs 泰-萨二氏病			
Breast Cancer 乳腺癌			
Other Cancer 其他癌症			
Fibroids 子宫肌瘤			
Infertility 不孕症			
Endometriosis 子宫内膜异位			
Ovarian Cysts 卵巢囊肿			
Familial Mediterranean Fever 家族性地中海热			
Other 其他			

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CURRENT MEDICATIONS （正在服用的药物）

Please list any medications that you are currently taking (请列举出您现在所服用的任何药物).

Medication （药物）	Dose （剂量）	Frequency （频率）

Are you allergic to any medications (您有药物过敏吗)? ☐ Yes ☐ No Please list （请列举）.

Medication （药物）	Reaction to the Medication （药物反应）

PREVIOUS SURGERIES (手术历史)

Procedure （手术）	Date（日期）	Outcome / Complications （结果/病发症）

Have you ever had any complications related to anesthesia? （您有过任何对麻醉的不良反应吗？）

☐ Yes ☐ No If yes, please explain （若有，请说明）: ______________________________

OBSTETRICAL HISTORY (产科病史)

Have you ever been pregnant before (怀孕史)? ☐ Yes ☐ No

Date （日期）	Current/ Prior Partner （现任/前任伴侣）	Live Birth Y/N （活产）	Miscarriage/ Abortion/ Ectopic （流产/堕胎/异位妊娠）	Wks （周）	Fetal Heart Y/N （胎心）	D&C Y/N （刮宫）	Natural or C-Section （顺产 / 剖腹产）	Boy/Girl (男 / 女）	Weight （体重）

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FAMILY HISTORY (家族病史)

Please state if any of your family members have any of the following conditions.
（若您的家庭成员有以下任何一项病症，请说明）

Condition （症状）	Yes	No	Comments （请说明）
Diabetes 糖尿病			
Heart Disease 心脏病			
High Blood Pressure 高血压			
Stroke 中风/脑溢血			
Kidney Disease 肾病			
Liver Disease / Hepatitis 肝病/肝炎			
Multiple Births 多胎生产			
Birth Defects 畸形胎			
Mental Retardation 智力障碍			
Fragile X Syndrome / Pre-mutation 脆弱性X染色体综合症/基因前突变			
Autism 自闭症			
Inherited / Genetic Diseases 遗传/基因疾病			
Thyroid Disease 甲状腺疾病			
Lupus 狼疮			
Bleeding disorders 出血性疾病			
Blood Clots in Lungs or Legs 肺部/胸部血栓			
Cystic fibrosis 囊泡性纤维症			
Tay Sachs 泰-萨二氏病			
Breast Cancer 乳腺癌			
Ovarian Cancer 卵巢癌			
Uterine cancer 子宫癌			
Other Cancer 其他癌症			
Infertility 不孕症			
Recurrent Miscarriage 多发性流产			
Early Menopause 过早停经			
Sickle Cell Disease 镰状细胞病			
Rheumatoid Arthritis 风湿性关节炎			
Thalassemia 地中海贫血			
Familial Mediterranean Fever 家族性地中海热			
Other 其他			

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SOCIAL HISTORY （生活习惯/历史）

Do you use tobacco (您抽烟吗)? ☐ Yes ☐ No # of packs per day 每天几包 ________

Have you ever used tobacco before （您抽烟吗）? ☐ Yes ☐ No # of years 几年________

Do you use alcohol (您喝酒吗)? ☐ Yes ☐ No # of drinks per week 每周几杯 ________

Do you use recreational / street drugs (娱乐性药物/毒品)? ☐ Yes ☐ No

If yes, what type and how often? （如有，请说明种类和频率?） ______________________________

Do you use caffeine (您食用咖啡因吗)? ☐ Yes ☐ No

What type? （种类） _________________________ # drinks per day （每天几杯） ________

Do you exercise regularly (您规律运动吗)? ☐ Yes ☐ No

What type of exercise do you do? 哪种运动? ______________________________________

Have you gained /lost weight in the last several years (近几年，您有增加/减少重量吗)? ☐ Yes ☐ No

Gained （增重） _____ lbs （ ____kg） Lost （减重） _____ lbs (_____kg)

What is your occupation(您的职业是) ?____

On a scale of 1-10 (10 being the worst), estimate the level of stress you feel due to your job:
(在 1-10 之间，请评价您的工作压力：)

Circle a number （打圈）: 1 2 3 4 5 6 7 8 9 10

Are you married? （您结婚了吗?） ☐ Yes ☐ No If yes, for how long? (几年)_______

How frequently do you have intercourse (性生活频率)? _______ times per wk / mo （每周 / 每月几次）

Do you use lubricant (您使用润滑剂吗)? ☐ Yes ☐ No

EMOTIONAL STATUS（心理状况）

On a scale of 1-10 (10 being the worst), estimate the level of stress you feel due to infertility:
(在 1-10 之间，请评价不孕不育给您带来的压力？)

Circle a number（打圈）: 1 2 3 4 5 6 7 8 9 10

Do you see a counselor （您看过心理咨询吗）? ☐ Yes ☐ No

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MALE HISTORY （男性病史）

Please indicate if you have had any of the following conditions or procedures in the past:
（如您有过以下任何一项症状 / 检查，请指出：）

Conditions / Procedure （症状 / 检查）	Date（日期）	Outcome（结果）
Orchitis / Infection of the testes （睾丸炎）		
Undescended testes （隐睾）		
Trauma to the groin （腹股沟创伤）		
Condition requiring Chemotherapy / Radiation（需要化疗 / 射线的治疗）		
Vasectomy （输精管切除术）		
Vasectomy reversal （输精管吻合术）		
Hernia repair （疝修补术）		
Varicocele ligation （结扎术）		
Cystic fibrosis （囊泡性纤维症）		
Other （其他）		

Please list any medications that you are currently taking (请列举出您现在正在服用的药物).

Medication（药品名称）	Dose （剂量）	Frequency （服用频率）

Are you allergic to any medications (药物过敏)? ☐ Yes ☐ No Please list.

Medication （药物）	Reaction to the Medication （不良反应）

Do you use tobacco (您吸烟吗)? ☐ Yes ☐ No # of packs per day （每天几包）_______

Have you ever used tobacco before? ☐ Yes ☐ No # of years（几年）_________

Do you use alcohol (您喝酒吗)? ☐ Yes ☐ No # of drinks per week （每周几杯）_____

Do you use recreational / street drugs （您使用娱乐性药物吗）? ☐ Yes ☐ No

If yes, what type and how often? （种类，使用频率）____

What is your occupation (您的职业)?____

On a scale of 1-10 (10 being the worst), estimate the level of stress you feel due to your job:
(从１－１０，请选择您认为工作给您带来的压力：)

Circle a number （打圈）: 1 2 3 4 5 6 7 8 9 10

Do you use a hot tub（您泡澡吗）? ☐ Yes ☐ No If yes, how many times per week?（每周几次）_______

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Are there any other aspects of your medical, surgical, family and/or social history that you think your doctor should know? （如您觉得有其它关于病史，手术，家族和社会背景的信息需要医生知晓，请说明：）

____
____
____
____
____

COMMENTS （其他）

____
____
____
____
____

Thank you for taking the time to complete our questionnaire. Your doctor will review this questionnaire with you. （感谢您宝贵的时间。您的医生会根据您的病史问诊。）

As a part of your initial evaluation your doctor may perform a focused physical exam and a pelvic ultrasound that is directed to assess reproductive health. This exam is in no way a replacement for a comprehensive routine physical exam that you should receive annually or more frequently as indicated by your age and medical history. （根据您填写的病历，您的医生会有针对性地给您做体检和盆腔超声检查。检查重点针对生育健康。这些检查不能替代您每年（或根据不同年龄和身体状况而定的）所需要做的常规体检。

I authorize CHA Fertility Center to (a) share my information with the companies and associates of CHA Fertility Center and CHA Health Systems and (b) aggregate and de-identify my patient information and use and share such aggregated and de-identified information for research and marketing purposes. My information shall not be shared outside of said parties without my written consent. I confirm that I have read this questionnaire entirely and have provided the information above truthfully and accurately. （ａ．我授权 CHA 内部人员知晓我的病史资料。ｂ．在匿名的情况下把我的病史资料与资料库归纳用于研究和医疗普及。在我没有另外授权的情况下，我的资料不被外界分享。 我确认我详细的阅读了病史调查问卷，并真实准确的填写了我的信息。）

Patient Signature（病人签字）. _ООО____________________________ Date（日期）: _______________

BSdf WdE[Y` SfgdW ŁSSSSSSSSSSSSSSSSSSSSSSSSSSSSSS 6SfW ŁSSSSSSSSSSSSS

I confirm that I have reviewed the information above. （我已检阅以上信息）

Physician's Signature:（医生签字）____________________________ Date（日期）: _______________

Ver.02.08.2017