Trellishealth.com
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TRELLIS

Welcome to Trellis

We are so excited to help you plan your future family. Our mission is to empower you to own your fertility by providing fertile health education and fertility preservation options.

New Client Forms

Please fill out the following questionnaire as accurately as possible. If you have difficulty completing the below, please let us know. We very much looking forward to joining you on your future family journey!

Client Name:	DOB:	Age:
Address:		
Telephone: (M)	(W)	
Social Security Number:		
How were you referred to Trellis? ☐ Friend ☐ Relative ☐ Seminar ☐ Internet ☐ Other		
OB/GYN:		
Date of Consultation:	Seeing Dr.:	

Insurance Information

Primary Insurance		Secondary Insurance	
Subscriber Name		Subscriber Name	
Insurance ID #		Insurance ID #	
Group #		Group #	
Customer Service #		Customer Service #	
HMO or PPO		HMO or PPO	

If you have an HMO insurance: You must obtain a referral from your insurance company, and/or your OB/GYN prior to your initial consultation. Please note: the only HMO insurance we are a contracted provider for is Health Plan of Nevada.

Social History

Occupation			
Do you use tobacco?	☐ Yes	☐ No	#Packs/Day
Do you use alcohol?	☐ Yes	☐ No	#Drinks/Wk
Are you currently married?	☐ Yes	☐ No	

Family History

Is there a history of any of the following conditions in your family?

CONDITION	YES/NO	COMMENTS
Diabetes		
Heart disease		
High blood pressure		
Birth defects		
Inherited diseases		
Thyroid disease		
Breast cancer		
Ovarian cancer		
Uterine cancer		
Rheumatoid arthritis		
Lupus erythematosis		

Gynecologic History

When was the first day of your last period?			
Are your periods regular?		☐ Yes	☐ No
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
Begins a few days prior to the onset of bleeding?		☐ Yes	☐ No
Persists more than 48 hours?		☐ Yes	☐ No
Do you experience pain with sexual intercourse?		☐ Yes	☐ No
When was your last pap smear?			
Have you ever had an abnormal pap smear?		☐ Yes	☐ No
If yes, what follow up was needed?			
Have you ever had a sexually transmitted disease? (i.e. Chlamydia, Gonorrhea, Syphilis, Herpes)		☐ Yes	☐ No
When?	Was it treated?	☐ Yes	☐ No
Have you ever had Pelvic Inflammatory Disease (PID)?		☐ Yes	☐ No
When?			
Do you experience milk or discharge from your breasts?		☐ Yes	☐ No

Obstetrical History

Have you ever tried to have a baby?	☐ Yes	☐ No
Have you ever been pregnant before?	☐ Yes	☐ No
Have you ever undergone IVF or fertility treatments?	☐ 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

Medical Conditions

Do you have a history of any of the following conditions?

CONDITION	YES/NO	COMMENTS
Migraine		
Thyroid problems		
Asthma		
Heart Murmur		
Rheumatic fever		
High blood pressure		
Gastric/duodenal ulcer		
Bleeding tendency		
Problems with anesthesia		
Diabetes		
Kidney stones		
Kidney infection		
Rheumatoid arthritis		
Other forms of arthritis		
Lupus erythematosis		
Neurologic disorders		
Thromobophlebitis		
Cancer		
Other		

Previous Surgeries

Have you ever had surgery?

PROCEDURE	DATE	INDICATION	OUTCOME

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

Comments

If there is anything additional you would like us to know, please comment below.