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RIA PATIENT CLINICAL INFORMATION

I. IDENTIFYING DATA

Date: _____
Name (Patient): _____ DOB: _____
Name (Partner): _____ DOB: _____
Duration of Relationship: _____

II. MEDICAL HISTORY

Height: _____ Weight: _____ Blood Type: _____

HAVE YOU EVER HAD THE FOLLOWING (CHECK ALL THAT APPLY):

- | | |
|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Autoimmune disease, unspecified |
| <input type="checkbox"/> Blood clots in extremities | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Cerebral vascular accident (stroke) |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Deep venous thrombosis |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Eclampsia or pre-eclampsia |
| <input type="checkbox"/> Edema | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Hair loss (>100 hairs/day) | <input type="checkbox"/> Idiopathic thrombocytopenic purpura |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Inflammatory bowel disease |
| <input type="checkbox"/> Irregular heart rhythm | <input type="checkbox"/> Mixed connective tissue disease (MCTD) |
| <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Myocardial infarction (MI/heart attack) |
| <input type="checkbox"/> Liver problems/jaundice | <input type="checkbox"/> Myofascial pain syndrome or fibrositis |
| <input type="checkbox"/> Memory impairment | <input type="checkbox"/> Polymyalgia rheumatica |
| <input type="checkbox"/> Photosensitivity | <input type="checkbox"/> Premature ovarian failure |
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Pulmonary embolus |
| <input type="checkbox"/> Raynaud's | <input type="checkbox"/> Raynaud's syndrome |
| <input type="checkbox"/> Sensory loss involving the extremities | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Systemic lupus erythematosus |
| <input type="checkbox"/> Visual abnormalities (except refractory) | <input type="checkbox"/> Thyroiditis |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Other |
| <input type="checkbox"/> Ulcers in mouth or genitalia | _____ |
| <input type="checkbox"/> Weight loss (unplanned) | _____ |
| <input type="checkbox"/> Other _____ | _____ |

MEDICATION (current)

SURGERY (non-reproductive)

ALLERGY OR SERIOUS SIDE-EFFECT TO MEDICATION:

Patient Name: _____

III. REPRODUCTIVE HISTORY

MISCARRIAGES

Diagnosis: _____

Number of pregnancies: _____

Number of live births: _____

Number of therapeutic abortions (TAB): _____

Number of miscarriages (SAB): _____

Pregnancy #	Year	SAB? (miscarry)	TAB? (abortion)	Age Fetus at Demise, Chemical?	Live Birth?	Current Partner Father?	Treatment or Procedure
1							
2							
3							
4							
5							
6							

INFERTILITY

Diagnosis: _____

Number of IUI: _____

Number of ART: _____

(includes IVF, GIFT, ZIFT, etc.)

Procedure #	Year	Type ART	Outcome (live birth?)	Medication Treatment(s)
1				
2				
3				
4				

Patient Name:

IV. LABORATORY AND OTHER DIAGNOSTIC PROCEDURES

	Date(s)	Results
Endometrial biopsy:	_____	_____
	_____	_____
Hysterosalpingogram:	_____	_____
	_____	_____
Hysteroscopy:	_____	_____
	_____	_____
Laparoscopy:	_____	_____
	_____	_____
APA:	_____	_____
	_____	_____
ANA:	_____	_____
	_____	_____
Thyroid Antibodies:	_____	_____
	_____	_____
Lupus Anticoagulant:	_____	_____
	_____	_____
Leukocyte Antibodies:	_____	_____
	_____	_____
DQ Alpha: wife	_____	_____
husband	_____	_____
	_____	_____
Factor II Gene Mutation:	_____	_____
	_____	_____
Factor V Gene Mutation:	_____	_____
	_____	_____
MTHFR Gene Mutation:	_____	_____
	_____	_____
Chromosomes: wife	_____	_____
husband	_____	_____
fetus	_____	_____
fetus	_____	_____

V. FAMILY HISTORY

- Cerebral vascular accident (stroke)
- Deep venous thrombosis
- Myocardial infarction (heart attack)
- Pulmonary embolus

- Systemic lupus erythematosus
- Other autoimmune disease:
