MAIA FERTILITY CARE INTAKE FORM

Family Information:

Client Name

Partner(s)

Coparent(s)

Children + Ages

Address

City / State / Zip

Phone

Email

Donor Information:

Known Donor Name + Location

Sperm Bank

Conception Information:

Planning to start / Trying since: ______

Number of cycles you have tried: ______

Methods of insemination: ______

Timing strategies: ______

Medicated cycles: ______

Possible conceptions: ______

Positive pregnancy tests: ______

Health History:

Date of Birth: ______

Height: ______

Weight: ______

What vitamins, supplements or herbs are you currently taking? ______

Do you have any ongoing health issues? ______

What medications do you take (including over the counter)? ______

Do you have allergies? To what? ______

What do you do for your allergies? ______

Have you had any major surgeries? ______

Do you go to the dentist regularly? ______ Any major dental work needed? ______

Is there any history in your family of the following?
Please explain.

- ☐ Hypertension ______
- ☐ Diabetes ______
- ☐ Infertility/Repeat Miscarriage ______
- ☐ Heritable Conditions ______
- ☐ Fraternal Twins ______
- ☐ What is your ethnic background? ______

Do you have personal history of any of the following:
Please note if current or past (and when).

- ☐ Depression ______
- ☐ Anxiety ______
- ☐ Bipolar Disorder ______
- ☐ Eating Disorder ______
- ☐ Substance Abuse ______
- ☐ Sexual Abuse/Trauma ______

Nutrition

Please conduct a 3 day diet history. For 3 days that are normal days for you, write down everything you eat and what time you eat. Include all meals, snacks and drinks.

Day 1

Wake time: ______________

Time: ____________________ Food/Drink: ____

Time: ____________________ Food/Drink: ____

Time: ____________________ Food/Drink: ____

Time: ____________________ Food/Drink: ____

Time: ____________________ Food/Drink: ____

Time: ____________________ Food/Drink: ____

Time: ____________________ Food/Drink: ____

Day 2

Wake time: ______________

Time: ____________________ Food/Drink: ____

Time: ____________________ Food/Drink: ____

Time: ____________________ Food/Drink: ____

Time: ____________________ Food/Drink: ____

Time: ____________________ Food/Drink: ____

Time: ____________________ Food/Drink: ____

Time: ____________________ Food/Drink: ____

Day 3

Wake time: ______________

Time: ____________________ Food/Drink: ____

Time: ____________________ Food/Drink: ____

Time: ____________________ Food/Drink: ____

Time: ____________________ Food/Drink: ____

Time: ____________________ Food/Drink: ____

Time: ____________________ Food/Drink: ____

Time: ____________________ Food/Drink: ____

For Clinic Use Only:

☐ Protein ____________	☐ Fats ____________	☐ Toxins ____________
☐ Vitamins ____________	☐ Iron ____________	☐ Stimulants ____________
☐ Minerals ____________	☐ Calcium ____________	☐ H2O ____________