

### NEW PATIENT PACKET

### **BEFORE YOUR FIRST VISIT**

Before your appointment, please complete the attached demographics and infertility history form online. Once complete, save the document and email to <a href="mailto:patientpaperwork@hsvrm.com">patientpaperwork@hsvrm.com</a>. You can also print the completed paperwork, scan and email to <a href="mailto:patientpaperwork@hsvrm.com">patientpaperwork@hsvrm.com</a>. In addition, if you have medical records, email those records with your completed paperwork. If you have had an HSG and are in possession of the films, please bring them with you to your initial consult.

#### WHAT TO EXPECT

**Please plan to arrive at our office 15 minutes prior to your appointment**, allowing ample time for parking and locating the office. A map and picture of our building are attached to better help you find us. Every effort will be made to start your consultation at the scheduled time. Please visit our website at <a href="https://www.huntsvillelVF.com">www.huntsvillelVF.com</a> for more information.

Your initial consultation will last approximately 45 minutes. We will need to get a copy of your insurance card and your driver's license for your first visit. Your co-payment will be collected when you check in and you will then meet with the doctor where he will review your history and discuss your options. If is preferable that your spouse/partner be present if at all possible. We understand that sometimes situations can't be avoided, but we ask that you not bring children to your initial consultation appointment.

#### **INSURANCE & FINANCES**

We participate with most insurance plans. However, make sure you have given us your insurance carrier's name before you come so that we can verify that we are approved providers with your particular plan. If we do not participate with your insurance carrier, you will be responsible for the entire visit. Your initial visit will be approximately \$200.00, but the fees could run several hundred dollars more depending up the testing and diagnostic work-up required. Please note that we are contractually obligated by insurance companies to collect copayments, and if we do not, we are subject to penalties from insurance companies. We will file your claims with your insurance carrier, but in the case of disputes over coverage and payments, the patient is ultimately responsible for communicating with their insurance company.

#### **CANCELLATION POLICY**

At least two business days before your appointment, we will call you to confirm your appointment. If we are unable to confirm your appointment after repeated attempts, we reserve the right to reschedule another new patient in your time slot. If it becomes necessary for you to cancel your appointment, we ask you give at least 24 hours notice, so that we can then contact other patients who may be able to use that appointment time slot. **Without 24 hours notice, a \$40.00 fee will be required to reschedule.** 

Thank you for choosing Huntsville Reproductive Medicine for your specialized care. We look forward to seeing you!

# **CONTACT US**

# Contact Huntsville Reproductive Medicine

Telephone: 256.213.BABY (2229)

Please see information about phone calls below.

Fax: 256.213.9978

Email: patientservices@hsvrm.com

Address: 20 Hughes Road, Suite 203, Madison, AL 35758

in front of Madison Surgery Center Map and driving directions

### Office Hours

Our office hours are by appointment only.

- · Monday through Thursday, 7:00am to 5:00pm
- · Friday, 7:00am to 2:00pm

We are closed on weekends and holidays except for scheduled procedures ordered by the physician.

## **Phone Calls**

Phone messages may be left on voice mail, but non-urgent calls after 2:00pm may not be returned until the next day. Please leave a detailed message when you call so that we are aware of the nature of your call and can better serve your needs. When scheduling blood work, ultrasound, or any other study, please mention your cycle day and nature of the testing. Please be ready to provide a pharmacy phone number for any medication-related inquiry.







Specializing in Reproductive Endocrinology & Infertility

# **Helpful Guidelines for Patient Phone Calls**

Huntsville Reproductive Medicine is committed to providing the best care possible to all of our patients. During in-office visits, we strive to give our complete attention to the individual patient. We cannot provide this one-on-one patient care while attending to a large volume of patient phone calls at the same time. Therefore, the nurses are only able to intermittently check messages during the hours of 7am-10am.

If you have an urgent issue during these hours, please speak directly with the receptionist. If you leave a message, the nurses will return your call as soon as possible. Calls received after 2pm may not be returned until the following day. Please remember that calling repeatedly during the day does not speed up a return call, as we will return any call at the earliest time possible.

Appropriate patient phone calls to the nurses include reporting worrisome symptoms, postoperative complaints, prescription refills, and other urgent or time-sensitive needs. Appropriate phone calls to the receptionist include scheduling of testing, insurance/billing questions, requests for work excuses, etc.

Some issues such as "What do my lab results mean?" or "What are my next treatment options?" are best addressed in person with your doctor at a return visit. Before the time of each diagnostic test (e.g. ultrasound, blood work, semen analysis, HSG, etc.), you should confirm with the staff how your results will be conveyed to you. Usually, the results are reviewed at the next scheduled appointment. We do not routinely give test results out over the phone due to multiple concerns (including medico-legal issues, and the limitations of the nurses to discuss what the results mean for the individual patient.

Thank you in advance for your understanding and cooperation with these helpful phone call guidelines.



# PRIOR AUTHORIZATION FEES (Effective June 1, 2006)

We recognize that our patients can save substantial amounts of money using a mail order pharmacy and we realize that patients have a choice in where to purchase their prescriptions, locally or by mail order. For those patients whose pharmacy, mail order or local, requires a Prior Authorization, we have instituted a one-time fee of \$20.00 to process this insurance-mandated authorization (this charge is not billable to your health insurance plan).

We appreciate your understanding and regret the need to charge for these services.



To Our Valued Patients,

As you know if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill. This is an advantage for both you and the hotel or rental company, since it makes checkout easier, faster, and more efficient.

Since 2006 we have utilized a similar policy. All new patients provide a credit card at the time of their check in and we hold that information securely until insurance has paid its portion and notified us of the patient's share.

Your card will **never** be charged until insurance has paid their share; you will receive a receipt by mail when charges are made; and you will always be notified in advance if the amount to be charged is greater than \$200.00.

This will be an advantage to you, since you will no longer have to write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and mail. This combination benefits everyone by helping to keep healthcare costs down. This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

Copays that are due at the time of the visit will, of course, still be collected at the time of the visit. For any outstanding balance of greater than 30 days, we reserve the right to charge the entire balance.

Patients who do not have a credit card will be required to pay \$200.00 into an "Escrow" account that will be used to pay remaining balances after insurance has paid its portion.

If you have any questions about this payment method, please do not hesitate to ask us.



# CREDIT CARD PAYMENT INFORMATION AND AUTHORIZATION

Name (as it appears on credit card):	-
Credit Card Name:VISAMasterCard	AMEXDiscover
Credit Card Account Number:	
Expiration Date: Security Code	e:
Your card will never be charged until insurance has paid their sharwhen charges are made; and you will always be notified in advance than \$200.00.	
This will be an advantage to you, since you will no longer have be an advantage to us as well, since it will greatly decrease the nur generate and mail. This combination benefits everyone by helping no way will compromise your ability to dispute a charge or que determination of payment.	nber of statements that we have to g to keep healthcare costs down. This in
Copays that are due at the time of the visit will, of course, still be outstanding balance of greater than 30 days, we reserve the right to	
Patients who do not have a credit card will be required to pay \$200 be used to pay remaining balances after insurance has paid its port	
By my signature below, I authorize Huntsville Reproduct to bill my credit card for balances that are deemed n company. I understand that this does not affect my abili my insurance company's determination of payment.	ny responsibility by my insuranc
Signature of Patient/Card Holder  OR	Date
I elect to deposit \$200.00 into an ESCROW AC balances left after insurance has paid their pos	



PATIENT INFORMATION	<b>N:</b>		
Full Name:	·	City/State:	Zip:
Address:			
Home Phone:	Work Phone:	Cell I	Phone:
Email address:			
Date of Birth:	Age:Mar	ital Status: Socia	I Security #:
Employer's Name and address	ss:		
Can we call at work or leave	message?		
Ob/Gyn's Name and address:			
Emergency Contact Name &	Phone:		
Emergency Contact Name & Referred by: Ob/Gyn l	Friend TV	Internet Other	
PARTNER'S INFORMAT	ION:		
Full Name:			
Address:		City/State:	Zip:
Home Phone:	Cell Phon	e:	
Email address:			
Date of Birth:	Social Sec	curity #:	
Employer's Name and Addre			
· -			
List all people we may talk	to about your general l	ealth and test results:	•
• •			onship:
			onship:
INSURANCE INFORMAT	ION:		
Primary Insurance:			
Policy #:		Group #:	
Cardholder's name:		Cardholder's DOB:	
Cardholder's employer:		Relation to patient:	
Secondary Insurance:		Address:	
Policy #:		Group #:	
Cardholder's name:		Cardholder's DOB:	
Cardholder's employer:		Relation to patient:	
l authorize the release of all medical r transmittal of my medical records, if no Medicine, P.C. should they elect to rect this assignment shall be considered as e I acknowledge full financial responsibili incurred is due at the time of service un attorney's fees and collection costs in the I authorize treatment by Huntsville Rel acknowledge receipt of Huntsville Rel have read and fully understand the aband acknowledgement of HIPPA privace.	ecessary. I authorize and request cive such payment. This is a direct frective and valid as the original, ity for services rendered by Hunts cless other definite financial arrange event of default of payment of renductive Medicine, P.C. physic productive Medicine, P.C.'s HII ove consent for treatment, financial	that insurance payments be made t assignment of my rights and ben ville Reproductive Medicine, P.G gements have been made prior to my charges. cians and personnel. PPA Privacy Notification.	e directly to Huntsville Reproductive effits under this policy. A photocopy of C. I understand that payment of charges treatment. I agree to pay all reasonable



# AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE **Infertility History Form**

## **IMPORTANT:**

Please complete this form and bring it with you to your scheduled visit.

This form was developed by the American Society for Reproductive

FOR OFFICE USE ONLY

Medicine to assist physicians and patients in obtaining a complete infertility history. It consists of three parts:  Part I: Contact information  Part II: Your medical history  Part III: Your male partner's medical history (if applicable)	
PART I: CONTACT INFORMATION	
First Name Middle Initial Last Name	Age
Date of Birth (MM/DD/YY)/ Occupation	
Home Street Address	
City         State         Zip/Postal Code         Country	
Indicate which number to call or leave messages.  □ Home Telephone ( ) □ Work Telephone ( )	Cell Phone ( )
Do you have a male partner? ☐ Yes ☐ No	
Male Partner's First Name Middle Initial Last Name   Not Applicable	
Date of Birth (MM/DD/YY)/ Occupation	
Home Street Address	
City         State         Zip/Postal Code         Country	
Indicate which number to call or leave messages.  □ Home Telephone ( ) □ Work Telephone ( )	_ Cell Phone ( )
By whom were you referred?	
□ Physician  Name Phone ( )  Address	Physician Notes (for office use only)
□ Former Patient/Friend □ Web Site	
☐ Insurance (Name of Insurance)	
Who is your Ob/Gyn?  Name Phone ( )  Address	
Who is your Primary Care Physician?  Name Phone ( ) Address	

### PART II: FEMALE MEDICAL HISTORY AND INFORMATION **Reason for Visit:** □ Infertility Evaluation □ Sperm Insemination □ Other **How many months** have you been trying to conceive (unprotected intercourse or inseminations)? **Pregnancy Summary** • Total Number of ALL Pregnancies: \_\_\_\_\_ • Number of Full Term Deliveries: \_\_\_\_\_ Of these, how many were live births? \_\_\_\_ How many were stillborn? \_\_\_ • Number of Premature (less than 37 weeks) Deliveries: \_\_\_\_\_ Of these, how many were live births? \_\_\_\_ How many were stillborn? \_\_\_\_ • Number of Miscarriages (less than 20 weeks): • Number of Ectopic/Tubal Pregnancies: \_\_\_\_\_ • Number of Elective Terminations (Abortions): • Any Pregnancies with Birth Defects? ☐ No ☐ Yes - explain \_\_ Treatments to Delivery Type/D&C/ Date Pregnancy Months to Current **Complications Ended or Delivered** Conception Conceive Partner? $\square Y \square N$ 6. \_\_\_\_\_ $\square Y \square N$ **Menstrual History** • Menstrual cycle pattern (check all that apply): ☐ Regular periods ☐ Irregular periods ☐ Spotting before periods ☐ No periods ☐ Heavy periods ☐ Light periods ☐ Bleeding between periods • Number of days between the start of one period to the start of the next period: \_\_\_\_\_days • How many days of bleeding do you have? \_\_\_\_\_days • Dates of the 1st day of your last 2 menstrual periods: \_\_\_\_/\_\_\_; \_\_\_\_/\_\_\_\_; • Age when you had your first period: years old • Age when you first noticed: Breast development: \_\_\_\_years old Pubic hair: \_\_\_\_years old Underarm hair: \_\_\_\_years old • How many periods do you have per year? \_\_\_ • Do you need medication to bring on a period? ☐ Yes - what type?\_\_\_\_\_ • If you do not have periods, at what age did you stop having them? \_\_\_\_\_ years old • Do you have severe cramping or pelvic pain with your periods? Yes: Always\_\_ Sometimes\_\_ Recently\_\_ In the past\_\_ No **Contraceptive History** □ None □ Condoms - dates of use\_\_\_\_ □ Diaphragm - dates of use\_\_\_\_ ☐ IUD - dates of use\_\_\_\_\_ ☐ Birth control pills - dates of use \_\_\_\_\_ - complications? \_\_\_\_\_ ☐ Never used birth control pills ☐ Injectable contraception (Depo-Provera®, Lunelle<sup>TM</sup>, etc.) - dates of use\_\_\_\_\_\_ - complications?\_\_\_\_\_ ☐ Skin patch - dates of use\_\_\_\_\_ - complications?\_\_\_\_\_ ☐ Tubal sterilization procedure (tubes tied) - date (month/year)\_\_\_\_/\_\_\_ ☐ Tubes untied - date (month/year)\_\_\_\_/\_\_\_ Did your mother take DES when she was pregnant with you? ☐ Yes ☐ No ☐ Don't know **Sexual History** • How many times do you have intercourse per week? \_\_\_\_\_times per week ☐ None ☐ Not applicable • Have you used over-the-counter ovulation kits to time intercourse? ☐ Yes ☐ No • Do you have pain with intercourse? ☐ Yes ☐ No • Do you use lubricants (K-Y Jelly<sup>®</sup>, etc.) during intercourse? Yes - what types? Any prior exposure to sexually transmitted diseases or pelvic infections? $\square$ Yes (check all that apply) $\square$ No ☐ Chlamydia - date ☐ Gonorrhea - date ☐ HIV/AIDS - date ☐ Herpes - date\_\_\_\_\_ Genital warts/HPV - date\_\_\_\_\_ ☐ HIV/AIDS - date\_\_\_\_ ☐ Syphilis - date\_\_\_\_\_ ☐ Hepatitis - date\_\_\_\_ Physician Notes (for office use only)

<ul> <li>Pap Smear History</li> <li>When was your last pap smear (month and year)?/_</li> <li>When was your last abnormal pap smear? □ Not</li> </ul>	
Have you undergone any procedures as a result of an abnorm  ☐ Yes (check all that apply) ☐ No ☐ Colposcopy ☐ Cryosurgery (Freezing) ☐ Laser	
Breast Screening History  Have you ever had a mammogram? □ No □ Yes - date_  Do you perform self breast exams? □ Yes □ No	Result: □ normal □ abnormal - explain
Medical History  • Are you allergic to any medications? □ No □ Yes (Ple	lease list and describe reactions)
• Are you allergic to any foods (peanuts, eggs, etc.)? ☐ No	☐ Yes (Please list and describe reactions)
• List any medications you are currently taking, including ov	ver the counter medicines.
• Do you take any herbal medicines/vitamins or health food	store supplements?   No Yes (Please list)
Do you have any medical problem(s)? □ No □ Yes (Pl	
Vaccinations  Chickenpox (Varicella):  MMR - Measles, Mumps, and Rubella (German Measles):  BCG (Tuberculosis):  Hepatitis B:  Polio:  Hepatitis A:  Tetanus:  Influenza:	□ No       □ Yes (dates
<ul> <li>Do you use any marijuana, cocaine, or any other similar dr</li> <li>Do you exercise? ☐ No ☐ Yes (describe</li> </ul>	
Physician Notes (for office use only)	

• Have you had any surgeries? ☐ No ☐	Yes (List all surgeries in chronologic order.)	
Year	Reason and Type of Surgery	
(/)		
• Did you have any anesthesia problems?	□ No □ Yes (describe	)
Physical Symptoms		
General:	Head, Eyes, Ears, Nose and Throat:	Respiratory:
☐ Recent weight gain or loss	☐ Dizziness ☐ Loss of sense of smell	☐ Shortness of breath
☐ Anorexia/Bulimia	☐ Headaches ☐ Chronic nasal congestion	☐ Asthma ☐ Bronchitis
☐ Lack of energy	☐ Blurred vision ☐ Ringing ears	☐ Pneumonia ☐ Tuberculosis
☐ Fever/Chills	☐ Hearing loss/deafness	☐ Bloody cough
□ Other	□ Other	□ Other
□ None	□ None	□ None
Endocrine/Hormonal:	Breasts:	Neurological Problems:
☐ Diabetes ☐ Hair loss	☐ Discharge (clear? bloody? milky?)	☐ Weakness/Loss of balance
☐ Thyroid gland problems	☐ Lumps ☐ Pain ☐ Cancer	☐ Seizures/Epilepsy
☐ Rapid weight gain or loss	☐ Abnormal mammogram	☐ Headaches
☐ Excessive hunger/thirst	□ Reduction	☐ Migraine headaches
☐ Temperature intolerance—	☐ Augmentation/Breast implants	□ Numbness
hot flashes or feeling cold	(saline? silicone?)	☐ Memory loss
Other	Other	Other
□ None	□ None	□ None
<b>Gastrointestinal:</b>	Genito-Urinary:	Skin/Extremities:
☐ Nausea/Vomiting ☐ Ulcers	☐ Bladder infections	☐ Unexplained rash/inflammation
☐ Hepatitis ☐ Diarrhea	☐ Kidney infections	□ Acne
☐ Blood in your stools ☐ Constipation	☐ Vaginal infections	☐ Skin cancer
☐ Irritable Bowel Syndrome	☐ Frequent urination ☐ Leaking urine	☐ Burn injury
☐ Change in bowel habits	Herpes	☐ Moles changing in appearance
☐ Colitis (ulcerative or Crohn's)	☐ Blood in the urine	☐ Excess hair growth
☐ Other ☐ None	☐ Other ☐ None	☐ Other ☐ None
Li None	Li Nolle	
Musculoskeletal:	Hematologic:	Cardiovascular:
☐ Unusual muscle weakness	☐ Blood clotting disorder/Blood clot	☐ Palpitations/Skipped beats
☐ Decreased energy/stamina	☐ Sickle cell Anemia ☐ Thrombophlebitis	☐ Chest pain ☐ Heart attack
☐ Rheumatoid arthritis	☐ Easy bruising	□ Stroke □ Murmurs
☐ Lupus Erythematosus	☐ Swollen glands/lymph nodes	☐ High blood pressure
☐ Myasthenia gravis	☐ Blood transfusions (dates/reasons)	☐ Rheumatic fever
Other	Other	☐ Mitral valve prolapse (Need antibiotics
□ None	□ None	before dental procedures? Yes No  Other
Mental Health Problems:		□ None
☐ Depression ☐ Anxiety disorder	Physician Notes (for office use only)	
☐ Schizophrenia	i nysician notes (for office use offiy)	
□ Other		

Family History					[	What is yourAncestry?
•	<u>Living</u>		Cause of Death/A	Age at De	eath_	☐ African-American
• Mother	□Yes - age □	lNo				
• Father	-	lNo				☐ American Indian/Native American
• Brother(s)	-	lNo				☐ Ashkenazi Jewish
2100101(0)	C	lNo				☐ Asian-American
• Sister(s)	C	lNo				☐ Cajun/French Canadian
Sister(s)	· ·	lNo				☐ Caucasian
Maternal Grandmother	~	lNo				☐ Eastern European
Maternal Grandfather	C	lNo				☐ Hispanic/Caribbean
	· · · · · ·	lNo				□ Northern European
Paternal Grandfather	· · · · · · · · · · · · · · · · · · ·	lNo				□ Southern European
Tuternar Grandratier	_ 105	1110				*
Disorders in Your Family	7					Other (specify)
	Relationsh	ip to Y	<u>ou</u>		-	
<ul> <li>Breast cancer</li> </ul>	□Yes		<u> </u>	□No	□Don't Know	W
<ul> <li>Ovarian cancer</li> </ul>	□Yes			□No	□Don't Know	N
<ul> <li>Colon cancer</li> </ul>	□Yes			$\square$ No	□Don't Know	W
• Other cancer	□Yes			$\square$ No	□Don't Know	N
• Diabetes	□Yes			□No	□Don't Know	N
<ul> <li>Thyroid problems</li> </ul>	□Yes			□No	□Don't Know	N
Heart disease	□Yes			□No	□Don't Know	W
<ul> <li>Blood clots</li> </ul>	□Yes			□No	□Don't Know	N
• Obesity	□Yes			□No	□Don't Know	W
<ul> <li>Psychiatric problems</li> </ul>	□Yes			□No	□Don't Know	N .
•				□No	□Don't Knov	W
• Endometriosis				□No	□Don't Knov	W
<ul> <li>Infertility</li> </ul>				□No	□Don't Knov	W
• Menopause before age 40				□No	□Don't Knov	V
• Birth defects	- x z			□No	□Don't Knov	
Cystic Fibrosis				□No	□Don't Know	
• Tay-Sachs disease				□No	□Don't Knov	
	□□Yes			□No	□Don't Knov	
Bloom syndrome	- x -			□No	□Don't Knov	
Gaucher disease				□No	□Don't Knov	
Niemann-Pick disease	□X/			□No	□Don't Knov	
Fanconi Anemia	□Yes			□No	□Don't Knov	
Familial Dysautonia	□Yes			□No	□Don't Know	
Muscular Dystrophy	□Yes			□No	□Don't Knov	
• Neurologic (brain/spine)				□No	□Don't Knov	
•	- x 7			□No	□Don't Know	
Bone/Skeletal Defects	DV.			□No	□Don't Knov	
				□No	□Don't Knov	
				□No	□Don't Knov	
• Learning problems				□No	□Don't Know	
<ul> <li>Polycystic kidney disease</li> </ul>				□No	□Don't Know	
• Heart defect from birth				□No	□Don't Know	
• Down syndrome	DV.			□No	□Don't Know	
Other chromosome defects	ΠVoc			□No	□Don't Know	
Marfan syndrome	□X/			□No	□Don't Know	
Hemophilia	DVac			□No	□Don't Know	
Sickle Cell Anemia	DVac			□No	□Don't Know	
Thalassemia	□Yes			□No	□Don't Know	
Galactosemia	□Yes			□No	□Don't Know	
Deafness/Blindness	DVac			□No	□Don't Know	
• Color Blindness	□Yes			□No	□Don't Know	
Hemochromatosis	□Yes			□No	□Don't Know	
☐ None of the above	☐ Other (Specify _					

### • Have you had prior infertility testing or treatment elsewhere? ☐ Yes □ No **Prior Tests** (check all that apply): □ Basal body temperature chart (date\_\_\_\_/results\_\_\_ ☐ Thyroid test (date\_\_\_/results\_\_\_\_\_\_) ☐ Ovulation test kit (date\_\_\_/results\_\_\_\_\_\_) ☐ Day 3 blood test for FSH level (date\_\_\_results\_\_\_\_\_\_) ☐ Hysterosalpingogram (HSG) (date\_\_\_results\_\_\_\_\_\_) □ Laparoscopy surgery (date\_\_\_\_results\_\_\_\_\_) □ Hysteroscopy surgery (date\_\_\_\_results\_\_\_\_\_ □ Progesterone blood test (date\_\_\_results\_\_\_\_\_) □ Prolactin blood test (date\_\_\_results\_\_\_\_\_ **Prior Treatment** (check all that apply): # of cycles Dates (mo/year) (mo/year) **Pregnant** ☐ Intrauterine insemination: From / to / Yes No From \_\_/\_\_\_ to\_\_\_/\_\_\_ Yes ☐ Clomiphene citrate with timed intercourse: No maximum # tablets per day?\_\_ From \_/\_\_\_\_ to\_\_\_\_/\_\_\_ □ Clomiphene citrate with insemination: Yes\_\_ No maximum # tablets per day? From / to / Yes\_\_\_ ☐ Daily fertility drug injections with insemination: No\_\_\_ maximum # vials per day?\_\_\_\_\_ ☐ Completed in vitro fertilization cycle(s): 1. # eggs\_\_\_ #embryos transferred\_\_\_ #frozen\_\_\_ Yes No\_\_\_ 2. # eggs\_\_\_ #embryos transferred\_\_\_ #frozen\_\_\_ Yes\_\_\_ No\_\_\_ 3. # eggs\_\_\_ #embryos transferred\_\_\_ #frozen\_\_\_ Yes\_\_\_ No 4. # eggs\_\_\_ #embryos transferred\_\_\_ #frozen\_\_\_ Yes\_\_\_ No\_\_\_ ☐ Frozen embryo transfers: 1. # embryos transferred\_\_\_\_\_ No\_\_\_ Yes Yes\_\_\_ No\_\_\_ 2. # embryos transferred 3. # embryos transferred\_\_\_\_\_ Yes\_\_\_ No 4. # embryos transferred\_\_\_\_\_ Yes No\_\_\_ Canceled in vitro fertilization attempt(s) Additional Information/Complications EMOTIONAL STATUS • On a scale of 1-10 (10 being the worst), estimate the level of stress you feel due to infertility and other pressures. • Do you see a counselor? ☐ Yes □ No Describe any emotional, marital, or sexual problems caused by your infertility. **PATIENT'S SIGNATURE** DATE I confirm that I have reviewed the information above. PHYSICIAN'S SIGNATURE DATE

PRIOR INFERTILITYTESTING AND TREATMENT

# PART III: MALE PARTNER MEDICAL HISTORY AND INFORMATION

# Complete with your male partner if applicable.

<ul> <li>Have you been evaluated by a urologist? ☐ Yes ☐ No</li> <li>Have you previously conceived with another woman? ☐ Yes: How many times? ☐ No: Birth control used? Yes No</li> <li>Have you had a semen analysis? ☐ Yes ☐ No</li> <li>Do you have difficulty with erections? ☐ Yes ☐ No</li> <li>Do you have retrograde ejaculation of sperm into the bladder? ☐ Yes ☐ No</li> <li>Any prior exposure to sexually transmitted diseases or infections?</li> <li>☐ Yes (check all that apply) ☐ No ☐ Chlamydia - date ☐ Gonorrhea - date ☐ Herpes - date ☐ Genital warts/HPV - date</li> <li>☐ Syphilis - date ☐ HIV/AIDS - date ☐ Hepatitis - date</li> <li>Have you had a history of undescended testicles? ☐ Yes - One side Both ☐ No</li> <li>Do you have scrotal or testicular pain? ☐ Yes ☐ No</li> <li>Have you had prior injury to your testicles requiring hospitalization? ☐ Yes ☐ No</li> </ul>
Have you been diagnosed with any of the following diseases?  □ Diabetes Mellitus - Yes No □ Cancer - Yes No □ Multiple Sclerosis - Yes No □ Other neurologic problems - Yes No □ Prostatic infections - Yes No □ Urinary infections - Yes No □ High Blood Pressure - Yes No If yes, any medications?
<ul> <li>Have you had any fever in the last 3 months? ☐ Yes ☐ No</li> <li>Have you had a vasectomy? ☐ Yes (date) ☐ No</li></ul>
List your current medications:
List any current medical problem(s):
<ul> <li>How many caffeinated beverages do you drink per day? □ None</li> <li>Do you smoke cigarettes? □ No □ Yes How many/day? How many years? □ Quit - when?</li> <li>Do you drink alcohol? □ No □ Yes</li> <li>□ Beer - # per week □ Wine- # per week □ Liquor - # per week</li> </ul>
• Do you use any marijuana, cocaine, or any other similar drug? ☐ No ☐ Yes (describe) • Do you use herbal medicines/vitamins or health food store supplements? ☐ No ☐ Yes (describe) • Are you aware of any radiation/toxic materials exposure? ☐ No ☐ Yes
<ul> <li>Do you use hot tubs regularly? ☐ Yes ☐ No</li> <li>Did your mother take DES during pregnancy to prevent miscarriage? ☐ Yes ☐ No ☐ Don't know</li> <li>Have any of your immediate family members had difficulty conceiving a child? ☐ Yes ☐ No</li> <li>If yes, please describe ☐ No</li> </ul>
Physician Notes (for office use only)

		Daladia malain da Wasa			What is yourAncestry?
<ul> <li>Cystic Fibrosis</li> </ul>	□Yes	Relationship to You	□No	□Don't Know	☐ African-American
• Tay-Sachs disease	□Yes		□No	□Don't Know	☐ American Indian/
• Canavan disease	□Yes		□No	□Don't Know	Native American
Bloom syndrome	□Yes		□No	□Don't Know	☐ Ashkenazi Jewish
• Gaucher disease	□Yes		□No	□Don't Know	☐ Asian-American
Niemann-Pick disease	□Yes		□No	□Don't Know	☐ Cajun/French Canadian
Fanconi Anemia	□Yes		□No	□Don't Know	☐ Caucasian
• Familial Dysautonia	□Yes		□No	□Don't Know	☐ Eastern European
Muscular Dystrophy	□Yes		□No	□Don't Know	=
• Neurologic (brain/spine)			□No	□Don't Know	☐ Hispanic/Caribbean
• Neural Tube Defects	□Yes		□No	□Don't Know	□ Northern European
Bone/Skeletal Defects	□Yes		□No	□Don't Know	☐ Southern European
• Dwarfism	□Yes		□No	□Don't Know	☐ Other (specify)
<ul> <li>Developmental delay</li> </ul>	□Yes		□No	□Don't Know	
<ul> <li>Learning problems</li> </ul>	□Yes		□No	□Don't Know	
• Polycystic kidney disease	e □Yes		□No	□Don't Know	
• Heart defect from birth	□Yes		□No	□Don't Know	
<ul> <li>Down syndrome</li> </ul>	□Yes		□No	□Don't Know	
• Other chromosome defect	s□Yes		□No	□Don't Know	
<ul> <li>Marfan syndrome</li> </ul>	□Yes		□No	□Don't Know	
<ul> <li>Hemophilia</li> </ul>	□Yes		□No	□Don't Know	
<ul> <li>Sickle Cell Anemia</li> </ul>	□Yes		□No	□Don't Know	
<ul> <li>Thalassemia</li> </ul>	□Yes		□No	□Don't Know	
<ul> <li>Galactosemia</li> </ul>	□Yes		$\square$ No	□Don't Know	
<ul> <li>Deafness/Blindness</li> </ul>	□Yes		$\square$ No	□Don't Know	
<ul> <li>Color Blindness</li> </ul>	□Yes		$\square$ No	□Don't Know	
<ul> <li>Hemochromatosis</li> </ul>	□Yes		□No	□Don't Know	
☐ None of the above	□ Othe	er (Specify			
MALE PARTNER'S SIG	GNATUF	RE		DA	TE
				DA	TE
		d the information above.		DA	.ΤΕ
	reviewe				TE
I confirm that I have	reviewe	d the information above.			
I confirm that I have	reviewe	d the information above.			
I confirm that I have	reviewe	d the information above.			
I confirm that I have	reviewe	d the information above.			
I confirm that I have	reviewe	d the information above.			
I confirm that I have	reviewe	d the information above.			
I confirm that I have	reviewe	d the information above.			
I confirm that I have	reviewe	d the information above.			
I confirm that I have	reviewe	d the information above.			
I confirm that I have	reviewe	d the information above.			
I confirm that I have	reviewe	d the information above.			
I confirm that I have	reviewe	d the information above.			