Huntsville Reproductive Medicine, P.C.

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 patientpaperwork@hsvrm.com. You can also print the completed paperwork, scan and email to patientpaperwork@hsvrm.com. 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 www.huntsvilleIVF.com 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 co-payments, 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!

Revised October 2022

CONTACT US

Contact Huntsville Reproductive Medicine

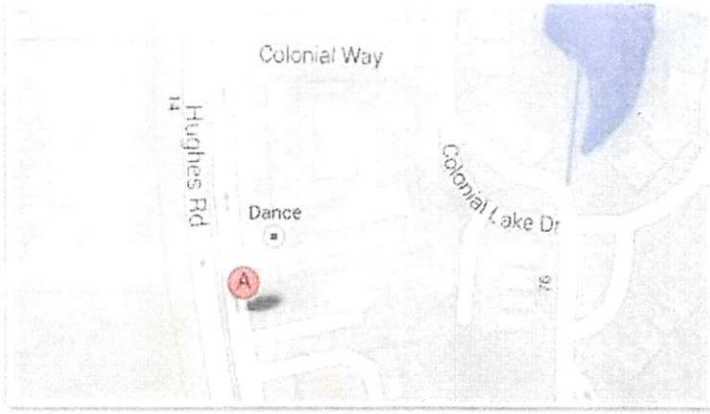
Telephone: 256.213.BABY (2229)
Please see information about phone calls below.
Fax: 256.213.9978
Email: patientservices@hsvrm.com
Address: 20 Hughes Road, Suite 203, Madison, AL 35758
In front of Madison Surgery Center
Map and driving directions

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.

Huntsville Reproductive Medicine, P.C.
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, post-operative 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.

20 Hughes Rd • Suite 203 • Madison, AL 35758
256.213.2229 (Phone) • 256.213.9978 (Fax)
www.HsvRM.com

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.

Huntsville Reproductive Medicine, P.C.

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.

Huntsville Reproductive Medicine, P.C.

CREDIT CARD PAYMENT INFORMATION AND AUTHORIZATION

Name (as it appears on credit card): _____

Credit Card Name: _____VISA ____MasterCard ____AMEX ___Discover

Credit Card Account Number: _____

Expiration Date: _____ Security Code: _____

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.

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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.

By my signature below, I authorize Huntsville Reproductive Medicine, or designated agents, to bill my credit card for balances that are deemed my responsibility by my insurance company. I understand that this does not affect my ability to dispute a charge or to question my insurance company's determination of payment.

_____ _____

Signature of Patient/Card Holder Date

OR

☐ I elect to deposit $200.00 into an ESCROW ACCOUNT to cover any balances left after insurance has paid their portion.

Huntsville Reproductive Medicine, P.C.

PATIENT INFORMATION:

Full Name: _____ City/State: _____ Zip: _____
Address: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email address: _____
Date of Birth: d_____ Age: _____ Marital Status: _____ Social Security #: _____
Employer's Name and address: _____
Can we call at work or leave message? _____
Ob/Gyn's Name and address: _____
Emergency Contact Name & Phone: _____
Referred by: Ob/Gyn _____ Friend ___ TV _____ Internet _____ Other_____

PARTNER'S INFORMATION:

Full Name: _____
Address: _____ City/State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Email address: _____
Date of Birth: _____ Social Security #: _____
Employer's Name and Address: _____

List all people we may talk to about your general health and test results:

_____ Relationship: _____
_____ Relationship: _____

INSURANCE INFORMATION:

Primary Insurance: _____ Address: _____
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: _____

I authorize the release of all medical records to the referring and family physicians and to my insurance company if applicable. I allow fax transmittal of my medical records, if necessary. I authorize and request that insurance payments be made directly to **Huntsville Reproductive Medicine, P.C.** should they elect to receive such payment. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.

I acknowledge full financial responsibility for services rendered by **Huntsville Reproductive Medicine, P.C.** I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney's fees and collection costs in the event of default of payment of my charges.

I authorize treatment by **Huntsville Reproductive Medicine, P.C.** physicians and personnel.

I acknowledge receipt of **Huntsville Reproductive Medicine, P.C.'s** HIPPA Privacy Notification.

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, insurance authorization and acknowledgement of HIPPA privacy notification.

Signature _____ Date g _____

AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE
Infertility History Form

FOR OFFICE USE ONLY

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

This form was developed by the American Society for Reproductive 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** _____ **Age**_____
☐ 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 _____

☐ 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 _____

Physician Notes
(for office use only)

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 _____

Date Pregnancy Ended or Delivered	Months to Conception	Treatments to Conceive	Delivery Type/D&C/ Complications	Current Partner?
1. _____	_____	_____	_____	☐Y ☐N
2. _____	_____	_____	_____	☐Y ☐N
3. _____	_____	_____	_____	☐Y ☐N
4. _____	_____	_____	_____	☐Y ☐N
5. _____	_____	_____	_____	☐Y ☐N
6. _____	_____	_____	_____	☐Y ☐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?_____ ☐ No
- 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 ☐ Sometime ☐ 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™, etc.) - dates of use_____ - complications?_____
☐ Skin patch - dates of use_____ - complications?_____ ☐ Foam or Jelly
☐ 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®, etc.) during intercourse? ☐ Yes - what types?_____ ☐ No

Any prior exposure to sexually transmitted diseases or pelvic infections?

☐ Yes (check all that apply) ☐ No
☐ Chlamydia - date_____ ☐ Gonorrhea - date_____ ☐ Herpes - date_____ Genital warts/HPV - date_____
☐ Syphilis - date_____ ☐ HIV/AIDS - date_____ ☐ Hepatitis - date_____

Physician Notes (for office use only) _____

Pap Smear History

• When was your last pap smear (month and year)?_____/_____ ☐ Normal ☐ Abnormal
• When was your last abnormal pap smear? _____ ☐ Not applicable

Have you undergone any procedures as a result of an abnormal pap smear?
☐ Yes (check all that apply) ☐ No
☐ Colposcopy ☐ Cryosurgery (Freezing) ☐ Laser treatment ☐ Conization ☐ LEEP procedure

Breast Screening History

Have you ever had a mammogram? ☐ No ☐ Yes - date_____ Result: ☐ normal ☐ abnormal - explain _____
Do you perform self breast exams? ☐ Yes ☐ No

Medical History

• Are you allergic to any medications? ☐ No ☐ Yes (Please 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 over 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 (Please list type, dates, and treatments.)
(1)_____
(2)_____
(3)_____
(4)_____
(5)_____

• Did you have either of these childhood illnesses? ☐ Chickenpox (Varicella) ☐ German Measles (Rubella) ☐ Don't know
Other childhood diseases:_____

Vaccinations

• Chickenpox (Varicella):	☐ No	☐ Yes (dates_____)	☐ Don't know
• MMR - Measles, Mumps, and Rubella (German Measles):	☐ No	☐ Yes (dates_____)	☐ Don't know
• BCG (Tuberculosis):	☐ No	☐ Yes (dates_____)	☐ Don't know
• Hepatitis B:	☐ No	☐ Yes (dates_____)	☐ Don't know
• Polio:	☐ No	☐ Yes (dates_____)	☐ Don't know
• Hepatitis A:	☐ No	☐ Yes (dates_____)	☐ Don't know
• Tetanus:	☐ No	☐ Yes (dates_____)	☐ Don't know
• Influenza:	☐ No	☐ Yes (dates_____)	☐ Don't know

Social History

• How many caffeinated beverages (coffee, tea, soda) do you drink per day?_____ ☐ None
• Do you smoke cigarettes? ☐ No ☐ Yes How many/day?_____ How many years?_____ ☐ Quit - when?_____
• Do you drink alcohol? ☐ No ☐ Yes
☐ Beer - # per week_____ ☐ Wine- # per week_____ ☐ Liquor - # per week_____
• Do you use any marijuana, cocaine, or any other similar drug? ☐ No ☐ Yes (describe_____)
• Do you exercise? ☐ No ☐ Yes (describe_____)
• Are you aware of any radiation exposures other than X-rays? ☐ No ☐ Yes (describe_____)

Physician Notes (for office use only) _____
_____
_____

Surgical History

• Have you had any surgeries? ☐ No ☐ Yes (List all surgeries in chronologic order.)

Year	Reason and Type of Surgery
_____	(1)_____
_____	(2)_____
_____	(3)_____
_____	(4)_____
_____	(5)_____
_____	(6)_____
_____	(7)_____

• Did you have any anesthesia problems? ☐ No ☐ Yes (describe _____)

Physical Symptoms

General:
- ☐ Recent weight gain or loss
- ☐ Anorexia/Bulimia
- ☐ Lack of energy
- ☐ Fever/Chills
- ☐ Other_____
- ☐ None

Head, Eyes, Ears, Nose and Throat:
- ☐ Dizziness ☐ Loss of sense of smell
- ☐ Headaches ☐ Chronic nasal congestion
- ☐ Blurred vision ☐ Ringing ears
- ☐ Hearing loss/deafness
- ☐ Other_____
- ☐ None

Respiratory:
- ☐ Shortness of breath
- ☐ Asthma ☐ Bronchitis
- ☐ Pneumonia ☐ Tuberculosis
- ☐ Bloody cough
- ☐ Other_____
- ☐ None

Endocrine/Hormonal:
- ☐ Diabetes ☐ Hair loss
- ☐ Thyroid gland problems
- ☐ Rapid weight gain or loss
- ☐ Excessive hunger/thirst
- ☐ Temperature intolerance– hot flashes or feeling cold
- ☐ Other_____
- ☐ None

Breasts:
- ☐ Discharge (clear?___ bloody?___ milky?___)
- ☐ Lumps ☐ Pain ☐ Cancer
- ☐ Abnormal mammogram
- ☐ Reduction
- ☐ Augmentation/Breast implants (saline?___ silicone?___)
- ☐ Other_____
- ☐ None

Neurological Problems:
- ☐ Weakness/Loss of balance
- ☐ Seizures/Epilepsy
- ☐ Headaches
- ☐ Migraine headaches
- ☐ Numbness
- ☐ Memory loss
- ☐ Other_____
- ☐ None

Gastrointestinal:
- ☐ Nausea/Vomiting ☐ Ulcers
- ☐ Hepatitis ☐ Diarrhea
- ☐ Blood in your stools ☐ Constipation
- ☐ Irritable Bowel Syndrome
- ☐ Change in bowel habits
- ☐ Colitis (ulcerative or Crohn's)
- ☐ Other_____
- ☐ None

Genito-Urinary:
- ☐ Bladder infections
- ☐ Kidney infections
- ☐ Vaginal infections
- ☐ Frequent urination ☐ Leaking urine
- ☐ Herpes
- ☐ Blood in the urine
- ☐ Other_____
- ☐ None

Skin/Extremities:
- ☐ Unexplained rash/inflammation
- ☐ Acne
- ☐ Skin cancer
- ☐ Burn injury
- ☐ Moles changing in appearance
- ☐ Excess hair growth
- ☐ Other_____
- ☐ None

Musculoskeletal:
- ☐ Unusual muscle weakness
- ☐ Decreased energy/stamina
- ☐ Rheumatoid arthritis
- ☐ Lupus Erythematosus
- ☐ Myasthenia gravis
- ☐ Other_____
- ☐ None

Hematologic:
- ☐ Blood clotting disorder/Blood clot
- ☐ Sickle cell Anemia ☐ Thrombophlebitis
- ☐ Easy bruising
- ☐ Swollen glands/lymph nodes
- ☐ Blood transfusions (dates/reasons_____)
- ☐ Other_____
- ☐ None

Cardiovascular:
- ☐ Palpitations/Skipped beats
- ☐ Chest pain ☐ Heart attack
- ☐ Stroke ☐ Murmurs
- ☐ High blood pressure
- ☐ Rheumatic fever
- ☐ Mitral valve prolapse (Need antibiotics before dental procedures? Yes___ No___
- ☐ Other_____
- ☐ None

Mental Health Problems:
- ☐ Depression ☐ Anxiety disorder
- ☐ Schizophrenia
- ☐ Other_____
- ☐ None

Physician Notes (for office use only) _____

_____

_____

Family History

	Living		Cause of Death/Age at Death
• Mother	☐ Yes - age___	☐ No	_____
• Father	☐ Yes - age___	☐ No	_____
• Brother(s)	☐ Yes - age___	☐ No	_____
	☐ Yes - age___	☐ No	_____
• Sister(s)	☐ Yes - age___	☐ No	_____
	☐ Yes - age___	☐ No	_____
• Maternal Grandmother	☐ Yes - age___	☐ No	_____
• Maternal Grandfather	☐ Yes - age___	☐ No	_____
• Paternal Grandmother	☐ Yes - age___	☐ No	_____
• Paternal Grandfather	☐ Yes - age___	☐ No	_____

What is yourAncestry?

- ☐ African-American
- ☐ American Indian/Native American
- ☐ Ashkenazi Jewish
- ☐ Asian-American
- ☐ Cajun/French Canadian
- ☐ Caucasian
- ☐ Eastern European
- ☐ Hispanic/Caribbean
- ☐ Northern European
- ☐ Southern European
- ☐ Other (specify_____)

Disorders in Your Family

		Relationship to You		
• Breast cancer	☐ Yes	_____	☐ No	☐ Don't Know
• Ovarian cancer	☐ Yes	_____	☐ No	☐ Don't Know
• Colon cancer	☐ Yes	_____	☐ No	☐ Don't Know
• Other cancer_____	☐ Yes	_____	☐ No	☐ Don't Know
• Diabetes	☐ Yes	_____	☐ No	☐ Don't Know
• Thyroid problems	☐ Yes	_____	☐ No	☐ Don't Know
• Heart disease	☐ Yes	_____	☐ No	☐ Don't Know
• Blood clots	☐ Yes	_____	☐ No	☐ Don't Know
• Obesity	☐ Yes	_____	☐ No	☐ Don't Know
• Psychiatric problems	☐ Yes	_____	☐ No	☐ Don't Know
• Tuberculosis	☐ Yes	_____	☐ No	☐ Don't Know
• Endometriosis	☐ Yes	_____	☐ No	☐ Don't Know
• Infertility	☐ Yes	_____	☐ No	☐ Don't Know
• Menopause before age 40	☐ Yes	_____	☐ No	☐ Don't Know
• Birth defects	☐ Yes	_____	☐ No	☐ Don't Know
• Cystic Fibrosis	☐ Yes	_____	☐ No	☐ Don't Know
• Tay-Sachs disease	☐ Yes	_____	☐ No	☐ Don't Know
• Canavan disease	☐ Yes	_____	☐ No	☐ Don't Know
• Bloom syndrome	☐ Yes	_____	☐ No	☐ Don't Know
• Gaucher disease	☐ Yes	_____	☐ No	☐ Don't Know
• Niemann-Pick disease	☐ Yes	_____	☐ No	☐ Don't Know
• Fanconi Anemia	☐ Yes	_____	☐ No	☐ Don't Know
• Familial Dysautonia	☐ Yes	_____	☐ No	☐ Don't Know
• Muscular Dystrophy	☐ Yes	_____	☐ No	☐ Don't Know
• Neurologic (brain/spine)	☐ Yes	_____	☐ No	☐ Don't Know
• Neural Tube Defects	☐ Yes	_____	☐ No	☐ Don't Know
• Bone/Skeletal Defects	☐ Yes	_____	☐ No	☐ Don't Know
• Dwarfism	☐ Yes	_____	☐ No	☐ Don't Know
• Developmental delay	☐ Yes	_____	☐ No	☐ Don't Know
• Learning problems	☐ Yes	_____	☐ No	☐ Don't Know
• Polycystic kidney disease	☐ Yes	_____	☐ No	☐ Don't Know
• Heart defect from birth	☐ Yes	_____	☐ No	☐ Don't Know
• Down syndrome	☐ Yes	_____	☐ No	☐ Don't Know
• Other chromosome defects	☐ Yes	_____	☐ No	☐ Don't Know
• Marfan syndrome	☐ Yes	_____	☐ No	☐ Don't Know
• Hemophilia	☐ Yes	_____	☐ No	☐ Don't Know
• Sickle Cell Anemia	☐ Yes	_____	☐ No	☐ Don't Know
• Thalassemia	☐ Yes	_____	☐ No	☐ Don't Know
• Galactosemia	☐ Yes	_____	☐ No	☐ Don't Know
• Deafness/Blindness	☐ Yes	_____	☐ No	☐ Don't Know
• Color Blindness	☐ Yes	_____	☐ No	☐ Don't Know
• Hemochromatosis	☐ Yes	_____	☐ No	☐ Don't Know

☐ None of the above ☐ Other (Specify _____)

PRIOR INFERTILITYTESTING AND TREATMENT

• 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☐
☐ Clomiphene citrate with timed intercourse: maximum # tablets per day?_____	_____	From_____/_____ to_____/_____	Yes☐ No☐
☐ Clomiphene citrate with insemination: maximum # tablets per day?_____	_____	From_____/_____ to_____/_____	Yes☐ No☐
☐ Daily fertility drug injections with insemination: maximum # vials per day?_____	_____	From_____/_____ to_____/_____	Yes☐ No☐
☐ 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_____		_____/_____	Yes☐ No☐
2. # embryos transferred_____		_____/_____	Yes☐ No☐
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**_____

PART III: MALE PARTNER MEDICAL HISTORY AND INFORMATION

Complete with your male partner if applicable.

- Have you been evaluated by a urologist? ☐ Yes ☐ No
- Have you previously conceived with another woman? ☐ Yes: How many times?_____ ☐ No: Birth control used? Yes___ No___
- Have you had a semen analysis? ☐ Yes ☐ No
- Do you have difficulty with erections? ☐ Yes ☐ No
- Do you have retrograde ejaculation of sperm into the bladder? ☐ Yes ☐ No
- Any prior exposure to sexually transmitted diseases or infections?

☐ Yes (check all that apply) ☐ No

☐ Chlamydia - date_____ ☐ Gonorrhea - date_____ ☐ Herpes - date_____ Genital warts/HPV - date_____

☐ Syphilis - date_____ ☐ HIV/AIDS - date_____ ☐ Hepatitis - date_____

- Have you had a history of undescended testicles? ☐ Yes - One side ☐ Both ☐ ☐ No
- Do you have scrotal or testicular pain? ☐ Yes ☐ No
- Did you have the mumps after puberty? ☐ Yes ☐ No
- Have you had prior injury to your testicles requiring hospitalization? ☐ Yes ☐ No

- 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?_____

- Have you had any fever in the last 3 months? ☐ Yes ☐ No
- Have you had a vasectomy? ☐ Yes (date_____) ☐ No

If yes, have you had a vasectomy reversal? ☐ Yes (date_____) ☐ No

- Have you had surgery for varicocele repair? ☐ Yes ☐ No
- Have you had hernia surgery? ☐ Yes ☐ No
- Did you undergo any bladder or penis surgery as a child? ☐ Yes ☐ No
- Are you exposed to prolonged heat in the workplace? ☐ Yes ☐ No
- Are you exposed to any radiation or harmful chemicals in the workplace? ☐ Yes ☐ No
- Have you had chemotherapy for cancer? ☐ Yes ☐ No
- Are you allergic to any medications? ☐ No ☐ Yes (Please list and describe reactions) _____

_____

_____

List your current medications:_____

List any current medical problem(s):_____

- How many caffeinated beverages do you drink per day?_____ ☐ None
- Do you smoke cigarettes? ☐ No ☐ Yes How many/day?_____ How many years?_____ ☐ Quit - when?_____
- Do you drink alcohol? ☐ No ☐ Yes

☐ Beer - # per week_____ ☐ Wine- # per week_____ ☐ Liquor - # per week_____

- 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

- Do you use hot tubs regularly? ☐ Yes ☐ No
- Did your mother take DES during pregnancy to prevent miscarriage? ☐ Yes ☐ No ☐ Don't know
- Have any of your immediate family members had difficulty conceiving a child? ☐ Yes ☐ No

If yes, please describe_____

Physician Notes (for office use only) _____

_____

_____

Disorders in Your Family

		Relationship to You		
• Cystic Fibrosis	☐ Yes	_____	☐ No	☐ Don't Know
• Tay-Sachs disease	☐ Yes	_____	☐ No	☐ Don't Know
• Canavan disease	☐ Yes	_____	☐ No	☐ Don't Know
• Bloom syndrome	☐ Yes	_____	☐ No	☐ Don't Know
• Gaucher disease	☐ Yes	_____	☐ No	☐ Don't Know
• Niemann-Pick disease	☐ Yes	_____	☐ No	☐ Don't Know
• Fanconi Anemia	☐ Yes	_____	☐ No	☐ Don't Know
• Familial Dysautonia	☐ Yes	_____	☐ No	☐ Don't Know
• Muscular Dystrophy	☐ Yes	_____	☐ No	☐ Don't Know
• Neurologic (brain/spine)	☐ Yes	_____	☐ No	☐ Don't Know
• Neural Tube Defects	☐ Yes	_____	☐ No	☐ Don't Know
• Bone/Skeletal Defects	☐ Yes	_____	☐ No	☐ Don't Know
• Dwarfism	☐ Yes	_____	☐ No	☐ Don't Know
• Developmental delay	☐ Yes	_____	☐ No	☐ Don't Know
• Learning problems	☐ Yes	_____	☐ No	☐ Don't Know
• Polycystic kidney disease	☐ Yes	_____	☐ No	☐ Don't Know
• Heart defect from birth	☐ Yes	_____	☐ No	☐ Don't Know
• Down syndrome	☐ Yes	_____	☐ No	☐ Don't Know
• Other chromosome defects	☐ Yes	_____	☐ No	☐ Don't Know
• Marfan syndrome	☐ Yes	_____	☐ No	☐ Don't Know
• Hemophilia	☐ Yes	_____	☐ No	☐ Don't Know
• Sickle Cell Anemia	☐ Yes	_____	☐ No	☐ Don't Know
• Thalassemia	☐ Yes	_____	☐ No	☐ Don't Know
• Galactosemia	☐ Yes	_____	☐ No	☐ Don't Know
• Deafness/Blindness	☐ Yes	_____	☐ No	☐ Don't Know
• Color Blindness	☐ Yes	_____	☐ No	☐ Don't Know
• Hemochromatosis	☐ Yes	_____	☐ No	☐ Don't Know

☐ None of the above ☐ Other (Specify _____

What is yourAncestry?

- ☐ African-American
- ☐ American Indian/ Native American
- ☐ Ashkenazi Jewish
- ☐ Asian-American
- ☐ Cajun/French Canadian
- ☐ Caucasian
- ☐ Eastern European
- ☐ Hispanic/Caribbean
- ☐ Northern European
- ☐ Southern European
- ☐ Other (specify_____)

MALE PARTNER'S SIGNATURE_____ **DATE**_____

I confirm that I have reviewed the information above.

PHYSICIAN'S SIGNATURE_____ **DATE**_____

Physician Notes (for office use only) _____