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.**

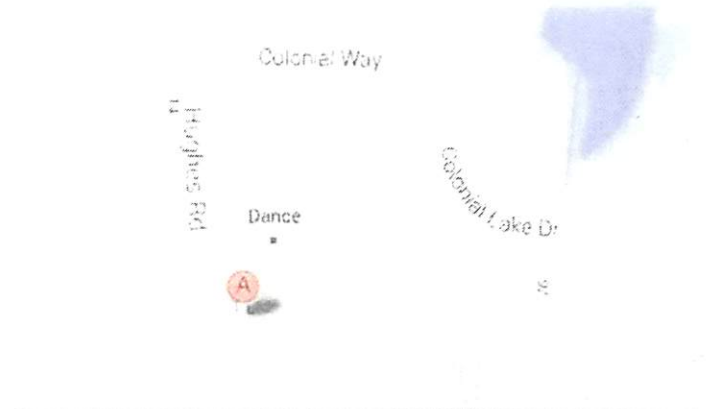
Thank you for choosing Huntsville Reproductive Medicine for your specialized care. We look forward to seeing you!

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.

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 7:00 a.m. and 10:00 a.m.

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 2:00 p.m. may not be returned until the following business 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. **Please note: we reserve the right to access a $20.00 fee for nursing calls over 10 minutes.**

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.

Andrew J. Harper, M.D.
Lynn Curry, CRNP-BC, Breana Spain, CRNP-BC
20 Hughes Rd • Suite 203 • Madison, AL 35758
256.213.2229 (Phone) 256.213.9978 (Fax)
HuntsvilleIVF.com

Huntsville Reproductive Medicine, P.C.

Reproductive Endocrinology & Infertility

Prior Authorization Fees
(Effective June 1, 2024)

For patients whose prescriptions or office procedures require Prior Authorization, we have instituted a fee of $20.00 per request 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.

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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.

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.

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: _____ 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 _____

Huntsville Reproductive Medicine, P.C.

Andrew J. Harper, M.D., Lynn Curry, CRNP, Breana Spain, CRNP

AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE
INFERTILITY HISTORY FORM

IMPORTANT: ***Please complete this form prior to your scheduled visit.*** ***This form must be signed by both partners (if applicable) to proceed with treatment.***

This form was developed by the American Society for Reproductive Medicine (ASRM) and Huntsville Reproductive Medicine to assist physicians and patients in obtaining a complete infertility history. It consists of three parts:
PART I: Contact Information and Demographics
PART II: Medical History
PART III: If applicable, Male Partner History
PART IV: Patient and Partner Signature Page

PART I: CONTACT INFORMATION AND DEMOGRAPHICS

First Name: _____ **Middle Initial:** ____ **Last Name**: _____ **Age:** _____

Date of Birth (MM/DD/YY): _____/_____/_____

Gender Identity: ☐ **Female** ☐ **Male** **Sex Assigned at Birth:** ☐ **Female** ☐ **Male**

Occupation: _____

Home Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **Country:** _____

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

Do you have a partner? ☐ **Yes** ☐ **No**

Are you married? ☐ **Yes** ☐ **No**

Partner's First Name: _____ **Middle Initial:** ____ **Last Name**: _____

Age: _____ **Date of Birth (MM/DD/YY):** _____/_____/_____

Gender Identity: ☐ **Female** ☐ **Male** **Sex Assigned at Birth:** ☐ **Female** ☐ **Male**

Occupation: _____

Home Street Address *(If Different)*: _____

City: _____ **State:** _____ **Zip Code:** _____ **Country:** _____

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

Who is your OBGYN? Name: _____

Address: _____ **Phone Number:** _____

Who is your Primary Care Physician? Name: _____

Address: _____ **Phone Number:** _____

By whom were you referred?

☐ **Physician**: _____
☐ **Former Patient/Friend**: _____
☐ **Web Site:** _____
☐ **Other:** _____

Preferred Pharmacy:
Pharmacy Name: _____
Pharmacy Address: _____
Pharmacy Phone Number: _____

PART II: FEMALE MEDICAL HISTORY AND INFORMATION:

Reason for visit: ☐ **Infertility** ☐ **Recurrent Pregnancy Loss** ☐ **PCOS** **OTHER**_____

How many months have you been trying to conceive (unprotected intercourse/inseminations)? _____

Pregnancy Summary

- Total Number of ALL Pregnancies: _____ Total number of living children: _____
- Number of Full Term Deliveries (>37 weeks): _____ of these, how many were live births? _____ Stillborn? _____
- Number of Premature (<37 weeks) Deliveries: _____ of these, how many were live births? _____ Stillborn? _____
- Number of Miscarriages (<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 Achieve Pregnancy	Treatments to Conceive	Delivery Vaginal/C-Section/D&C	With 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 ☐ No periods ☐ Spotting before 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 bleeding do you have? _____ days
- Dates of the 1st day of your last 2 menstrual periods: _____/_____/_____; _____/_____/_____
- Do you need medication to bring on a period? ☐ No ☐ Yes – What type? _____
- If you do not have periods, at what age did you stop having them? _____ years old
- Severe cramping or pain with your periods? In the past ☐ No ☐ Yes: Always ☐ Sometimes ☐ Recently ☐
- Do you have bowel changes with menses? In the past ☐ No ☐ Yes: Always ☐ Sometimes ☐ Recently ☐

Contraceptive History

☐ None ☐ IUD- dates of use _____ ☐ Birth control pills – dates of use _____

☐ Injectable Contraception (Depo-Provera®, Nexplanon®, etc.) - dates of use _____

☐ Tubal sterilization procedure – date (month/year) _____ ☐ Tubal reversal procedure – date (month/year) _____

Sexual History

- How many times do you have intercourse per week? _____ times per week ☐ None ☐ N/A
- Have you used over-the-counter ovulation kits to time intercourse ☐ No ☐ Yes
- Do you use lubricants during intercourse? ☐ No ☐ Yes – what types? _____
- Do you have pain with intercourse? ☐ No ☐ Sometimes ☐ Yes
- Any prior exposure to sexually transmitted diseases or pelvic infections? ☐ No ☐ Yes (check all that apply)

☐ Chlamydia – date _____ ☐ Gonorrhea – date _____ ☐ Herpes – date _____

☐ Genital Warts/HPV – date _____ ☐ Syphilis – date _____ ☐ HIV/AIDS – date _____

☐ Hepatitis – date _____

Pap Smear History

- When was your last pap smear (month and year)? _____/_____ ☐ Normal ☐ Abnormal
- When was your last abnormal pap smear? _____ ☐ N/A

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

Medical History

- Are you allergic to any medications? ☐ No ☐ Yes (please list and describe reactions) _____

  _____

  Are you allergic to Latex? ☐ No ☐ Yes (please list and describe reactions) _____
- Do you have any medical problem(s)? ☐ No ☐ Yes (please list type, dates and treatments)

  *_____

  *_____

  *_____

  *_____
- 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):

  _____

  _____

Vaccination History

- Chickenpox (Varicella): ☐ No ☐ Yes ☐ Unknown
- MMR (Measles, Mumps, Rubella): ☐ No ☐ Yes ☐ Unknown
- COVID: ☐ No ☐ Yes ☐ Unknown
- Hepatitis B: ☐ No ☐ Yes ☐ Unknown
- Influenza: ☐ No ☐ Yes ☐ Unknown

Social History

- 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 marijuana, cocaine, or any other similar drug? ☐ No ☐ Yes – Describe _____
  Do you vape or use E-cigarettes? No Yes How Often?_____
- Do you exercise? ☐ Yes ☐ No If yes, how often?
- Are you aware of any radiation exposure other than X-rays? ☐ No ☐ Yes - Describe _____
  _____

Surgical History

Have you had any surgeries? ☐ No ☐ Yes (List all surgeries in chronological order):

Year **Reason and Type of Surgery**

_____ 1. _____

_____ 2. _____

_____ 3. _____

_____ 4. _____

- Did you have any anesthesia problems? ☐ No ☐ Yes - Describe _____

  _____

Current Height _____ Current Weight _____

Physical Symptoms (Check all that apply)

General: ☐ Recent weight gain/ loss; How much? _____ ☐ Anorexia/Bulimia ☐ Lack of energy ☐ Other _____	Endocrine/Hormonal: ☐ Diabetes ☐ Hair loss / thinning ☐ Thyroid gland problems ☐ Rapid weight gain or loss ☐ Excessive hunger/thirst ☐ Temperature intolerance ☐ Other _____	Breasts: ☐ Discharge- if yes, describe _____ ☐ Pain ☐ Cancer ☐ Augmentation/Breast implants – if yes, date _____ ☐ Breast Reduction – if yes, date _____ ☐ Other _____
Gastrointestinal: ☐ Hepatitis ☐ Nausea/vomiting ☐ Blood in stool ☐ Diarrhea/Constipation ☐ Change in Bowel Habits ☐ Other _____	Genito-Urinary: ☐ Bladder/Kidney infections ☐ Vaginal infections ☐ Frequent urination ☐ Blood in urine ☐ Other _____	Hematologic: ☐ Blood clotting disorder/Blood clots ☐ Sickle cell Anemia ☐ Blood transfusions ☐ Easy bruising ☐ Other _____
Cardiovascular: ☐ Palpitations/Skipped beats ☐ High blood pressure ☐ Heart murmur ☐ Heart attack or Stroke ☐ Other _____	Mental Health Problems: ☐ Depression ☐ Anxiety Disorder ☐ Bipolar Disorder ☐ Schizophrenia ☐ Other _____	

What is your Ancestry?

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

Family History

	Living	Cause of Death/Age
Mother	☐ Yes- age ___	☐ No _____
Father	☐ Yes- age ___	☐ No _____
Brother(s)	☐ Yes- age ___	☐ No _____
	☐ Yes- age ___	☐ No _____
Sister(s)	☐ Yes- age ___	☐ No _____
	☐ Yes- age ___	☐ No _____

Disorders in Your Family (Check all that apply)

	Relationship to You
Breast cancer	☐ Yes _____
Ovarian cancer	☐ Yes _____
Other cancer _____	☐ Yes _____
Diabetes	☐ Yes _____
Thyroid Problems	☐ Yes _____
Blood clots	☐ Yes _____
Psychiatric problems	☐ Yes _____
Endometriosis	☐ Yes _____
Infertility	☐ Yes _____
Menopause before age 40	☐ Yes _____
Birth defects	☐ Yes _____
Cystic Fibrosis	☐ Yes _____
Muscular Dystrophy	☐ Yes _____
Neural Tube Defects	☐ Yes _____
Dwarfism	☐ Yes _____
Bone/Skeletal Defects	☐ Yes _____
Polycystic kidney disease	☐ Yes _____
Heart defect from birth	☐ Yes _____
Down syndrome	☐ Yes _____
Hemophilia	☐ Yes _____
Sickle Cell Anemia	☐ Yes _____
Other chromosome defects	☐ Yes _____

If yes, explain _____

☐ None of the Above

Prior Infertility Testing and Treatment

Have you had prior infertility testing or treatment elsewhere? ☐ No ☐ Yes- Where? _____

Prior Tests (check all that apply):

- ☐ Thyroid test (date/results) _____
- ☐ Ovulation Predictor Kit (results) _____
- ☐ Progesterone level to confirm ovulation (date/results) _____
- ☐ AMH (date/results) _____
- ☐ Hysterosalpingogram (HSG) (date/results) _____
- ☐ Saline Infusion Sonogram (SIS) (date/results) _____
- ☐ Laparoscopy (date/results) _____
- ☐ Hysteroscopy (date/results) _____
- ☐ Other _____

Prior Treatment: (Check all that apply)

	# of cycles	Dates (Mo./Yr.) (Mo./Yr.)	Pregnant
☐ **Clomid/letrozole with timed intercourse** Where? _____	_____	From ____/____ to ____/_____	☐ Yes ☐ No
☐ **Clomid/letrozole with IUI** Where? _____	_____	From ____/____ to ____/_____	☐ Yes ☐ No
☐ **Letrozole with timed intercourse** Where?_____	_____	From ____/____ to ____/_____	☐ Yes ☐ No
☐ **Letrozole with IUI** Where? _____	_____	From ____/____ to ____/_____	☐ Yes ☐ No
☐ **IUI without fertility drugs** Where? _____	_____	From ____/____ to ____/_____	☐ Yes ☐ No
☐ **Daily fertility drug injections with IUI** Where? _____	_____	From ____/____ to ____/_____	☐ Yes ☐ No
☐ **Completed IVF cycle(s)** Where? _____ 1. # eggs ___ # embryos transferred ___# frozen ___ 2. # eggs ___ # embryos transferred ___# frozen ___ 3. # eggs ___ # embryos transferred ___# frozen ___	_____	_____/_____ _____/_____ _____/_____ _____/_____	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
☐ **Frozen embryo transfer(s):** Where? _____ 1. # embryos transferred _____ 2. # embryos transferred _____ 3. # embryos transferred _____	_____	_____/_____ _____/_____ _____/_____ _____/_____	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
☐ **Cancelled IVF attempt(s)** Where? _____	_____		

PART III: MALE PARTNER MEDICAL HISTORY AND INFORMATION *(IF APPLICABLE)*

- Have you been evaluated by a urologist? ☐ No ☐ Yes If Yes, who? _____
- Have you previously conceived with another woman? ☐ Yes - How many times? _____ ☐ No
- Have you had a semen analysis? ☐ No ☐ Yes If Yes, Results:_____
- Do you have difficulty with erections? ☐ No ☐ Yes
- Do you have difficulty with ejaculation? ☐ No ☐ Yes
- Any prior exposure to sexually transmitted diseases or infections? ☐ No ☐ Yes (check all that apply)
  - ☐ 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? ☐ No ☐ Yes – One side ___ Both __
- Do you have scrotal or testicular pain? ☐ No ☐ Yes
- Did you have the mumps after puberty? ☐ No ☐ Yes
- Have you been diagnosed with any of the following disease?

  ☐ Diabetes ☐ No ☐ Yes ☐ Cancer ☐ No ☐ Yes ☐ Multiple Sclerosis ☐ No ☐ Yes
  ☐ Prostatic Infection ☐ No ☐ Yes ☐ High Blood Pressure ☐ No ☐ Yes ☐ Urinary Infection ☐ No ☐ Yes
  ☐ Other Neurologic problems ☐ No ☐ Yes
- Have you had prior injury to your testicles requiring hospitalization? ☐ No ☐ Yes

- Have you had any fever in the last 3 months? ☐ No ☐ Yes
- Have you had a vasectomy? ☐ No ☐ Yes (Date: _____) If yes, have had a reversal? ☐ Yes (Date: _____)
- Have you had a surgery for varicocele repair? ☐ No ☐ Yes
- Have you had hernia surgery? ☐ No ☐ Yes
- Did you undergo any bladder or penis surgery as a child? ☐ No ☐ Yes
- Have you had any other surgeries? ☐ No ☐ Yes - _____
- Are you exposed to prolonged heat in the workplace? ☐ No ☐ Yes
- Are you exposed to any radiation or harmful chemicals in the workplace? ☐ No ☐ Yes
- Have you had chemotherapy for cancer? ☐ No ☐ Yes
- Are you taking or have you taken testosterone in the past? ☐ No ☐ Yes When was the most recent dose? _____
- Have any of your immediate family members had difficulty conceiving a child? ☐ No ☐ Yes (Please describe) _____

_____

- Do you smoke cigarettes? ☐ No ☐ Yes How many/day? ____ How many years? ____ Quit – when? ____ E-cigarettes?
- Do you drink alcohol? ☐ No ☐ Yes If so, how many per week?
- Do you use marijuana, cocaine, or any other similar drug? ☐ No ☐ Yes
- Do you use herbal medicines/vitamins or health food store supplements? ☐ No ☐ Yes

Disorders in your Family (Check all that apply)

		Relationship to You
Other cancer _____	☐ Yes	_____
Diabetes	☐ Yes	_____
Psychiatric problems	☐ Yes	_____
Infertility	☐ Yes	_____
Birth defects	☐ Yes	_____
Cystic Fibrosis	☐ Yes	_____
Tay-Sachs disease	☐ Yes	_____
Muscular Dystrophy	☐ Yes	_____
Neural Tube Defects	☐ Yes	_____
Dwarfism	☐ Yes	_____
Bone/Skeletal Defects	☐ Yes	_____
Polycystic kidney disease	☐ Yes	_____
Heart defect from birth	☐ Yes	_____
Down syndrome	☐ Yes	_____
Hemophilia	☐ Yes	_____
Sickle Cell Anemia	☐ Yes	_____
Other chromosome defects	☐ Yes	_____

If yes, explain _____

None of the Above ☐

What is your Ancestry?

☐ African-American
☐ Asian/Asian-American
☐ Eastern European
☐ Southern European
☐ Ashkenazi Jewish
☐ Hispanic/Caribbean
☐ Other (specify) _____
☐ American Indian/Native American
☐ Caucasian
☐ Northern European

PART IV: Certification

I hereby certify that I have provided and reviewed the above information and all questions thus far have been addressed and answered.

Signature of Patient _____Date_____

Signature of Partner, if applicable_____ Date_____