Huntsville Reproductive Medicine, P.C.
Specializing in Reproductive Endocrinology & Infertility

WELCOME & 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 a 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. 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. It is preferable that your spouse/partner be present if at all possible.

WHAT YOU NEED TO BRING WITH YOU TO YOUR VISIT
We will need to get a copy of your insurance card and your driver’s license for your first visit. We make every effort to obtain any records from previous infertility treatment before your visit. If you have any of these records, we would like for you to bring them with you. **Please fill out and FAX the 8-page infertility history form to 256-213-9978.** If you have had an HSG and are in possession of the films, please bring them with you to your initial consult. *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, but the fees could run several hundred dollars more depending upon 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 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 that you give us 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, we will be unable to reschedule your appointment.**

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

Sincerely,

Diane Castillo
Practice Manager
CONTACT US

Contact Huntsville Reproductive Medicine
Telephone: 256.213.BABY (2229)
Fax: 256.213.9878
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, 7:00 am to 5:00 pm
- Friday, 7:00 am to 2:00 pm

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 2:00 pm 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.
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.
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.

Sincerely,

Diane Castillo
Office Manager
Huntsville Reproductive Medicine
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.
Specializing in Reproductive Endocrinology & Infertility

PATIENT INFORMATION:

Full Name: ____________________________  City/State _______________  Zip __________
Street Address: _________________________  Mailing Address (if Different):
Home Phone: ___________________________  Work Phone: _______________  Cell Phone: __________
Date Of Birth: _______________  Age: _______________  Marital Status: _______________  Social Security #: __________
Employer’s Name: _______________________
Address: _______________________________
Can we call at work or leave message? _______________
Ob/Gyn’s Name: _________________________
Address: _______________________________
Emergency Contact Name & Phone: _______________________
Referral by: Ob/Gyn ______  Friend ______  Radio ______  TV ______  Newspaper ______  Other ______

SPOUSE’S INFORMATION:

Full Name: ____________________________  City/State _______________  Zip __________
Address: _______________________________
Home Phone: ___________________________  Work Phone: _______________
Date of Birth: ___________________________  Social Security #: __________
Relationship to Patient: _______________________
Employer’s Name and Address: _______________________
Can we talk to Spouse/Partner about your health information? _______________

INSURANCE INFORMATION:

Primary Insurance: _______________________
Subscriber’s Name: _______________________
Address: _______________________________
Policy #: _______________________
Group #: _______________________
Secondary Insurance: _______________________
Subscriber’s Name: _______________________
Address: _______________________________
Policy #: _______________________
Group #: _______________________

I authorize the release of all medical records to the referring and family physicians and to my insurance company if applicable. I allow for transmittal of my medical records, if necessary. I authorize and request that insurance payments be made directly to Huntsville Reproductive Medicine, PC 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, PC. 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 attorneys fees and collection costs in the event of default of payment of my charges.
I authorize treatment by Huntsville Reproductive Medicine, PC physicians and personnel.
I acknowledge receipt of Huntsville Reproductive Medicine, PC’s HIPAA Privacy Notification.
I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, insurance authorization and Acknowledgement of HIPAA privacy notification.

X ____________________________  Signature of Patient or Parent if Minor ____________________________  Date ____________________________
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
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)

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

Page 1
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

<table>
<thead>
<tr>
<th>Date Pregnancy Ended or Delivered</th>
<th>Months to Conception</th>
<th>Treatments to Conceive</th>
<th>Delivery Type/D&amp;C/Complications</th>
<th>Current Partner?</th>
</tr>
</thead>
<tbody>
<tr>
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<td>4.</td>
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<td>5.</td>
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<td>□Y □N</td>
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<td>6.</td>
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<td>□Y □N</td>
</tr>
</tbody>
</table>

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__ 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™, 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  □ LEAP 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

(1)________________________
(2)________________________
(3)________________________
(4)________________________
(5)________________________
(6)________________________
(7)________________________

Reason and Type of Surgery

• 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

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

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

Musculoskeletal:
□ Unusual muscle weakness
□ Decreased energy/stamina
□ Rheumatoid arthritis
□ Lupus Erythematosus
□ Myasthenia gravis
□ Other
□ None

Mental Health Problems:
□ Depression □ Anxiety disorder
□ Schizophrenia
□ 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

Breasts:
□ Discharge (clear?__ bloody?__ milky?___)
□ Lumps □ Pain □ Cancer
□ Abnormal mammogram
□ Reduction
□ Augmentation/Breast implants
(saline?__ silicone?___)
□ Other
□ None

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

Hematologic:
□ Blood clotting disorder/Blood clot
□ Sickle cell Anemia □ Thrombophlebitis
□ Easy bruising
□ Swollen glands/lymph nodes
□ Blood transfusions (dates/reasons______________________)
□ Other
□ None

Respiratory:
□ Shortness of breath
□ Asthma □ Bronchitis
□ Pneumonia □ Tuberculosis
□ Bloody cough
□ Other
□ None

Neurological Problems:
□ Weakness/Loss of balance
□ Seizures/Epilepsy
□ Headaches
□ Migraine headaches
□ Numbness
□ Memory loss
□ Other
□ None

Skin/Extremities:
□ Unexplained rash/inflammation
□ Acne
□ Skin cancer
□ Burn injury
□ Moles changing in appearance
□ Excess hair growth
□ 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

Physician Notes (for office use only) ____________________________________
______________________________________________________________

Page 4
### Family History

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<th>Living</th>
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### Disorders in Your Family

<table>
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<tr>
<th>Disorder</th>
<th>Relationship to You</th>
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<td>Other cancer</td>
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<td>Blood clots</td>
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<td>Menopause before age 40</td>
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<tr>
<td>Gaucher disease</td>
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□ None of the above □ Other (Specify [insert other condition])
PRIOR INFERTILITY TESTING 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):

<table>
<thead>
<tr>
<th>Intrauterine insemination:</th>
<th># of cycles</th>
<th>Dates (mo/year)</th>
<th>Pregnant</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>___</td>
<td>From__/to__/</td>
<td>Yes___ No___</td>
</tr>
</tbody>
</table>

| 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) __________________________________________________________

______________________________________________________

Page 7
## Disorders in Your Family

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<th>Relationship to You</th>
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☐ None of the above  ☐ 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)

_________________________________________________________________________

_________________________________________________________________________

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