Arizona Associates
for Reproductive Health

Ketan S. Patel, M.D., F.A.C.O.G.

REGISTRATION FORM

Date _____ ❒ Married ❒ Single ❒ Seperated ❒ Divorced ❒ Partnered

Patient last name_____ First Name_____ MI _____ Sex (circle) M/F

Age _____ Date of birth _____ Email _____

Address _____ City_____ State _____ Zip _____

Phone _____ Cell _____ Social Security #_____

May we leave a voicemail message ❒ YES ❒ NO

Employer_____ Phone_____

Address_____ Occupation _____

Primary Insurance_____ Phone_____

Insured_____ ID#_____ Group#_____

Primary care doctor_____ Phone_____

Referring GYN physician _____ Phone_____

Spouse last name_____ First Name_____ MI _____

Age _____ Date of birth _____ Email _____

Phone _____ Cell _____ Social Security #_____

Employer_____ Phone_____

Address_____ Occupation _____

Referring GYN physician _____ Phone_____

Primary Insurance_____ Phone_____

Insured_____ ID#_____ Group#_____

Emergency Contact: Name_____ Phone_____

Authorizations and Release (please initial)

__ If I have no medical coverage and/or benefits, I am aware that payment is due at the time of services when services are rendered.
__ I am aware that I am responsible to pay co-pays and deductibles at the time of services.
__ I hereby authorize to release any MEDICAL information which might be needed in connection with payment for medical services rendered. I request that all amounts payable under my medical insurance policies be made directly to Arizona Associates for Reproductive Health.When a non-contracted health insurance company rejects a claim, the total amount of the fee is due from me. I understand that I am responsible for charges related to any services deemed non-covered by my insurance company.
__ I am aware that if I fail to pay my account and if it is deemed neccessary to turn any past due balances to collections, I have been informed that there will be additional costs accessed in addition to my account balance.

By signing below, I acknowledge that I have read and understand the above statements.

Patient Name _____ Signature _____ Date _____

Arizona Associates
for Reproductive Health

PAYMENT TERMS AND CONDITIONS

Once Dr. Patel has determined your treatment protocol, Arizona Associates for Reproductive Health will provide you with an estimate of charges of the anticipated costs for your treatment. Because each patient situation is unique, additional procedures such as ultrasounds or blood tests may be required and may not be included in your estimate of charges.

Please note, you will be financially responsible for all services provided, even for services not included in your estimate.

Insurance

Please realize that it is your responsibility to know what coverage yot1 have through your insurance. Benefits through each insurance plan vary greatly. For example, some insurance plans limit the number of procedures that will be covered during a treatment cycle. Our charge estimate reflects what we believe your Insurance will cover. However, the estimate is not a guarantee and may not be complete. Co-pays, deductibles, co-insurance and self-pay amount are due at the time of treatment.

Laboratory & Procedure Charges

Due to the technical complexities of our laboratory testing and the need for ·consistency across testing cycles, it is important that we perform a majority of laboratory and ancillary procedures (ultrasounds, etc.) at Arizona Associates for Reproductive Health. If you have insurance that requires you to go to an outside facility, we will make every attempt to utilize these benefits. However, most laboratory procedure charges will be performed at AZARH and charged directly to you.

Cancellation and Prepaid Cycles

If a cycle of packaged services is canceled for clinical reasons such as poor stimulation response or potential for hyperstimulation, your costs will be re-calculated based on actual services provided. Any services that were not provided, but were pre-paid, will be refunded.

Financial Agreement

I agree to be responsible for all charges incurred and will provide payment as requested. If my account is sent to collections, I agree to pay collection fees and/or attorney fees. Delinquent accounts will also be assessed reasonable interest charges.

I HAVE READ AND UNDERSTAND THE ARIZONA ASSOCIATES FOR REPRODUCTIVE HEALTH PAYMENT TERMS AND CONDITIONS. I ALSO UNDERSTAND THAT I AM PRIMARILY RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED.

Patient Name _____ Signature _____ Date _____

8573 E Princess Drive, #101 | Scottsdale, Arizona 85255 | 3885 S Val Vista Dr., #105 | Gilbert, Arizona 85297
Office: (480) 946-9900 Fax: (480) 946-9914

Arizona Associates for Reproductive Health

Online Communications Informed Consent

THE FOLLOWING AGREEMENT INCLUDES ONLINE COMMUNICATIONS WITH ANY PHYSICIAN, NURSE, OR ANY STAFF MEMBER OF ARIZONA ASSOCIATES FOR REPRODUCTIVE HEALTH.

Instructions for Using Online Communications

You agree to take the following steps to keep your online communications to and from AzARH confidential:

- Do not store messages on your employer provided computer; otherwise personal information could be accessible and/or owned by the employer.
- Use screen savers, or close your window out instead of leaving your messages on the screen for passerby's to read, and keep your password safe and private.
- Do not allow other individuals or other third party access to the computer(s) which you store medical messages or other personal medical information.
- Do not send any e-mails to any staff's personal e-mail addresses. Standard e-mail lacks security and privacy features that could expose medical communications to employers or other unidentified third parties.

Use good communications etiquette:

- Confirm that your name and other personal information in the message is correct.
- Always give your date of birth and social security number so that we can confirm that you are the person sending the e-mail.
- Review the message before sending it to make sure that it is clear and that all relevant information is included.

Conditions or Using Online Communications

- The following agreements and procedures relate to online communications:
- AzARH will print out a copy of all medically prudent online communications and include it in your medical record. This means that all appropriate members of AzARH staff will have access to these communications as part of our medical records keeping, treatment and billing.
- You should print or store (on a computer or storage device owned by your and controlled by you) a copy of all online communications that are important to you.
- AzARH will not forward online communications with you to third parties, except as authorized or required by law.
- You agree to follow the procedures that AzARH requires that will allow AzARH to verify your identity in connection with online communications. You also acknowledge that failure to comply with those procedures may terminate our online communications.
- Online communications will be used for only limited purposes. It cannot be used for emergencies, time sensitive matters, or requesting copies of your medical records. It should be used with caution. It should not be used to communicate highly sensitive medical information, such as treatment for or info1D1ation related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependency, etc)
- AzARH will make every attempt to respond within 24 hours Monday through Friday. However, there may be times when this is not feasible, and you understand and agree to accept variations in response times and use other forms of communications with AZARH if online responses are not satisfactory to you. Please note that online communications should never be used for emergency communications or urgent matters.
- While AzARH will take reasonable precautions to protect your information, AzARH is not liable for improper disclosure of confidential information unless it was caused by our intentional misconduct.

- Follow-up is your responsibility. You are responsible for scheduling any necessary appointments and for determining if an unanswered online communications was received.
- You are responsible for taking steps to protect yourself from unauthorized use of online communications, such as keeping your password confidential. AZARH is not responsible for breaches of confidentiality caused by you or an independent third party.

Access to Online Communications
The following pertains to access and use of online communications:

- Online communication does not decrease or diminish any other ways in which you can communicate with AzARH. It is an additional option and not a replacement You are encouraged to contact AzARH via telephone, mail or in person, as always, if you have any questions or needs.
- AzARH may stop providing online communications with you or change online services provided at any time without prior notification to you.

Risks of Using Online Communications
All medical communications carry some level of risk. While the likelihood of risks associated with the use of online communications, particularly in a secure environment, is substantially reduced, the risks are nonetheless real and very important to understand. It is very important that you consider these risks each time you plan to communicate with AZARH, and communicate in such fashion as to mitigate the potential for any of these risks. These risks include, but are not limited to:

- Online communication may travel farther than you planned. It is easier for online communications to be forwarded, intercepted, or even changed without-your knowledge.
- It is harder to get rid of online communications. Back up copies may exist on a computer in cyberspace, even after both parties have deleted their copies.
- Online communication is not private simply because it related to your own medical information. AzARH uses a secure network to avoid using standard e-mail or e-mail systems provided by employers.
- Online communications are also admissible as evidence in court.
- Online communications may disrupt or damage your computer if a computer virus is attached.

Patient Acknowledgment and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of online communications between AZARH physicians, nurses, staff, and me, and consent to the conditions outlined herein. In addition. I agree to the instructions outlined herein, as well as any other instructions that AZARH may impose to communicate with patients via online communications. I have had the chance to ask any questions that I had and to receive answers. I have been proactive about asking questions related to this consent agreement. My questions have been answered and I understand and concur with the information provided in the answers.

Patient Name _____ Signature _____ Date _____

Partner Signature _____ Signature _____ Date _____

Arizona Associates
for Reproductive Health

PATIENT'S BILL OF RIGHTS

- You have a right to seek consultation with the physician(s) of your choice
- You have a right to contract with your physician(s) on mutually agreeable terms
- You have a right to talk privately with your physician(s) and to have your health care information protected
- You have a right to use your own resources to choose the care of your choice
- You have a right to refuse medical treatment even if it is recommended by your physician(s)
- You have a right to be informed about your medical condition/treatment and take part in decisions about your care. To be informed about the risks and benefits of treatment and appropriate alternatives
- You have a right to refuse third-party interference in your medical care, and to be confident that your actions in seeking or declining medical care will not result in third-party-imposed penalties for patients or physicians
- You have a right to receive full disclosure of your insurance plan explaining the coverage and benefits

_____ _____ _____

Patient Name Date of birth Date

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Arizona Associates for Reproductive Health

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

INTRODUCTION

This Notice of Privacy Practices is being provided to you on behalf of Arizona Associates for Reproductive Health with respect to reproductive medical services provided at Arizona Associates for Reproductive Health's facilities (collectively referred to herein as "We" or "Our). We understand that your medical information is private and confidential. Further, we are required by law to maintain the privacy of "protected health information." Protected health information includes any individually identifiable information that we obtain from you or others that relates to your past, present or future physical or mental health, the health care you have received, or payment for your health care.

YOUR RIGHTS

Although your health record is the physical property of Arizona Associates for Reproductive Health, you have the right to:

- request a restriction on certain uses and disclosures of your information as provided by applicable law
- obtain a paper copy of this Notice of Privacy Practices upon request
- inspect and copy your health record as provided for by applicable law
- request an electronic copy of your electronic health record
- request to amend your health record as provided by applicable law
- obtain an accounting of disclosures of your health information as provided by applicable law.
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken
- request a restriction of disclosure of your healthy information to your health insurer for services for which you pay "out of pocket" in full
- transmit copies of your health information to third parties when request by you, in writing

OUR RESPONSIBILITIES:

We are required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations
- where required by law, notify you in the event that there has been a breach of your unsecured health information

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post the revised Notice of Privacy Practices on our website at as **http://www.azarh.com** and our offices and provide you with a hard copy upon request.

We will not use or disclose your health information without your authorization, except as described in this notice. We will not sell your health information (unless permitted by law) or use or disclose such information for paid marketing (for which re receive payment from a third party) without your authorization. If we obtain your authorization, you may revoke it at any time, and this revocation will take effect except where we have already relied upon your authorization.

PERMITTED USES AND DISCLOSURES

We will use and disclose your health information for treatment. For example: information obtained by a nurse, physician or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way the physician will know how you are responding to treatment. We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him/her in treating you once you're discharged from this practice. We will use your health information for payment. For example: A bill may be sent to you or a third party payor, such as an insurance company or health plan, for the purposes of receiving payment for treatment and services that you receive. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment. If you indicate your interest in participating in the Attain IVF

Program, we will provide relevant information concerning your medical condition to AzARH for determination of your qualifications for this financing program. We will use and disclose your health information for our health care operations. For example: Members of the clinical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and the reproductive medicine service we provide.

OTHER USES OR DISCLOSURES OF PROTECTED HEALTH INFORMATION

Business Associates: There are some services provided at Arizona Associates for Reproductive Health through contacts with business associates. For example: the management services of AzARH and certain laboratory tests. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we have asked them to do, and bill you or your third party payer for services rendered. So that your health information is protected, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition. Communication with Spouse/Family: Health professionals, using their best judgment, may disclose to your spouse, family member, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. We will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object.

Research: We may disclose information to researchers when their research has been approved by an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Marketing: Where permitted by law, we may contact you to tell you about or recommend possible treatment alternatives or other medical technology and services that may be of interest to you. We may also seek your authorization to contact you with other marketing communications.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post marketing surveillance information to enable product recalls, repairs or replacement.

Public Health: As required by law, your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, disability or for other health oversight activities.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law, or in response to a valid subpoena. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Note: HIV-related information, genetic information, mental health records and other specially protected health information may be subject to certain special confidentiality protections under applicable State and Federal law. Any disclosures of these types of records will be subject to these special protections. For More Information or to Report a Problem/Complaint

If you believe your privacy rights have been violated, you should immediately contact: (480) 946-9900

We will not take action against you for filing a complaint. You may also file a complaint with the Secretary of Health and Human Services.

If you have any questions or would like further information about this notice, please contact us at the above number. This notice is also available on our website at http://www.azarh.com/

This notice is effective as of August 31, 2017

_____ _____

Patient Name Date of birth

_____ _____

Patient Signature Date

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Arizona Associates for Reproductive Health

Ketan S. Patel, M.D., F.A.C.O.G.

SCOTTSDALE
8573 E. Princess Drive, #101
Scottsdale, AZ 85255

GILBERT
3885 S. Val Vista Dr., #105
Gilbert, AZ 85297

Central Scheduling Office: (480) 946-9900 | Central Scheduling Fax: (480) 946-9914

AUTHORIZATION FOR USE AND/OR RELEASE OF MEDICAL RECORDS

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand that if the organization authorized to receive the information is not an insurance company or healthcare provider, the released information may no longer be protected by federal privacy regulations.

Patient's Name: _____
First Middle/Maiden Last

Address: _____
Street City State Zip

Phone #:_____ **Date of Birth:**_____

Information Released From:

Facility Name: _____

Address: _____

_____

Phone #: _____

Fax #: _____

Information to be Released TO:

Facility Name: _____

Address: _____

_____

Phone #: _____

Fax #: _____

Dates of services being requested: From _____ To _____

Check the specific information to be released
(used or disclosed):
- ☐ Office Notes
- ☐ Radiology Reports
- ☐ Laboratory I Pathology Reports

Purpose of Disclosure:
- ☐ Medical Review
- ☐ Legal Review
- ☐ Insurance
- ☐ Personal Use
- ☐ Other_____

The named entity is authorized to (select both if applicable):
- ☐ Use protected health information for treatment, payment and operations
- ☐ Disclose protected health information to entity named

I understand that l have the right to revoke this authorization at any time by notifying the Medical Records Department of the providing organization in writing. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when disclose of the private health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or obtain a copy of this information to be used or disclosed.

Reason for Request: _____

Printed Name: _____

Signature: _____ Date: _____

Arizona Associates for Reproductive Health

INSURANCE PAYMENT TERMS AND CONDITIONS

It is your responsibility to provide AzARH with your current insurance information including primary and secondary policies. If your insurance coverage changes at any time it is your responsibility to inform AzARH immediately to prevent any delay in billing. AzARH will not be responsible for any unpaid fees by your insurance if the information was not provided timely. In addition, we are unable to accept insurance after a cycle has begun due to pre-authorization requirements of insurance plans. It is extremely important you provide us with any insurance coverage changes prior to treatment.

We cannot submit claims for non-contracted insurance plans and full payment is due before starting treatment. If it is determined that you do have benefits through a contracted plan, you will be responsible for paying an estimated deposit of applicable deductibles, co-insurances, and co-pays up front. In the event your insurance does not cover the services billed due to being "non-covered" or "not medically necessary" you will become ultimately responsible for any unpaid claims at AzARH usual and customary rates. If you have a maximum on your plan and that maximum is reached mid-treatment, you will become responsible for the AzARH full usual and customary rates. You will not receive any insurance contractual adjustments on any services unpaid by your insurance due to no coverage, not medically necessary or a benefit has maxed out. If authorization is required for any of your services AzARH will request the authorization, but we encourage you to independently ensure authorization is on file prior to receiving treatment. You will become responsible for payment if you decide to move forward with treatment without prior authorization. We encourage you to independently confirm the exact extent of coverage of benefits, if any, with your insurance carrier. We assume no responsibility for representations made by your insurance carrier.

If a cycle is canceled or stopped mid-cycle for any reason, any credited monies on your account will first be applied to outstanding balances, until determination has been made that account is paid in full; please keep in mind that claims pending out to insurance can take at least 30-45 days for processing. Refunds will only be issued once all claims have been processed and account balance is zero.

- I acknowledge that I have been informed in advance of receiving services that it is my responsibility to provide AzARH with my most current insurance coverage, primary, secondary, and any subsequent policies, to prevent any billing delays.
- I acknowledge that I am responsible to pay an estimated deposit up front.
- I acknowledge that I will be financially responsible for applicable charges as indicated above and will be asked to pay for these services prior to the service being rendered.
- I further acknowledge that I understand and agree to the refund policy as outlined by AzARH.

Patient Signature _____ Date _____

Partner Signature _____ Date _____

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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 physicans and patients in obtaining a complete infertility history. It consists of three parts:

Part I: Contact Information
Part 2: Your Medical History
Part 3: Your spouse/male partner's medical history (if applicable)

PART I: CONTACT INFORMATION

First Name _____ Middle Initial _____ Last Name _____ Age _____

Indicate which number to call or leave messages.
☐ Home _____ ☐ Work _____ ☐ Cell _____

Spouse/Male Partner's First Name _____ Middle Initial _____ Last Name _____ Age _____

Indicate which number to call or leave messages.
☐ Home _____ ☐ Work _____ ☐ Cell _____

Who Referred You?
☐ Physician
Name _____ Phone _____
Address _____

☐ Former Friend / Patient _____
☐ 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 _____

What are your expecations for this visit? _____

What questions do you want answered at this visit? _____

_____

Do you have any personal, ethical, or religious objections to any of our tests or treatments such as insemination, in vitro fertilization, egg donation, sperm donation, masterbation to collect semen sample, etc.? ☐ No ☐ Yes _____

How many months have you been having intercourse without using any form of birth control? _____

Pregnancy Summary

- Total Number of ALL Pregnancies: _____
- Number of Miscarriages (less than 20 weeks): _____
- Number of Ectopic / Tubal Pregnancies: _____
- Number of Elective Terminations (Abortions): _____
- Number of Full Term Deliveries: _____ Of these, how many were live births? _____ How many were still born? _____
- Number of Premature (less than 37 weeks) Deliveries: _____ Of these, how many were live births? _____ How many were still born? _____
- 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 between ☐ 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
- Date of the 1st day of your last 2 mentrual periods: _____/_____/_____ ; _____/_____/_____
- Age when you had your first period: _____ 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 _____ ☐ Diaphram - 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 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

Have you had any of the following 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 _____ ☐ Other - date _____

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 procedure 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 breast self 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 suplements? ☐ 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 marijuana, cocaine, or any other similar drugs? ☐ No ☐ Yes (describe _____)
- Do you exercise? ☐ No ☐ Yes (describe _____)
- Are you aware of any radiation exposure 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 chronological 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 Vistion ☐ 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 stool ☐ 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
- ☐ Blood in the urine
- ☐ Herpes
- ☐ 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
- ☐ Rheumatiod 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 your Ancestry?

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

Would you like to be screened for:

- ☐ Cystic Fribrosis: __Y __N
- ☐ Sickle Cell Anemia: __Y __N
- ☐ Tay-Sachs Disease: __Y __N
- ☐ Thalasemia: __Y __N

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
• 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 INFERTILITY TESTING AND TREATMENT

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

Prior Tests (check all that apply): ☐ Basal body temperature chart (date_____/results_____)

☐ Thyriod 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_____)

Prioe Treatment (check all that apply):

	# of cycles	Dates (mo/year) (mo/year)	Outcome
☐ Intrauterine insemination:	_____	From___/___to___/___	__Pregnant: __Delivered ___Ectopic __Miscarriage; ___Not Pregnant
☐ Clomiphene citrate with timed intercourse maximum # tablets per day? _____	_____	From___/___to___/___	__Pregnant: __Delivered ___Ectopic __Miscarriage; ___Not Pregnant
☐ Clomiphene citrate with insemination: maximum # tablets per day? _____	_____	From___/___to___/___	__Pregnant: __Delivered ___Ectopic __Miscarriage; ___Not Pregnant
☐ Daily fertility drug injections w/ insemination maximum # vials per day? _____	_____	From___/___to___/___	__Pregnant: __Delivered ___Ectopic __Miscarriage; ___Not Pregnant
☐ Comleted in vitro fertilization cycle(s): 1. # eggs__#embryos transferred___#frozen ___ 2. # eggs__#embryos transferred___#frozen ___ 3. # eggs__#embryos transferred___#frozen ___ 4. # eggs__#embryos transferred___#frozen ___	_____	From___/___to___/___	__Pregnant: __Delivered ___Ectopic __Miscarriage; ___Not Pregnant
☐ Frozen embryo transfers: 1. # embryos transferrred _____ 2. # embryos transferrred _____ 3. # embryos transferrred _____ 4. # embryos transferrred _____	_____	From___/___to___/___	__Pregnant: __Delivered ___Ectopic __Miscarriage; ___Not Pregnant
Canceled in vitro fertilization attempt(s):	_____	From___/___to___/___	__Pregnant: __Delivered ___Ectopic __Miscarriage; ___Not Pregnant
☐ Any other prior treatments (describe): _____			

- 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? ☐ No ☐ Yes - For how long? _____ How often? _____
- List any antidepressant/antianxiety medications you are currently taking. _____
- 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 MEDICAL HISTORY AND INFORMATION

Complete with your male partner if applicable.

- Have you ever 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
- Have you had any of the following 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 _____ ☐ Other - date _____
- Have you had a history of undescended testitcles? ☐ 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 to 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 marijuana, cocaine, or any other similar drugs? ☐ No ☐ Yes (describe _____)
- Do you exercise? ☐ No ☐ Yes (describe _____)
- Are you aware of any radiation exposure other than X-rays? ☐ No ☐ Yes (describe _____)

- Do you use hot tubs regularly? ☐ No ☐ Yes
- 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
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• 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 your Ancestry?

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

Would you like to be screened for:

☐ Cystic Fribrosis: __Y __N
☐ Sickle Cell Anemia: __Y __N
☐ Tay-Sachs Disease: __Y __N
☐ Thalasemia: __Y __N

SPOUSE/MALE PARTNER'S SIGNATURE _____ DATE _____

I confirm that I have reviewed the information above.

PHYSICIAN'S SIGNATURE_____ DATE _____

Physician Notes (for office use only) _____