



Marwan M. Shaykh, M.D., F.A.C.O.G.

Diplomate
American Board
of Obstetrics and
Gynecology

Certified Division
of Reproductive
Endocrinology and
Infertility

Member of
The Society of
Reproductive
Surgeons

Member of
The Society of
Reproductive
Endocrinologists

Member of The
Society of Assisted
Reproductive
Technology

Dear Prospective Patient:

We appreciate your interest in our infertility services. Please find enclosed the following forms: Infertility History Form, Patient Information Form and a Medical Records Release Form.

Please complete the Infertility History Form and the Patient Information Form and bring them with you to your consultation appointment. This will expedite the check-in process on the day of your appointment.

Also, we encourage you to use the Medical Release Form in requesting a copy of your medical records from all physicians from whom you have received infertility, gynecological, or obstetrical treatment. Please include male evaluation and treatment records as well.

As a patient of Assisted Fertility Program of North Florida, we will be glad to file your insurance claims if the carrier is one with whom we have a contract. We recommend that you begin your research into fertility coverage now to ensure there will be no misunderstanding of coverage once treatment begins. If you have no insurance/fertility coverage, we will be happy to provide you with several lending institutions who offer financing programs.

If you have any questions before your appointment, please do not hesitate to call. We do ask that you provide us with at least 48 hours' notice if you are unable to keep your scheduled appointment.

There will be a \$100.00 "No-Show" fee if your appointment is not cancelled at least 24 hours before your scheduled time.

Sincerely,

Assisted Fertility Program

JACKSONVILLE

3627 University Blvd. South Suite 450
Jacksonville, FL 32216
Ph 904.398.1473

ORLANDO

752 Stirling Center Place #1008
Lake Mary, FL 32746
Ph 407.493.7765





Marwan M. Shaykh, M.D., F.A.C.O.G.

JACKSONVILLE

3627 University Blvd. South Suite 450.
Jacksonville, FL 32216
Ph 904.398.1473

ORLANDO

752 Stirling Center Place #1008
Lake Mary, FL 32746
Ph 407.493.7765

1.800.777.IVF1 • FAX 904.399.3436 • www.assistedfertility.org

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to your Individually Identifiable Health Information.

PLEASE REVIEW CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- ▶ How we may use and disclose your IIHI
- ▶ Your privacy rights in your IIHI
- ▶ Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practice. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT Lina Shaykh, Office Mgr.

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI without obtaining your consent:

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.

For purposes of proper medical treatment, this practice will give the IIHI, including medical history and all test and lab results, of pregnant patients directly to the birthing hospital, baby's pediatrician, and other specialist needed for the baby's care. The hospital, the pediatrician and any other needed specialist may make the patient's IIHI part of their medical record for the patient's baby. Transfer of this information will help hospital staff, the pediatrician, and any other needed specialist appropriately care for and treat a patient's newborn baby.



Marwan M. Shaykh, M.D., F.A.C.O.G.

JACKSONVILLE

3627 University Blvd. South Suite 450.
Jacksonville, FL 32216
Ph 904.398.1473

ORLANDO

752 Stirling Center Place #1008
Lake Mary, FL 32746
Ph 407.493.7765

1.800.777.IVF1 • FAX 904.399.3436 • www.assistedfertility.org

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurance insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items.

3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.

4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment either by telephone or mail. We may call your home or other designated location and leave a message on your voicemail or in person to notify you of an upcoming appointment, or in the alternative, we may mail an appointment reminder card.

5. Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatments options or alternatives.

6. Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

7. Baby Photos. Our practice may post within our office photographs submitted by patients.

8. Disclosures Required by Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your IIHI:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- ▶ Maintaining vital records, such as births and deaths
- ▶ Reporting child abuse or neglect
- ▶ Preventing or controlling disease, injury or disability
- ▶ Notifying a person regarding potential exposure to a communicable disease
- ▶ Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- ▶ Reporting reactions to drugs or problems with products or devices
- ▶ Notifying individuals if a product or device they may be using has been recalled
- ▶ Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information.
- ▶ notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.



Marwan M. Shaykh, M.D., F.A.C.O.G.

JACKSONVILLE

3627 University Blvd. South Suite 450.
Jacksonville, FL 32216
Ph 904.398.1473

ORLANDO

752 Stirling Center Place #1008
Lake Mary, FL 32746
Ph 407.493.7765

1.800.777.IVF1 • FAX 904.399.3436 • www.assistedfertility.org

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- ▶ Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- ▶ Concerning a death we believe has resulted from criminal conduct
- ▶ Regarding criminal conduct at our offices
- ▶ In response to a warrant, summons, court order, subpoena or similar legal process
- ▶ To identify/locate a suspect, material witness, fugitive or missing person
- ▶ In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

7. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

8. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

9. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

10. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. In order to request a type of confidential communication you must make a written request to the practice specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.



Marwan M. Shaykh, M.D., F.A.C.O.G.

JACKSONVILLE

3627 University Blvd. South Suite 450.
Jacksonville, FL 32216
Ph 904.398.1473

ORLANDO

752 Stirling Center Place #1008
Lake Mary, FL 32746
Ph 407.493.7765

1.800.777.IVF1 • FAX 904.399.3436 • www.assistedfertility.org

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in our care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to the Practice. Your request must describe in a clear and concise fashion:

- ▶ The information you wish restricted;
- ▶ Whether you are requesting to limit our practice's use, disclosure or both; and
- ▶ To whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Practice in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the Practice. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures". An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI. Use of your IIHI for treatment, payment, operations or disclosures authorized by you is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to the Practice. All requests for an accounting of disclosures must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the Practice.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Lina Shaykh, Office Manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact our office.

ASSISTED FERTILITY PROGRAM PATIENT FACE SHEET

| | |
|--|------------------------|
| Name: | Date |
| Social Security # | Date of Birth |
| Sex: <input type="radio"/> Female <input type="radio"/> Male | Email _____ |
| Cell Phone _____ | Home Phone _____ |
| Address _____ | |
| City _____ | State: _____ Zip _____ |
| Employer _____ | Occupation _____ |
| Employer Phone _____ | |
| Primary Care Physician _____ | Primary Phone _____ |
| Pharmacy Phone _____ | Referred By _____ |

| | |
|--|--|
| <input type="radio"/> Partner <input type="radio"/> Spouse _____ | |
| Social Security # _____ Date of Birth _____ | |
| Sex: <input type="radio"/> Female <input type="radio"/> Male Email _____ | |
| Cell Phone _____ Home Phone _____ | |
| Employer _____ Occupation _____ | |
| Employer Phone _____ | |

| |
|---|
| Insurance Company _____ |
| Policy Holder _____ Date of Birth _____ |
| Member ID _____ Group # _____ |
| Secondary Insurance _____ |
| Policy Holder _____ Date of Birth _____ |
| Member ID _____ Group # _____ |

I consent to the use or disclosure of my protected health information by Dr. Shaykh for the purpose of: obtaining claim payment, providing medical treatment or to conduct health care operations. I understand that this information must be updated on an annual basis and is true and correct to my knowledge. I also understand that I have the right to revoke this consent, in writing, at any time, except to the extent that it affects the quality of care that is provided by Dr. Shaykh. Furthermore, I agree to be fully responsible for all lawful debts incurred by myself for services rendered by Dr. Shaykh, whether covered by my insurance company or not.

PATIENT SIGNATURE _____



Marwan M. Shaykh, M.D., F.A.C.O.G.

JACKSONVILLE

3627 University Blvd. South Suite 450.
Jacksonville, FL 32216
Ph 904.398.1473

ORLANDO

752 Stirling Center Place #1008
Lake Mary, FL 32746
Ph 407.493.7765

1.800.777.IVF1 • FAX 904.399.3436 • www.assistedfertility.org

OFFICE POLICY REGARDING FINANCIAL ARRANGEMENTS AND PATIENT RESPONSIBILITIES

We are committed to providing you with the best care possible. In order to achieve these goals, we need your assistance and your understanding of our office policies.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Payment is due at the time services are rendered, unless alternative payment arrangements have been approved in advance by our staff. This includes applicable coinsurance and co-payments for participating insurance companies. This policy is in accordance with legal requirements for collecting patient responsibility amounts. We accept cash, checks and all major credit cards. There is a \$25 service charge for returned checks.

Patients with an outstanding balance greater than 30 days past-due must make arrangements for payment prior to scheduling appointments. Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of \$100.00. Please help us serve you better by keeping scheduled appointments.

INSURANCE

As a courtesy to our patients, our office makes every reasonable effort to obtain payment according to your coverage. We will accept assignment for those companies which we are contracted with. However, please understand that as a medical provider, our relationship is with you, not your insurance company.

Regardless of your insurance coverage, you are ultimately responsible for any charges incurred.

If you have any questions and are in need of assistance regarding the above information, please do not hesitate to ask our office staff. We are here to help you.

AUTHORIZATION

I agree to abide by the terms of the above financial policy and accept responsibility for any balance not covered by my insurance company. I authorize my insurance company, attorney or other parties to pay directly to Dr. Marwan M. Shaykh, MD and/or provide any information regarding payment of my bill. If my account becomes delinquent, I agree to pay all costs incurred in collecting the account, including attorney fees.

I understand that not all services are covered by my insurance company, and that it is my responsibility to obtain benefit information for services that I receive.

Patient's Signature _____ Date _____



Marwan M. Shaykh, M.D., F.A.C.O.G.

JACKSONVILLE

3627 University Blvd. South Suite 450.
Jacksonville, FL 32216
Ph 904.398.1473

ORLANDO

752 Stirling Center Place #1008
Lake Mary, FL 32746
Ph 407.493.7765

1.800.777.IVF1 • FAX 904.399.3436 • www.assistedfertility.org

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by **Dr. Marwan Shaykh** for the purpose of diagnosing and providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations by Dr. Shaykh. I understand the diagnosis or treatment of me by **Dr. Shaykh** may be conditioned upon my consent as evidenced by my signature on this document.

My "Protected Health Information" means any information, including my demographic information, created or received by **Dr. Shaykh**, that relates to my past, present or future physical or mental health or condition; the provision of healthcare to me; or the past, present, or future payment for the provision of healthcare services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand that I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of **Dr. Shaykh**. If **Dr. Shaykh** agrees to a restriction that I request, the restriction is binding.

I understand I have the right to review **Dr. Shaykh's** Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and **Dr. Shaykh's** duties regarding the types of uses and disclosures of my Protected Health Information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of the **Dr. Shaykh**. The Notice of Privacy Practices for **Dr. Shaykh** is also posted in the front lobby of the office.

I have the right to revoke this consent, in writing at any time, except to the extent that Dr. Shaykh has taken action in reliance on this consent.

Signature of Patient or Legal Representative _____

Printed Name of Patient or Legal Representative _____

Date Signed _____



Marwan M. Shaykh, M.D., F.A.C.O.G.

Diplomate
American Board
of Obstetrics and
Gynecology

Certified Division
of Reproductive
Endocrinology and
Infertility

Member of
The Society of
Reproductive
Surgeons

Member of
The Society of
Reproductive
Endocrinologists

Member of The
Society of Assisted
Reproductive
Technology

PATIENT HISTORY ADDENDUM

I certify that all information given is true to the best of my knowledge. I agree to notify the doctor of any developments pertinent to my care. I understand that an accurate health history is vital to effective treatment.

Patient Name _____

Patient Signature _____ Date _____

JACKSONVILLE

3627 University Blvd. South Suite 450
Jacksonville, FL 32216
Ph 904.398.1473

ORLANDO

752 Stirling Center Place #1008
Lake Mary, FL 32746
Ph 407.493.7765





Marwan M. Shaykh, M.D., F.A.C.O.G.

Diplomate
American Board
of Obstetrics and
Gynecology

Certified Division
of Reproductive
Endocrinology and
Infertility

Member of
The Society of
Reproductive
Surgeons

Member of
The Society of
Reproductive
Endocrinologists

Member of The
Society of Assisted
Reproductive
Technology

**RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM**

I, _____ have read a copy of the Notice of Privacy
Practices for **Dr. Marwan Shaykh**.

Patient Signature _____

Date Signed _____

JACKSONVILLE

3627 University Blvd. South Suite 450
Jacksonville, FL 32216
Ph 904.398.1473

ORLANDO

752 Stirling Center Place #1008
Lake Mary, FL 32746
Ph 407.493.7765



RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT 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 spouse/male partner's medical history (if applicable)

FOR OFFICE USE ONLY

PART I: CONTACT INFORMATION

First Name _____ Middle Initial _____ Last Name _____ Age _____

Date of Birth _____ Occupation _____

Home Street Address _____

City _____ State _____ Zip/Postal Code _____ Country _____

Indicate which number to call or leave messages.

Home Telephone _____ Work Telephone _____ Cell Phone _____

Are you married? Yes No Divorced Other _____

Spouse/Male Partner _____ N/A

First Name _____ Middle Initial _____ Last Name _____ Age _____

Date of Birth _____ Occupation _____

Home Street Address _____

City _____ State _____ Zip/Postal Code _____ Country _____

Indicate which number to call or leave messages.

Home Telephone _____ Work Telephone _____ Cell Phone _____

WHO REFERRED YOU?

- Physician, Name _____ Phone _____
Address _____
- Former Patient/Friend _____
- WebSite _____
- Insurance (Name of Insurance) _____

Physician Notes (for office use only)

WHO IS YOUR OB/GYN?

Name _____ Phone _____
Address _____

WHO IS YOUR PRIMARY CARE PHYSICIAN?

Name _____ Phone _____
Address _____

PART II: FEMALE HISTORY AND INFORMATION

Reason for Visit Infertility Evaluation Sperm Insemination Other _____

What are your expectations 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, masturbation to collect a 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 Ectopic/Tubal Pregnancies _____
- > Number of miscarriages (less than 20 weeks): _____
- > Number of Elective Terminations (Abortions): _____
- > Number of Full Term Deliveries: _____ Of these, how many were live births? _____ How many were stillborn? _____
- > 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? <input type="radio"/> No <input type="radio"/> Yes |
|-----------------------------------|----------------------|------------------------|---------------------------------|--|
| 1. _____ | _____ | _____ | _____ | <input type="radio"/> No <input type="radio"/> Yes |
| 2. _____ | _____ | _____ | _____ | <input type="radio"/> No <input type="radio"/> Yes |
| 3. _____ | _____ | _____ | _____ | <input type="radio"/> No <input type="radio"/> Yes |
| 4. _____ | _____ | _____ | _____ | <input type="radio"/> No <input type="radio"/> Yes |
| 5. _____ | _____ | _____ | _____ | <input type="radio"/> No <input type="radio"/> Yes |
| 6. _____ | _____ | _____ | _____ | <input type="radio"/> No <input type="radio"/> Yes |

MENSTRUAL HISTORY

Menstrual cycle pattern (check all that apply):

- Regular periods Spotting before periods
 Irregular 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? No Yes:
 Always Sometimes Recently In the Past

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? _____
 Tubal sterilization procedure (tubes tied) - date (month/year) Foam or jelly
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
- > 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? _____ N/A
- > Have you undergone any procedures as a result of an abnormal pap smear? (check all that apply)
 Yes 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 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 every 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 drug? No Yes (describe _____)
- > Do you exercise? No Yes (describe _____)
- > Are you aware of any radiation exposures other than X-rays? No Yes (describe _____)

PHYSICIAN NOTES (FOR OFFICE USE ONLY)

SURGICAL HISTORY

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

Year Reason and Type of Surgery

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

PHYSICAL SYMPTOMS

General

- Recent weight gain or loss
 Anorexia/Bulimia Dizziness
 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: None

- 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
 Blood in the urine
 Herpes
 Other _____
 None

Hematologic:

- Blood clotting disorder/Blood clot
 Sickle Cell Anemia Thrombophlebitis
 Easy bruising
 Swollen glands/lymph nodes
 Blood transfusions _____

- 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
 Excessive 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?) Y N
 Other _____
 None

PHYSICIAN NOTES (FOR OFFICE USE ONLY)

FAMILY HISTORY

- > Mother
 - > Father
 - > Brother (s)
 - > Sister (s)
 - > Maternal Grandmother
 - > Maternal Grandfather
 - > Paternal Grandmother
 - > Paternal Grandfather

DISORDERS IN YOUR FAMILY

 - > Breast cancer
 - > Ovarian cancer
 - > Colon cancer
 - > Other cancer
 - > Diabetes
 - > Thyroid problems
 - > Heart disease
 - > Blood clots
 - > Obesity
 - > Psychiatric problems
 - > Tuberculosis
 - > Endometriosis
 - > Infertility
 - > Menopause before age 45
 - > Birth defects
 - > Cystic Fibrosis
 - > Tay-Sachs disease
 - > Canavan disease
 - > Bloom syndrome
 - > Gaucher disease
 - > Niemann-Pick disease
 - > Fanconi Anemia
 - > Familial Dysautonomia
 - > Muscular Dystrophy
 - > Neurologic (brain/spine)
 - > Neural Tube Defects
 - > Bone/Skeletal Defects
 - > Dwarfism
 - > Developmental delay
 - > Learning problems
 - > Polycystic kidney disease
 - > Heart defect from birth
 - > Down syndrome
 - > Other chromosome disorders
 - > Marfan syndrome
 - > Hemophilia
 - > Sickle Cell Anemia
 - > Thalassemia
 - > Galactosemia
 - > Deafness/Blindness
 - > Color Blindness
 - > Hemochromatosis
 - None of the above

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 Fibrosis: Yes No

Sickle Cell Anemia: Yes No

Tay-Sachs Disease: Yes No

Thalassemia: Yes No

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 _____) Hysterectomy surgery (date _____ /results _____)

Progesterone blood test (date _____/results _____) Prolactin blood test (date _____ /results _____)

| Prior Treatment (check all that apply) | # of cycles | Dates (mo/yr) (mo/yr) | Outcome |
|---|-------------|--------------------------|---------|
|---|-------------|--------------------------|---------|

Intrauterine insemination: _____ From _____ to _____ Pregnant Delivered Ectopic Miscarriage Not Pregnant

Intrauterine insemination: _____ From _____ to _____ Pregnant Delivered Ectopic Miscarriage Not Pregnant

| Prior Treatment (check all that apply) | # of cycles | Dates (mo/yr) (mo/yr) From To | Outcome |
|---|-------------|----------------------------------|--|
| <input type="checkbox"/> Intrauterine insemination: | | | <input type="checkbox"/> Pregnant <input type="checkbox"/> Delivered <input type="checkbox"/> Ectopic <input type="checkbox"/> Miscarriage <input type="checkbox"/> Not Pregnant |
| <input type="checkbox"/> Clomiphene citrate with timed intercourse: Maximum # tablets per day? | | | <input type="checkbox"/> Pregnant <input type="checkbox"/> Delivered <input type="checkbox"/> Ectopic <input type="checkbox"/> Miscarriage <input type="checkbox"/> Not Pregnant |
| <input type="checkbox"/> Clomiphene citrate with insemination: Maximum # tablets per day? | | | <input type="checkbox"/> Pregnant <input type="checkbox"/> Delivered <input type="checkbox"/> Ectopic <input type="checkbox"/> Miscarriage <input type="checkbox"/> Not Pregnant |
| <input type="checkbox"/> Daily fertility drug injections with insemination: Maximum # vials per day? | | | <input type="checkbox"/> Pregnant <input type="checkbox"/> Delivered <input type="checkbox"/> Ectopic <input type="checkbox"/> Miscarriage <input type="checkbox"/> Not Pregnant |
| <input type="checkbox"/> Completed in vitro fertilization cycle(s): | | | |
| 1. # eggs _____ # embryos transferred _____ # frozen _____ | | | <input type="checkbox"/> Pregnant <input type="checkbox"/> Delivered <input type="checkbox"/> Ectopic <input type="checkbox"/> Miscarriage <input type="checkbox"/> Not Pregnant |
| 2. # eggs _____ # embryos transferred _____ # frozen _____ | | | <input type="checkbox"/> Pregnant <input type="checkbox"/> Delivered <input type="checkbox"/> Ectopic <input type="checkbox"/> Miscarriage <input type="checkbox"/> Not Pregnant |
| 3. # eggs _____ # embryos transferred _____ # frozen _____ | | | <input type="checkbox"/> Pregnant <input type="checkbox"/> Delivered <input type="checkbox"/> Ectopic <input type="checkbox"/> Miscarriage <input type="checkbox"/> Not Pregnant |
| 4. # eggs _____ # embryos transferred _____ # frozen _____ | | | <input type="checkbox"/> Pregnant <input type="checkbox"/> Delivered <input type="checkbox"/> Ectopic <input type="checkbox"/> Miscarriage <input type="checkbox"/> Not Pregnant |
| <input type="checkbox"/> Frozen embryo transfers: | | | |
| 1. # embryos transferred _____ | | | <input type="checkbox"/> Pregnant <input type="checkbox"/> Delivered <input type="checkbox"/> Ectopic <input type="checkbox"/> Miscarriage <input type="checkbox"/> Not Pregnant |
| 2. # embryos transferred _____ | | | <input type="checkbox"/> Pregnant <input type="checkbox"/> Delivered <input type="checkbox"/> Ectopic <input type="checkbox"/> Miscarriage <input type="checkbox"/> Not Pregnant |
| 3. # embryos transferred _____ | | | <input type="checkbox"/> Pregnant <input type="checkbox"/> Delivered <input type="checkbox"/> Ectopic <input type="checkbox"/> Miscarriage <input type="checkbox"/> Not Pregnant |
| 4. # embryos transferred _____ | | | <input type="checkbox"/> Pregnant <input type="checkbox"/> Delivered <input type="checkbox"/> Ectopic <input type="checkbox"/> Miscarriage <input type="checkbox"/> Not Pregnant |
| Canceled in vitro fertilization attempt(s): | | | |
| Any other prior treatment (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 _____

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
- > 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 _____
- > 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 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? Yes No (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 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? No Yes
- > Did your mother take DES during pregnancy to prevent miscarriage? No Yes Don't Know
- > Have any of your immediate family members had difficulty conceiving a child? No Yes
- If yes, please describe _____

PHYSICIAN NOTES (FOR OFFICE USE ONLY) _____

DISORDERS IN YOUR FAMILY

- > Cystic Fibrosis
 - > Tay-Sachs disease
 - > Canavan disease
 - > Bloom syndrome
 - > Gaucher disease
 - > Niemann-Pick disease
 - > Fanconi Anemia
 - > Familial Dysautonia
 - > Muscular Dystrophy
 - > Neurologic (brain/spine)
 - > Neural Tube Defects
 - > Bone/Skeletal Defects
 - > Dwarfism
 - > Developmental delay
 - > Learning problems
 - > Polycystic kidney disease
 - > Heart defect from birth
 - > Down syndrome
 - > Other chromosome defects
 - > Marfan syndrome
 - > Hemophilia
 - > Sickle Cell Anemia
 - > Thalassemia
 - > Galactosemia
 - > Deafness/Blindness
 - > Color Blindness
 - > Hemochromatosis
- None of the above

Relationship to You

| | | |
|---|-----------------------------------|---|
| <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No _____ | <input type="checkbox"/> Don't Know _____ |
| <input type="checkbox"/> 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 Fibrosis: Yes No
- Sickle Cell Anemia: Yes No
- Tay-Sachs Disease: Yes No
- Thalassemia: Yes No

PATIENT'S SIGNATURE _____ Date _____

I confirm that I have reviewed the information above.

PYHSICIAN'S SIGNATURE _____ Date _____

PHYSICIAN NOTES (FOR OFFICE USE ONLY) _____

MALE PATIENT HISTORY

I. IDENTIFYING INFORMATION

Name _____ Partner's Name _____ Date _____

Address _____

Telephone Number - Day _____ Evening: _____

Date of Birth _____ Partner's Date of Birth _____ Duration of Relationship _____ Duration of Infertility _____

Insurance Company _____ Insurance ID# _____

II. TRAVEL/WORK AND GENERAL BACKGROUND

All present employment - title(s), location, brief description, number of years employed:

Are you or have you ever been exposed to any of the following during employment or military service:

- Heat Toxic Fumes Other (specify): _____
 Chemicals Nuclear Radiation _____

III. MEDICAL HISTORY YES NO

YES NO

Weight _____ Height _____ Blood Type (if known) _____

Have you lost greater than 20 pounds of weight in the last year? _____

Do you follow a particular food diet or have any special dietary habits? _____

If yes, specify: _____

List the forms and frequency of regular vigorous exercise (swimming, cycling, running) and the age you began:

Exercise: _____ Hrs/Week _____ Age _____ Exercise: _____ Hrs/Week _____ Age _____

Do you frequently take saunas or steam baths? _____

Have you ever had surgery in the pelvic area? _____

If yes, specify date and type of surgery: _____

Do you have or have you had (check all that apply):

- | | | |
|---|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Parasitic infection |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Gallbladder Problems | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Prostatitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Breast Milky Discharge | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Breast Soreness | <input type="checkbox"/> Herpes | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Breast Tenderness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Cancer? Specify _____ | <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> Testes infection |
| <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Testes Injury | <input type="checkbox"/> Chlamydia |
| <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Testes Tumor | <input type="checkbox"/> Chronic Bronchitis |
| <input type="checkbox"/> Measles: German | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Chronic Headaches |
| <input type="checkbox"/> Measles: Regular | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Colitis Mumps |
| <input type="checkbox"/> Nongonococcal Urethritis | <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Visual Disturbances |
| <input type="checkbox"/> Mumps with Testes Involved | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neurological Problems |
| <input type="checkbox"/> Any Allergies? List _____ | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Dizziness |

| | YES | NO |
|--|-----------------------|-----------------------|
| Have you ever been treated for cancer? | <input type="radio"/> | <input type="radio"/> |
| If yes, explain therapy: _____ | | |
| Within the last year, have you taken any prescription medications? | <input type="radio"/> | <input type="radio"/> |
| If yes, list all prescriptions and problems for which you were taking them: _____ | | |
| Are you taking any over-the-counter medications on a regular basis? | <input type="radio"/> | <input type="radio"/> |
| If yes, list all medications and diagnoses: _____ | | |
| Have you had a high fever (over 102°F) during the past 3-4 months? | <input type="radio"/> | <input type="radio"/> |
| Do you use or have you ever used (check all that apply): | | |
| <input type="checkbox"/> Alcohol - How many glasses per week do you usually drink? Wine _____ Beer _____ Cocktails _____ | | |
| <input type="checkbox"/> Cigarettes - Number of packs per day _____ | | |
| <input type="checkbox"/> Illicit or Recreational Drugs (Marijuana, Cocaine, etc.) If you would feel more comfortable not writing anything down, please | | |
| Discuss this directly with your physician. Specify: _____ | | |

| | YES | NO |
|--|-----------------------|-----------------------|
| IV. SEXUAL HISTORY YES NO | | |
| Are you circumcised? | <input type="radio"/> | <input type="radio"/> |
| When you were a child, were both testes descended into the scrotum? | <input type="radio"/> | <input type="radio"/> |
| At what age did you begin shaving regularly or start to grow a beard? _____ | | |
| How many times have you been married? _____ | | |
| Have you ever produced a child with another partner? | <input type="radio"/> | <input type="radio"/> |
| If yes, how long did it take to produce a child? _____ When was this (dates)? _____ | | |
| Have you ever tried to produce a child with another partner? | <input type="radio"/> | <input type="radio"/> |
| Do you have trouble getting an erection? | <input type="radio"/> | <input type="radio"/> |
| Maintaining an erection? | <input type="radio"/> | <input type="radio"/> |
| Do you have trouble with ejaculations? | <input type="radio"/> | <input type="radio"/> |
| If yes, <input type="checkbox"/> Premature ejaculations <input type="checkbox"/> Retrograde ejaculations | | |
| Do you feel that some of your ejaculate is deposited in the vagina? | <input type="radio"/> | <input type="radio"/> |
| Do you ever have orgasms without ejaculation during masturbation? | <input type="radio"/> | <input type="radio"/> |
| Do you have any discharge from the penis? | <input type="radio"/> | <input type="radio"/> |
| How many times per week do you and your partner now have intercourse? _____ | | |
| How many times do you have intercourse around ovulation? _____ | | |
| Have you noticed a change in your sexual drive recently? | <input type="radio"/> | <input type="radio"/> |
| V. FAMILY HISTORY YES NO | | |
| Is there a family history of infertility? | <input type="radio"/> | <input type="radio"/> |
| If yes, who (list all members and relationship to you): _____ | | |
| Is there a history of hormonal disorders in your family? | <input type="radio"/> | <input type="radio"/> |
| If yes, list who (relationship to you) and what type: _____ | | |

VI. HISTORY OF FERTILITY THERAPY

YES NO

Have you been treated for infertility before?

If yes, who was your physician?

What cause of infertility was diagnosed?

What drugs have you taken for infertility? Check all that apply:

- | | |
|---|--|
| <input type="checkbox"/> clomiphene citrate (Serophene®, Clomid®) | <input type="checkbox"/> hCG |
| <input type="checkbox"/> hMG | <input type="checkbox"/> fluoxymesterone (Halotestin®) |
| <input type="checkbox"/> tamoxifen | <input type="checkbox"/> GnRH or LHRH (Factrel®) |
| <input type="checkbox"/> testolactone | <input type="checkbox"/> FSH |
| <input type="checkbox"/> bromocriptine (Parlodel®) | <input type="checkbox"/> Other - Specify _____ |
| <input type="checkbox"/> testosterone or Male Hormone | <input type="checkbox"/> None |

Have you ever had varicocele repair?

If yes, when?

Have you ever had vasectomy reversal repair?

If yes, when?

Have you and your partner ever tried artificial insemination?

If yes: using your sperm? donor sperm?

Have you and your partner ever tried in vitro fertilization?

If yes, when and explain

Which of the following tests have you had performed? Check all that apply and the results, if known:

- | | |
|--|----------------------------|
| <input type="checkbox"/> Semen Analysis | When? _____ Results: _____ |
| <input type="checkbox"/> Chlamydia Test | When? _____ Results: _____ |
| <input type="checkbox"/> Mycoplasma Test | When? _____ Results: _____ |
| <input type="checkbox"/> Antibody Test | When? _____ Results: _____ |
| <input type="checkbox"/> Hamster Egg Test | When? _____ Results: _____ |
| <input type="checkbox"/> Chromosome Test | When? _____ Results: _____ |
| <input type="checkbox"/> Testicular Biopsy | When? _____ Results: _____ |
| <input type="checkbox"/> X-ray or Ultrasound of Testes | When? _____ Results: _____ |
| <input type="checkbox"/> Hormonal Tests (FSH, LH, prolactin, testosterone) | When? _____ Results: _____ |
| <input type="checkbox"/> Thyroid Tests | When? _____ Results: _____ |
| <input type="checkbox"/> Other - Specify _____ | When? _____ Results: _____ |

Is your partner currently seeing a doctor for evaluation of infertility?

If yes, specify physician name and location:

Does the doctor feel that your partner has an infertility problem?

If yes, what is the diagnosis and how is she being treated?

Has she ever had children with another man?

If yes, when?



Marwan M. Shaykh, M.D., F.A.C.O.G.

JACKSONVILLE

3627 University Blvd. South Suite 450.
Jacksonville, FL 32216
Ph 904.398.1473

ORLANDO

752 Stirling Center Place #1008
Lake Mary, FL 32746
Ph 407.493.7765

1.800.777.IVF1 • FAX 904.399.3436 • www.assistedfertility.org

REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient's Name _____

Address _____

City/State/Zip _____

Phone _____ Fax _____

I hereby request that my medical records be released to: **Marwan M. Shaykh, M.D., F.A.C.O.G.**

I understand these records contain information from other health care providers, as well as information which is administrative in nature. I specifically consent in the release of any information contained in the medical records which may relate to infection with Human Immunodeficiency Virus (HIV), AIDS or related conditions.

Patient Name: _____

Date of Birth _____ Social Security Number _____

Patient Signature _____ Date _____

Please send the following information:

- > All semen analyses
- > Hysterosalpingogram (HSG) reports
- > Reports of other hormonal assays, such as testosterone, prolactin, LH, FSH, TSH, T4, etc. and report of Rubella titer ,varicella titer,Infection and genetic screening
- > Reports of endometrial biopsies and serum progesterone
- > Any operative reports, including major surgery and laparoscopy, and prior ultrasound or genetic study reports
- > Pap smear reports, Chlamydia and Gonorrhea reports
- > Any other pertinent reports related to infertility, including notes on IVF OR **Tubal Ligation Operative Report**

Thank you for your assistance.