ASSISTED
FERTILITY
PROGRAM

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

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

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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.

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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 your 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.

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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.

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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: ○ Female ○ Male Email _____

Cell Phone _____ Home Phone _____

Address _____

City _____ State: _____ Zip _____

Employer _____ Occupation _____

Employer Phone _____

Primary Care Physician _____ Primary Phone _____

Pharmacy Phone _____ Referred By _____

○ Partner ○ Spouse _____

Social Security # _____ Date of Birth _____

Sex: ○ Female ○ 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 _____

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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 _____

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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 _____

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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 _____

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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 _____

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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) _____

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 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?
1.					☐ No ☐ Yes
2.					☐ No ☐ Yes
3.					☐ No ☐ Yes
4.					☐ No ☐ Yes
5.					☐ No ☐ Yes
6.					☐ No ☐ 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? ☐ Foam or jelly
☐ Tubal sterilization procedure (tubes tied) – date (month/year) Tubes untied – date (month/year)

- Did your mother take DES when she was pregnant with you? ☐ Yes ☐ No ☐ Don't know

SEXUAL HISTORY

- How many times do you have intercourse per week? times per week ☐ None ☐ Not applicable
- Have you used over-the-counter ovulation kits to time intercourse? ☐ Yes ☐ No
- Do you have pain with intercourse? ☐ Yes ☐ No
- Do you use lubricants (K-Y Jelly®, etc) during intercourse? ☐ Yes-what types? _____ ☐ No
- 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

	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	_____

DISORDERS IN YOUR FAMILY

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

☐ None of the above

☐ Other (Specify _____)

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 _____) ☐ Hysteroscopy 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)		**Outcome**
		From	To	
☐ Intrauterine insemination:				☐ Pregnant ☐ Delivered ☐ Ectopic ☐ Miscarriage ☐ Not Pregnant
☐ Clomiphene citrate with timed intercourse: Maximum # tablets per day?_____				☐ Pregnant ☐ Delivered ☐ Ectopic ☐ Miscarriage ☐ Not Pregnant
☐ Clomiphene citrate with insemination: Maximum # tablets per day?_____				☐ Pregnant ☐ Delivered ☐ Ectopic ☐ Miscarriage ☐ Not Pregnant
☐ Daily fertility drug injections with insemination: Maximum # vials per day?_____				☐ Pregnant ☐ Delivered ☐ Ectopic ☐ Miscarriage ☐ Not Pregnant
☐ Completed in vitro fertilization cycle(s):				
1. # eggs_____ # embryos transferred_____ # frozen_____				☐ Pregnant ☐ Delivered ☐ Ectopic ☐ Miscarriage ☐ Not Pregnant
2. # eggs_____ # embryos transferred_____ # frozen_____				☐ Pregnant ☐ Delivered ☐ Ectopic ☐ Miscarriage ☐ Not Pregnant
3. # eggs_____ # embryos transferred_____ # frozen_____				☐ Pregnant ☐ Delivered ☐ Ectopic ☐ Miscarriage ☐ Not Pregnant
4. # eggs_____ # embryos transferred_____ # frozen_____				☐ Pregnant ☐ Delivered ☐ Ectopic ☐ Miscarriage ☐ Not Pregnant
☐ Frozen embryo transfers:				
1. # embryos transferred_____				☐ Pregnant ☐ Delivered ☐ Ectopic ☐ Miscarriage ☐ Not Pregnant
2. # embryos transferred_____				☐ Pregnant ☐ Delivered ☐ Ectopic ☐ Miscarriage ☐ Not Pregnant
3. # embryos transferred_____				☐ Pregnant ☐ Delivered ☐ Ectopic ☐ Miscarriage ☐ Not Pregnant
4. # embryos transferred_____				☐ Pregnant ☐ Delivered ☐ Ectopic ☐ Miscarriage ☐ 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

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

☐ None of the above ☐ Other (Specify _____)

What is 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.

PHYSICIAN'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):

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

	YES	NO
Have you ever been treated for cancer?	○	○

If yes, explain therapy: _____

Within the last year, have you taken any prescription medications?	○	○

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?	○	○

If yes, list all medications and diagnoses: _____

_____

Have you had a high fever (over 102°F) during the past 3-4 months?	○	○

Do you use or have you ever used (check all that apply):

☐ Alcohol – How many glasses per week do you usually drink? Wine _____ Beer _____ Cocktails _____

☐ Cigarettes – Number of packs per day _____

☐ 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: _____

_____

IV. SEXUAL HISTORY YES NO

	YES	NO
Are you circumcised?	○	○
When you were a child, were both testes descended into the scrotum?	○	○

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?	○	○

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?	○	○
Do you have trouble getting an erection?	○	○
Maintaining an erection?	○	○
Do you have trouble with ejaculations?	○	○

If yes, ☐ Premature ejaculations ☐ Retrograde ejaculations

Do you feel that some of your ejaculate is deposited in the vagina?	○	○
Do you ever have orgasms without ejaculation during masturbation?	○	○
Do you have any discharge from the penis?	○	○

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?	○	○

V. FAMILY HISTORY YES NO

	YES	NO
Is there a family history of infertility?	○	○

If yes, who (list all members and relationship to you): _____

_____

Is there a history of hormonal disorders in your family?	○	○

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:

- ☐ clomiphene citrate (Serophene®, Clomid®)
- ☐ hMG
- ☐ tamoxifen
- ☐ testolactone
- ☐ bromocriptine (Parlodel®)
- ☐ testosterone or Male Hormone
- ☐ hCG
- ☐ fluoxymesterone (Halotestin®)
- ☐ GnRH or LHRH (Factrel®)
- ☐ FSH
- ☐ Other – Specify _____
- ☐ 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:

- ☐ Semen Analysis When? _____ Results: _____
- ☐ Chlamydia Test When? _____ Results: _____
- ☐ Mycoplasma Test When? _____ Results: _____
- ☐ Antibody Test When? _____ Results: _____
- ☐ Hamster Egg Test When? _____ Results: _____
- ☐ Chromosome Test When? _____ Results: _____
- ☐ Testicular Biopsy When? _____ Results: _____
- ☐ X-ray or Ultrasound of Testes When? _____ Results: _____
- ☐ Hormonal Tests (FSH, LH, prolactin, testosterone) When? _____ Results: _____
- ☐ Thyroid Tests When? _____ Results: _____
- ☐ 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? _____

ASSISTED
FERTILITY
PROGRAM

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.