



WELCOME

Dear Patient,

Thank you again for choosing Shady Grove Fertility.

This packet contains the paperwork necessary for your initial appointment. In order to make your initial consultation the most productive, and to provide for a comprehensive review of your personal and family medical history, we require that you bring the following completed forms with you to your initial consultation.

Please find and complete the following (as applicable):

- Female Questionnaire*
- Male Questionnaire*
- Patient Registration Form
- Genetic Family History and Questionnaire
- Email Authorization Form

*Please fill out the appropriate male/female questionnaire(s) for each partner. Disregard any extra or non-applicable copies.

We look forward to seeing you!

Shady Grove Fertility



shady grove fertility

QUESTIONNAIRE FOR FEMALES

Name: _____

Email: _____

Date of Birth: _____

Age: _____

Referred by: _____

Please indicate the reason for your visit:

- Infertility (trouble getting pregnant)
- Recurrent miscarriages
- Interested in conceiving using donor sperm
- Egg or embryo freezing (fertility preservation)
- Other _____

SECTION 1 [SKIP ANY QUESTIONS THAT ARE NOT APPLICABLE]

MENSTRUAL AND GYNECOLOGIC HISTORY

Age at first period _____	With your period, do you experience: <input type="checkbox"/> Very heavy periods <input type="checkbox"/> Significant pain or cramps <input type="checkbox"/> Other symptoms: _____
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Are your periods:

Regular [if yes, answer questions below]

How often do your periods come? (# of days from 1st day of 1 period to the 1st day of the next period) _____
 For how many days do you bleed? _____

Irregular [if yes, answer questions below]

Over the last year:

How many periods have you had? _____

How close have 2 periods come together? _____

How far apart have 2 periods been? _____

Do you have?

Extra hair growth on your face or body

Significant acne

Breast discharge

Changes in your weight

<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">When was your last:</th> <th style="width: 20%;">Date:</th> <th style="width: 50%;">Result:</th> </tr> </thead> <tbody> <tr> <td>Pap smear</td> <td></td> <td></td> </tr> <tr> <td>Gynecologic exam</td> <td></td> <td></td> </tr> <tr> <td>Mammogram</td> <td></td> <td></td> </tr> </tbody> </table> <p>Have you ever had an abnormal Pap smear? <input type="checkbox"/> No <input type="checkbox"/> Yes, please explain follow up and treatment: _____</p> <p>Have you had any of the following? [check all that apply] List dates of treatment. <input type="checkbox"/> Gonorrhea _____ <input type="checkbox"/> Chlamydia _____ <input type="checkbox"/> Pelvic inflammatory disease (PID) _____ <input type="checkbox"/> Other sexually transmitted infections _____</p>	When was your last:	Date:	Result:	Pap smear			Gynecologic exam			Mammogram			<p>In your current relationship, have you used contraception? [check all that apply] Approximate dates? <input type="checkbox"/> Oral contraceptive pills, vaginal ring, patch _____ <input type="checkbox"/> Intrauterine device (IUD) _____ <input type="checkbox"/> Contraceptive implant _____ <input type="checkbox"/> Injection _____ <input type="checkbox"/> Condoms _____ <input type="checkbox"/> Tubal ligation _____ <input type="checkbox"/> Vasectomy _____ <input type="checkbox"/> Natural family planning _____ <input type="checkbox"/> Withdrawal _____ <input type="checkbox"/> Other: _____</p>
When was your last:	Date:	Result:											
Pap smear													
Gynecologic exam													
Mammogram													

Do you track your menstrual cycles? Please write any pertinent information:

- No
- Calendar/app _____
- Ovulation predictor kits _____
- Basal body temperature _____
- Other _____

How long have you been having unprotected intercourse? _____

How often do you have unprotected intercourse? _____

Do you have pain with intercourse? Please explain. _____

FERTILITY TESTING AND TREATMENT

Testing completed and results:

- None
- FSH _____
- LH _____
- Estradiol _____
- Anti-Müllerian hormone (AMH) _____
- TSH _____
- Pelvic ultrasound/follicle count _____
- Hysterosalpingogram (HSG) _____
- Saline sonogram _____
- Hysteroscopy _____
- Laparoscopy _____
- Other _____

Have you undergone any type of fertility treatment?

Treatment type	# of cycles and outcome
Oral medication (clomiphene / letrozole)	
Injectable medication	
Intrauterine insemination (IUI)	
In vitro fertilization (IVF)	

<p>Are you:</p> <ul style="list-style-type: none"> <input type="checkbox"/> In a heterosexual relationship <input type="checkbox"/> In a same sex relationship <input type="checkbox"/> Single <input type="checkbox"/> Other _____ 	<p>Do you plan to use:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Partner's sperm <input type="checkbox"/> Anonymous sperm donor (sperm bank) <input type="checkbox"/> Known sperm donor <input type="checkbox"/> Unsure <input type="checkbox"/> Not applicable
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MEDICATIONS AND ALLERGIES

<p>List all current prescription and over-the-counter medications, vitamins, and supplements:</p> 	<p>List medication allergies:</p> <p>List non-medical allergies:</p> <p>Are you allergic to latex?</p>
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OBSTETRIC HISTORY

If you have been pregnant, please fill out chart below:

Year	Length of time to conceive	Fertility treatment used to conceive? Type of treatment?	Pregnancy outcome <ul style="list-style-type: none"> • Miscarriage • Termination • Ectopic pregnancy • Preterm birth • Term birth 	Describe complications, if any

MEDICAL HISTORY

Describe any current medical problems:

Describe any previous medical problems:

SURGICAL HISTORY

Have you had any surgeries? Please list below with dates:

SOCIAL HISTORY

Occupation: _____
Race/Ethnicity: _____

<p>Do you use tobacco or nicotine products?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Cigarettes How many per day? _____</p> <p><input type="checkbox"/> Chew How often? _____</p> <p><input type="checkbox"/> E-cigarette/nicotine vaporizer ("Vape") How many per day? _____</p>	<p>Do you consume alcohol?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Number of drinks each week _____</p> <p>Do you use any recreational drugs?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes Type and frequency: _____</p>
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Do you exercise regularly? Please describe exercise type, frequency and duration: _____

Is your weight:

- stable
- increasing
- decreasing

FAMILY HISTORY: Please list any medical issues for the following family members:

Father: _____

Mother: _____

Siblings: _____

<p>Do you have a family history of:</p> <p><input type="checkbox"/> Birth defects: _____</p> <p><input type="checkbox"/> Cognitive impairments: _____</p> <p><input type="checkbox"/> Menopause prior to age 40: _____</p>	<p><input type="checkbox"/> Genetic diseases: _____</p> <p><input type="checkbox"/> Other: _____</p>
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Is there anything else you would like to discuss with your doctor?



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Email: _____

Date of Birth: _____

Age: _____

Referred by: _____

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MEDICAL HISTORY

Describe any current medical problems:

Describe any previous medical problems:

SURGICAL HISTORY

Have you had any surgeries? Please list below with dates:

SOCIAL HISTORY

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Race/Ethnicity: _____

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--	---

Do you exercise regularly? Please describe exercise type, frequency and duration: _____

Is your weight:

stable

increasing

decreasing

FAMILY HISTORY: Please list any medical issues for the following family members:

Father: _____

Mother: _____

Siblings: _____

Do you have a family history of: <input type="checkbox"/> Birth defects: _____ <input type="checkbox"/> Cognitive impairments: _____ <input type="checkbox"/> Menopause prior to age 40: _____	<input type="checkbox"/> Genetic diseases: _____ <input type="checkbox"/> Other: _____
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Is there anything else you would like to discuss with your doctor?

QUESTIONNAIRE FOR MALES

Name: _____

Email: _____

Date of Birth: _____

Age: _____

Cell Phone #: _____

Referred by: _____

Reason for visit:

- Fertility consult with female partner
- Fertility consult with same sex partner
- Vasectomy consultation
- Sexual function concerns

Partner name: _____

FERTILITY/ UROLOGIC HISTORY

How long have you been having unprotected intercourse? _____

Have you ever conceived in your current relationship?

- Yes; outcome: _____
- No

Have you ever conceived in another relationship?

- Yes; outcome: _____
- No

Do you have any issues with erection, ejaculation, or sex drive? If so, please explain:

Have you ever had testing and/or treatment by a urologist or endocrinologist (as a child, adolescent, or adult)? If so, please explain: _____

Have you ever used or are you currently on testosterone replacement or using anabolic steroids?

- Yes (current use)
- Prior use
- No

Have you had a semen analysis?

- No
- Yes

Result of prior semen analysis:

Volume (milliliters or cc): _____

Concentration (million sperm per milliliter or cc of semen): _____

Motility (%): _____

Morphology (%): _____

MEDICAL HISTORY

Describe any current medical problems:

Describe any previous medical problems:

SURGICAL HISTORY

Have you had any surgeries? Please list below with dates:

MEDICATIONS AND ALLERGIES

List all current prescription and over-the-counter medications, vitamins, and supplements:	List medication allergies: List non-medical allergies: Are you allergic to latex?
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SOCIAL HISTORY

Occupation: _____

Race/Ethnicity: _____

Do you use tobacco or nicotine products? <input type="checkbox"/> No <input type="checkbox"/> Cigarettes How many per day? _____ <input type="checkbox"/> Chew How often? _____ <input type="checkbox"/> E-cigarette/nicotine vaporizer ("Vape") How many per day? _____	Do you consume alcohol? <input type="checkbox"/> No <input type="checkbox"/> Number of drinks each week _____ Do you use any recreational drugs? <input type="checkbox"/> No <input type="checkbox"/> Yes Type and frequency: _____
---	--

FAMILY HISTORY

Please list any medical issues for the following members:

Father: _____

Does your father have a history of prostate cancer?

Mother: _____

Siblings: _____

Do you have a family history of: <input type="checkbox"/> Birth defects: _____ <input type="checkbox"/> Cognitive impairments: _____	<input type="checkbox"/> Genetic diseases: _____ <input type="checkbox"/> Other: _____
---	---

Is there anything else you would like to discuss with your doctor?

QUESTIONNAIRE FOR MALES

Name: _____

Email: _____

Date of Birth: _____

Age: _____

Cell Phone #: _____

Referred by: _____

Reason for visit:

- Fertility consult with female partner
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- Vasectomy consultation
- Sexual function concerns

Partner name: _____

FERTILITY/ UROLOGIC HISTORY

How long have you been having unprotected intercourse? _____

Have you ever conceived in your current relationship?

- Yes; outcome: _____
- No

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- Yes; outcome: _____
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Have you ever used or are you currently on testosterone replacement or using anabolic steroids?

- Yes (current use)
- Prior use
- No

Have you had a semen analysis?

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- Yes

Result of prior semen analysis:

Volume (milliliters or cc): _____

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MEDICAL HISTORY

Describe any current medical problems:

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Have you had any surgeries? Please list below with dates:

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---	---

Is there anything else you would like to discuss with your doctor?



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WHO REFERRED YOU/HOW DID YOU HEAR ABOUT US? (please check all that apply)

- Physician*** **Other Patient**
 Friend/Relative **Resolve/AIA**
 Internet/Web Site **Radio** _____
 Insurance Directory **Other** _____

***Physician Name:** _____
Street Address: _____
City: _____ **Phone:** _____
Specialty: _____

PATIENT

SOCIAL SECURITY NO:		PATIENT ID NO:	
LEGAL NAME (LAST, FIRST, MIDDLE INITIAL)			
ADDRESS			
CITY/STATE/ZIP			
HOME PHONE		WORK PHONE	
CELL PHONE		DATE OF BIRTH	AGE
SINGLE	MARRIED	MARRIAGE DATE	
IS IT OK TO CONTACT YOU BY E:MAIL? E:MAIL ADDRESS: _____			

PARTNER

SOCIAL SECURITY NO:		PATIENT ID NO:	
LEGAL NAME (LAST, FIRST, MIDDLE INITIAL)			
ADDRESS (IF DIFFERENT FROM FEMALE PATIENT)			
CITY/STATE/ZIP			
HOME PHONE		WORK PHONE	
CELL PHONE		DATE OF BIRTH	AGE
SINGLE	MARRIED	MARRIAGE DATE	
IS IT OK TO CONTACT YOU BY E:MAIL? E:MAIL ADDRESS: _____			

Patient's Employment

COMPANY NAME		OCCUPATION	
ADDRESS			
CITY/STATE/ZIP			

Partner's Employment

COMPANY NAME		OCCUPATION	
ADDRESS			
CITY/STATE/ZIP			

Patient's Primary Insurance

INSURANCE COMPANY NAME	
POLICY HOLDER NAME	RELATIONSHIP TO POLICY HOLDER
POLICY #	GROUP #

Partner's Primary Insurance

INSURANCE COMPANY NAME	
POLICY HOLDER NAME	RELATIONSHIP TO POLICY HOLDER
POLICY #	GROUP #

Patient's Secondary Insurance

INSURANCE COMPANY NAME	
POLICY HOLDER NAME	
POLICY #	GROUP #

Partner's Secondary Insurance

INSURANCE COMPANY NAME	
POLICY HOLDER NAME	
POLICY #	GROUP #

Emergency Contact

NAME	DAY PHONE	NIGHT PHONE	RELATIONSHIP
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I authorize the release of any medical information necessary to process a claim to the above named insurance carrier(s). I hereby assign my medical benefits to, and direct that payments be made to my Shady Grove Fertility physician. I/we have disclosed all insurance policies including insurance policies that Shady Grove Fertility is a non-participating provider. I/we understand that if we choose not to disclose all insurance policies, we waive our insurance coverage and will be financially responsible to pay for all services.

Signature: _____ Date: _____

Partner's Signature: _____ Date: _____



Genetic Family History & Questionnaire

Date of Appointment _____

Section 1. Patient Information

Name _____ Date of Birth _____
 Address _____ City _____ State _____ Zip _____
 Home phone _____ Work phone _____ Cell phone _____

Section 2. Partner Information

Name _____ Date of Birth _____

The following questions will help us to determine if genetic counseling is advised and if certain tests are appropriate. If you are unsure about your family history, please speak with family members.

Section 3. What is your ethnic background?

Please check all that apply

Patient | Partner

- Chinese, Taiwanese, Asian Indian, Pakistani, Filipino or Southeast Asian
- Italian, Greek, Middle Eastern, Spanish or Portuguese
- Jewish
- French Canadian or Cajun
- African American, African descent, Black
- Latin American, Central American, Puerto Rican, Caribbean, Hispanic or Mexican
- Caucasian
- Other (specify)

Check if:

- You and/or your partner had carrier testing for cystic fibrosis?
- You and/or your partner had carrier testing for Jewish associated genetic diseases?
- You and/or your partner had carrier testing for spinal muscular atrophy?

Section 4. Have you, your partner or anyone in your families ever had the following conditions:

- | | |
|--|---|
| <input type="checkbox"/> Down syndrome | <input type="checkbox"/> polycystic kidney disease |
| <input type="checkbox"/> other chromosome problem | <input type="checkbox"/> Huntington disease |
| <input type="checkbox"/> mental retardation | <input type="checkbox"/> heart defect at birth |
| <input type="checkbox"/> spina bifida (open spine) | <input type="checkbox"/> cleft lip/cleft palate |
| <input type="checkbox"/> anencephaly (opening in head/brain) | <input type="checkbox"/> blindness / deafness |
| <input type="checkbox"/> blood disorder, such as hemophilia, thalassemia | <input type="checkbox"/> fragile X syndrome |
| <input type="checkbox"/> muscular dystrophy or neuromuscular disease | <input type="checkbox"/> autism or autistic-like syndrome |
| <input type="checkbox"/> cystic fibrosis | <input type="checkbox"/> baby who died after birth or within first year |
| <input type="checkbox"/> neurofibromatosis | <input type="checkbox"/> stillborn baby |
| <input type="checkbox"/> skeletal disorder, like dwarfism | <input type="checkbox"/> any birth defect not listed above |
| <input type="checkbox"/> sickle cell anemia | <input type="checkbox"/> any other inherited (genetic) condition |
| <input type="checkbox"/> Tay-Sachs disease | <input type="checkbox"/> other serious medical condition or surgery |
| <input type="checkbox"/> Are you or your partner related to each other - other than by marriage? (blood relatives) | |

Patient's signature _____ Date _____

Section 5. Physician to Complete:

I have reviewed genetic screening information with the patient and the following has been decided:

- Patient/partner to complete genetic screening
- Patient/partner previously completed genetic screening
- Patient/partner declined genetic screening
- Patient/partner would like additional information about genetic screening prior to making a decision:
 ___ Financial ___ Clinical
- Patient/partner referred for genetic counseling

Physician's Signature _____



EMAIL AUTHORIZATION

Patient MPI# _____

Partner MPI#: _____

The physicians and staff of Shady Grove Fertility (SGF) offer patients the opportunity to communicate electronically using secure messaging for general questions or concerns. In order to use secure messaging, we require an email address. Although secure messaging will be used for communication, there may be times when it is necessary to send an email. Because your privacy and security are some of our primary concerns, e-mail has certain risks that patients should consider before giving consent. These risks include but are not limited to:

- 1) E-mail can be circulated, forwarded and stored in numerous paper and electronic files.
- 2) E-mail can occasionally be broadcast to both intended and unintended recipients.
- 3) E-mail senders can misaddress e-mail.
- 4) E-mail can be more easily falsified than handwritten or signed documents.
- 5) Backup copies of e-mail may exist, even after the sender or the recipient has deleted his or her copy.
- 6) E-mail can be altered, forwarded or used without authorization or detection.
- 7) E-mail can be used to introduce viruses into computer systems.

The physicians and staff of SGF will use reasonable means to protect security and confidentiality of e-mail information sent and received. Because of the risks outlined above, however, we cannot guarantee the security and confidentiality of e-mail communication and therefore you should not ever include your social security number or date of birth in any e-mail communications to us.

In addition, *secure messaging should never be used to communicate acute and/or urgent clinical problems* such as pain or abnormal bleeding. Our physicians and staff always try to respond to secure messages in a timely fashion, but for any clinical problems, you should follow proper guidelines by calling our office or the answering service after hours. In a medical emergency, call 911.

Please be advised that while it is not mandatory to provide an email address, we will not be able to communicate via secure messaging without an email address on file.

By signing below, I/we authorize SGF to communicate with me/us by email in regards to my/our medical care and associated charges. I/We also agree to promptly notify SGF of change in my/our email address.

Patient's printed name

Patient's signature

Date

Patient's email address (please print very clearly)

Partner's printed name (if applicable)

Partner's signature

Date

Partner's email address (please print very clearly)