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.

We look forward to seeing you!

Shady Grove Fertility

QUESTIONNAIRE FOR FEMALES

Name: ____________________ **Email:** ____________________

Date of Birth: ____________________ **Age:** __________

Referred by: ____________________

OB/Gyn Name and Phone #: ____________________ **PCP Name and Phone #:** ____________________

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____________________

Partner name: ____________________

Marriage date (if applicable): ____________________

SECTION 1 [SKIP ANY QUESTIONS THAT ARE NOT APPLICABLE]

MENSTRUAL AND GYNECOLOGIC HISTORY

Age at first period__________

1st day of last period: __________

With your period, do you experience:

[ ] Very heavy periods

[ ] Significant pain or cramps

[ ] Other symptoms: ____________________

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

When was your last:	Date:	Result:
Pap smear		
Gynecologic exam		
Mammogram		

Have you ever had an abnormal Pap smear?

[ ] No

[ ] Yes, please explain follow up and treatment:

____

Have you had any of the following? [check all that apply] List dates of treatment.

[ ] Gonorrhea __________

[ ] Chlamydia __________

[ ] Pelvic inflammatory disease (PID) __________

[ ] Other sexually transmitted infections __________

In your current relationship, have you used contraception? [check all that apply]

Approximate dates?

[ ] Oral contraceptive pills, vaginal ring, patch __________

[ ] Intrauterine device (IUD) __________

[ ] Contraceptive implant __________

[ ] Injection __________

[ ] Condoms __________

[ ] Tubal ligation __________

[ ] Vasectomy __________

[ ] Natural family planning __________

[ ] Withdrawal __________

[ ] Other: __________

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)	

Are you:	**Do you plan to use:**
[ ] In a heterosexual relationship [ ] In a same sex relationship [ ] Single [ ] Other_______________	[ ] Partner's sperm [ ] Anonymous sperm donor (sperm bank) [ ] Known sperm donor [ ] Unsure [ ] Not applicable

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?**

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

Year	Length of time to conceive	Conceived with current partner?	Fertility treatment used to conceive? Type of treatment?	Pregnancy outcome • Miscarriage • Termination • Ectopic pregnancy • Preterm birth • Term birth	Describe complications

MEDICAL HISTORY
Height: __________ Weight: __________
Please check any medical problems that you have currently or have had in the past:

[ ] high blood pressure
[ ] diabetes
[ ] thyroid problems
[ ] asthma
[ ] depression
[ ] anxiety
[ ] seizures
[ ] blood clots (DVT or PE)
[ ] cancer

Describe any other medical problems:
____
____

Describe any previous medical problems and hospitalizations:
____
____
____

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

SOCIAL HISTORY
Occupation: ____
Race/Ethnicity: ____

Do you use tobacco or nicotine products? [ ] No [ ] Cigarettes | How many per day? ______ [ ] Chew | How often? ________________ [ ] E-cigarette/nicotine vaporizer (“Vape”) | How many per day? ______	**Do you consume alcohol?** [ ] No [ ] Number of drinks each week _______ **Do you use any recreational drugs?** [ ] No [ ] Yes | Type and frequency: __________

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

Is your weight: [ ] stable [ ] increasing [ ] decreasing

Do you consume caffeine? Describe your intake: ____

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

Father: ____

Mother: ____

Siblings: ____

____

____

Do you have a family history of: [ ] Birth defects: ______________________________ [ ] Cognitive impairments:________________________ [ ] Menopause prior to age 40: ____________________	 [ ] Genetic diseases: ___________________________ [ ] Blood clots (DVT or PE): ______________________ [ ] 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
[ ] Fertility consult with same sex partner
[ ] Vasectomy consultation
[ ] Sexual function concerns

Partner name: ________________________________
Marriage date (if applicable): ____________________

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 (milliter): ______
Concentration (million sperm per milliliter of semen): ______
Motility (%): ______
Morphology %): ______

MEDICAL HISTORY

Height: __________ Weight: __________

Please check any medical problems that you have currently or have had in the past:

[ ] high blood pressure
[ ] diabetes
[ ] thyroid problems
[ ] asthma
[ ] depression
[ ] anxiety
[ ] seizures
[ ] blood clots (DVT or PE)
[ ] cancer

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?**

SOCIAL HISTORY

Occupation: ____

Race/Ethnicity: ____

Do you use tobacco or nicotine products?	**Do you consume alcohol?**
[ ] No [ ] Cigarettes | How many per day? ______ [ ] Chew | How often? ________________ [ ] E-cigarette/nicotine vaporizer (“Vape”) | How many per day? ______	[ ] No [ ] Number of drinks each week _______ **Do you use any recreational drugs?** [ ] No [ ] 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: [ ] Birth defects: ____________________________ [ ] Cognitive impairments: ________________________	 [ ] Genetic diseases: ____________________________ [ ] Other: ______________________

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

____

____

____

____

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

☐ Physician*	☐ Other Patient	*Physician Name: ____________
☐ Friend/Relative	☐ Resolve/AIA	Street Address: ____________
☐ Internet/Web Site	☐ Radio ________	City: ________ Phone: ________
☐ Insurance Directory	☐ Other ________	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

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
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
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?

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:

- ☐ Down syndrome
- ☐ other chromosome problem
- ☐ mental retardation
- ☐ spina bifida (open spine)
- ☐ anencephaly (opening in head/brain)
- ☐ blood disorder, such as hemophilia, thalassemia
- ☐ muscular dystrophy or neuromuscular disease
- ☐ cystic fibrosis
- ☐ neurofibromatosis
- ☐ skeletal disorder, like dwarfism
- ☐ sickle cell anemia
- ☐ Tay-Sachs disease
- ☐ polycystic kidney disease
- ☐ Huntington disease
- ☐ heart defect at birth
- ☐ cleft lip/cleft palate
- ☐ blindness / deafness
- ☐ fragile X syndrome
- ☐ autism or autistic-like syndrome
- ☐ baby who died after birth or within first year
- ☐ stillborn baby
- ☐ any birth defect not listed above
- ☐ any other inherited (genetic) condition
- ☐ other serious medical condition or surgery
- ☐ 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

Patient/partner referred for genetic counseling

Physician's Signature ______________________
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 dress, 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)