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
- Email Authorization Form

*Please fill out the appropriate male/female questionnaire(s) for each partner.

We look forward to seeing you!

Shady Grove Fertility

Date Completed: ___

FEMALE QUESTIONNAIRE

Name: ___ **Date of Birth:** ___
Phone: ☐ Cell ☐ Home ☐ Work ___ **Email:** ___
Height: ___ **Weight:** ___
Occupation: ___ **Referred By:** ___
Partner Name: ___ **Date of Marriage** (if applicable)**:** ___
OB/GYN Name and Phone: ___
Primary Care Provider Name and Phone: ___

Please indicate the reason for your visit:

- ☐ Infertility (difficulty getting pregnant)
- ☐ Interested in conceiving using sperm donor
- ☐ Other: ___
- ☐ Recurrent miscarriage
- ☐ Fertility Preservation (egg or embryo freezing)

MENSTRUAL AND GYNECOLOGIC HISTORY

Age at first period: ___ ***First day of last period:*** ___

Are your periods regular or irregular?

☐ Regular

How often do your periods come? ___
(Number of days between start of one menses to start of next menses)

How many days do you bleed? ___

☐ Irregular

In the last year:
How many periods have you had? ___
How close have two periods been? ___
How far apart have two periods been? ___

Do you have?
- ☐ Extra hair growth on face or body
- ☐ Significant acne
- ☐ Breast discharge
- ☐ Changes in weight

When was your last:

Gynecologic Exam	Date: ___	Result: ___
Mammogram	Date: ___	Result: ___
Pap smear	Date: ___	Result: ___

With your period, do you experience any of the following?
- ☐ Very heavy periods
- ☐ Significant pain or cramping
- ☐ Other symptoms:

Have you ever had an abnormal Pap smear?
- ☐ No
- ☐ Yes - Please explain follow up and treatment:

Have you had any sexually transmitted infections (STIs)? If so, please provide date(s) of treatment.
- ☐ Gonorrhea: ___
- ☐ Chlamydia: ___
- ☐ Pelvic inflammatory disease (PID): ___
- ☐ Other STIs: ___

Do you track your menstrual cycles? Select all tracking methods used below:
- ☐ No tracking method used
- ☐ Ovulation predictor kit(s)
- ☐ Other: ___
- ☐ Calendar or App: ___
- ☐ Basal body temperature

Have you ever used contraception? Select all applicable and approximate date(s) of use.

- ☐ Birth control pills, vaginal ring, patch: ____________
- ☐ Contraceptive implant: ____________
- ☐ Condoms: ____________
- ☐ Vasectomy: ____________
- ☐ Withdrawal: ____________
- ☐ Intrauterine device (IUD): ____________
- ☐ Injection: ____________
- ☐ Tubal ligation: ____________
- ☐ Natural family planning: ____________
- ☐ Other: ____________

How long have you been having unprotected intercourse?

How often do you have unprotected intercourse?

Do you have pain with intercourse? If so, please explain:

FERTILITY TESTING AND TREATMENT

Please note prior fertility testing completed and results:

- ☐ Follicle Stimulating Hormone (FSH) ____________
- ☐ Luteinizing Hormone (LH) ____________
- ☐ Estradiol (E2) ____________
- ☐ Anti-Müllerian Hormone (AMH) ____________
- ☐ Thyroid Stimulating Hormone (TSH) ____________
- ☐ Pelvic ultrasound/Follicle count ____________
- ☐ Hysterosalpingogram (HSG) ____________
- ☐ Saline sonogram ____________
- ☐ Hysteroscopy ____________
- ☐ Laparoscopy ____________
- ☐ Other ____________

Have you undergone any fertility treatment in the past? If so, please provide treatment information below.

Type	*Number of Cycles*	*Dates of Treatment*	*Cycle Outcome*
Oral Medication (Clomiphene or Letrozole)			
Injectable Medication			
Intrauterine Insemination (IUI)			
In-Vitro Fertilization (IVF)			

OBSTETRIC HISTORY

If you have been pregnant, please complete the chart below:

Year	*Length of time to conceive*	*Was fertility treatment used to conceive? If so, what type of treatment?*	*Pregnancy Outcome* (Miscarriage, Termination, Ectopic pregnancy, Preterm birth, Term birth)	*Describe complications* (If applicable)

MEDICAL AND SURGICAL HISTORY

List all medication allergies:

Are you allergic to latex? ☐ No ☐ Yes

List non-medical allergies:

List all current prescription and over-the-counter medications, vitamins, and supplements:

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

- ☐ Anxiety
- ☐ Cancer
- ☐ High blood pressure
- ☐ Asthma
- ☐ Depression
- ☐ Seizures
- ☐ Blood clots (DVT or PE)
- ☐ Diabetes
- ☐ Thyroid problems

Describe any other medical problems:

Describe prior medical problems and hospitalizations:

List any surgeries and include date(s) of procedure(s):

SOCIAL HISTORY

Do you consume alcohol?

☐ No ☐ Yes – Number of drinks per week: ______________

Do you consume caffeine?

☐ No ☐ Yes – Please describe daily intake:

Do you use tobacco or nicotine products?

☐ No ☐ Yes – Please specify type(s) and frequency of use:

Do you use recreational drugs (including marijuana)?

☐ No ☐ Yes – Please specify type(s) and frequency of use:

Do you exercise regularly?

☐ No ☐ Yes – Please note exercise type, frequency, and duration:

FAMILY HISTORY

Please list any medical issues for the following family members:

Father:	Mother:	Sibling(s):

What is your ethnic background? Please select all that apply.

- ☐ Asian or Southeast Asian
- ☐ Cajun or French Canadian
- ☐ Italian, Greek, Middle Eastern, Spanish, or Portuguese
- ☐ Jewish
- ☐ Native Hawaiian or other Pacific Islander
- ☐ African American, African descent, or Black
- ☐ Caucasian
- ☐ Hispanic or Latino
- ☐ Native American
- ☐ Other: ______________________________

Do you have a family history of:

- ☐ Ancephaly (opening in head/brain)
- ☐ Blindness and/or deafness
- ☐ Birth defects
- ☐ Cystic fibrosis
- ☐ Fragile X
- ☐ Genetic Disease(s) or other chromosome problem
- ☐ Huntington's Disease
- ☐ Muscular dystrophy or neuromuscular disease
- ☐ Polycystic Kidney Disease
- ☐ Skeletal disorder – such as dwarfism
- ☐ Stillborn baby or infant death after birth or within the first year
- ☐ Autism or autistic-like syndrome
- ☐ Blood disorder or clots
- ☐ Cleft lip and/or cleft palate
- ☐ Down Syndrome
- ☐ Intellectual disability and/or cognitive impairments
- ☐ Heart defect at birth
- ☐ Menopause prior to age 40
- ☐ Neurofibromatosis
- ☐ Sickle cell anemia
- ☐ Spina bifida
- ☐ Tay Sachs disease
- ☐ Other birth defect not listed above: ____________________
- ☐ Other inherited (genetic) condition not listed above: ____________________

Are you and your partner related to each other (blood relatives)? ☐ No ☐ Yes – Please explain relation:

Have you and/or your partner completed prior carrier testing for genetic diseases? ☐ No ☐ Yes – Results:

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

Date Completed: ___________________

MALE QUESTIONNAIRE

Name: ______________________________ **Date of Birth:** ______________________________

Phone: ☐ Cell ☐ Home ☐ Work ____________________ **Email:** ______________________________

Height: ______________________________ **Weight:** ______________________________

Occupation: ______________________________ **Referred By:** ______________________________

Partner Name: ______________________________ **Date of Marriage** (if applicable)**:** ____________________

Primary Care Provider Name and Phone: ______________________________

Please indicate the reason for your visit:

☐ Fertility consultation with female partner
☐ Vasectomy consultation
☐ Other: ______________________________
☐ Fertility consult with same sex partner
☐ Sexual function concerns

FERTILITY AND UROLOGIC HISTORY

How long have you been having unprotected intercourse?

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

☐ No ☐ Prior Use ☐ Yes (current use)

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

Have you ever conceived in your current relationship?

☐ No ☐ Yes – Outcome:

Have you ever conceived in another relationship?

☐ No ☐ Yes – Outcome:

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 completed a semen analysis? ☐ No ☐ Yes – If yes, please provide result(s) of prior semen analyses below:

	Result(s)
Volume (Milliliter)	
Concentration (Million sperm per milliliter of semen)	
Motility (%)	
Morphology (%)	

MEDICAL AND SURGICAL HISTORY

List all medication allergies:

Are you allergic to latex? ☐ No ☐ Yes

List non-medical allergies:

List all current prescription and over-the-counter medications, vitamins, and supplements:

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

☐ Anxiety
☐ Cancer
☐ High blood pressure
☐ Asthma
☐ Depression
☐ Seizures
☐ Blood clots (DVT or PE)
☐ Diabetes
☐ Thyroid problems

Describe any other medical problems:

Describe prior medical problems and hospitalizations:

List any surgeries and include date(s) of procedure(s):

SOCIAL HISTORY

Do you consume alcohol?
☐ No ☐ Yes – Number of drinks per week:

Do you use tobacco or nicotine products? ☐ No ☐ Yes – Please specify type(s) and frequency of use:

Do you use recreational drugs (including marijuana)? ☐ No ☐ Yes – Please specify type(s) and frequency of use:

FAMILY HISTORY

Please list any medical issues for the following family members:

Father:	Mother:	Sibling(s):

Does your father have a history of prostate cancer? ☐ No ☐ Yes

What is your ethnic background? Please select all that apply.

☐ Asian or Southeast Asian
☐ Cajun or French Canadian
☐ Italian, Greek, Middle Eastern, Spanish, or Portuguese
☐ Jewish
☐ Native Hawaiian or other Pacific Islander
☐ Other: ____
☐ African American, African descent, or Black
☐ Caucasian
☐ Hispanic or Latino
☐ Native American
☐ Unknown

Do you have a family history of:

☐ Ancephaly (opening in head/brain)
☐ Blindness and/or deafness
☐ Birth defects
☐ Cystic fibrosis
☐ Fragile X
☐ Genetic Disease(s) or other chromosome problem
☐ Huntington's disease
☐ Muscular dystrophy or neuromuscular disease
☐ Polycystic kidney disease
☐ Skeletal disorder – such as dwarfism
☐ Stillborn baby or infant death after birth or within the first year
☐ Autism or autistic-like syndrome
☐ Blood disorder or clots
☐ Cleft lip and/or cleft palate
☐ Down Syndrome
☐ Intellectual disability and/or cognitive impairments
☐ Heart defect at birth
☐ Menopause prior to age 40
☐ Neurofibromatosis
☐ Sickle cell anemia
☐ Spina bifida
☐ Tay Sachs disease
☐ Other birth defect not listed above: ____
☐ Other inherited (genetic) condition not listed above: ____

Are you and your partner related to each other (blood relatives)? ☐ No ☐ Yes – Please explain relation:

Have you and/or your partner completed prior carrier testing for genetic diseases? ☐ No ☐ Yes – Results:

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

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

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

*Physician Name: ____________________________________
Street Address: ____________________________________
City: ____________________ Phone: ____________________
Specialty: ____________________________________

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

Patient's Employment		Partner's Employment	
COMPANY NAME	OCCUPATION	COMPANY NAME	OCCUPATION
ADDRESS		ADDRESS	
CITY/STATE/ZIP		CITY/STATE/ZIP	

Patient's Primary Insurance		Partner's Primary Insurance	
INSURANCE COMPANY NAME		INSURANCE COMPANY NAME	
POLICY HOLDER NAME	RELATIONSHIP TO POLICY HOLDER	POLICY HOLDER NAME	RELATIONSHIP TO POLICY HOLDER
POLICY #	GROUP #	POLICY #	GROUP #

Patient's Secondary Insurance		Partner's Secondary Insurance	
INSURANCE COMPANY NAME		INSURANCE COMPANY NAME	
POLICY HOLDER NAME		POLICY HOLDER NAME	
POLICY #	GROUP #	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:** ____________________

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)