# BUFFALO INFERTILITY & IVF ASSOCIATES

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**PATIENT INFORMATION – ALL INFORMATION IS STRICTLY CONFIDENTIAL**

# FEMALE PATIENT FORMS

Patient Name: _____

Date of Birth: _____ Age: _____

Marital Status: _____

Gender Identity: _____

Address: _____

City: _____ State: _____ Zip: _____

Email:_____

Social Security Number: _____

Employer: _____

Spouse/Partner's Name: _____

Date of Birth: _____ Age: _____

Marital Status: _____

Gender Identity: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Social Security Number: _____

Employer: _____

Cell Phone: _____

**Preferred contact number(s)** **OK to leave voicemail**

Cell Phone: _____ □ Yes □ No

Home Phone: _____ □ Yes □ No

Work Phone: _____ □ Yes □ No

**PREFERRED PHARMACY**

Name _____

Address: _____

Phone # _____

**OB/GYN**

Name _____

Address: _____

Phone # _____

**INSURANCE INFORMATION – PRIMARY (SELF)**

Group Number: _____

Plan Name: _____

Name of Policy Holder: _____

Date of Birth: _____

ID Number: _____ Suffix ____

Employer: _____

Member ID (Self) _____ Suffix ____

Relationship: _____

Insurance Effective Date: _____

**ASSIGNMENT AND RELEASE**

I, the undersigned, have insurance coverage with _____, and assign directly to Infertility & IVF Medical Associates of WNY all medical benefits. If any, otherwise payable to us for services rendered I understand that I am financially responsible for all charges whether or not paid by insurance, including 35% collection costs and 50% attorney fees. I hereby authorize the doctor to release all information necessary to secure the payment of benefits and authorize the use of this signature on all submissions.

Signature of Insured: _____ Date: _____

**PRESENT COMPLAINT** Please state briefly what you would like to address during your visit

_____
_____
_____
_____
_____
_____
_____
_____
_____

**OBSTETRICAL HISTORY** Please list all previous pregnancies

□ **I have never been pregnant**

| | MM/YYYY | Duration of Pregnancy | If delivered, Method of Delivery, (Vaginal or C-Section) | If Miscarriage, was a procedure required (D&C)? If live birth: Sex, birth weight | Complications? |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |
| 4 | | | | | |
| 5 | | | | | |
| 6 | | | | | |

**GYNECOLOGIC HISTORY**

| | | | Comments |
|---|---|---|---|
| Do you menstruate? | □ Yes | □ No | _____ |
| Date that your last period began: | _____ | | _____ |
| Date that your previous period began: | _____ | | _____ |
| At what age did you have your first period? | _____ | | _____ |
| My periods are: | □ Regular | □ Irregular | _____ |
| Average number of days between periods: | _____ | | _____ |
| Average number of days that you have bleeding: | _____ | | Menstrual flow is: □ Scant □ Moderate □ Heavy □ Excessive |
| Do you pass clots with your periods? | □ Yes | □ No | _____ |
| Do you have pain with your periods? | □ Yes | □ No | _____ |
| Do you have pain during/after intercourse? | □ Yes | □ No | |
| Have you ever missed school or work due to pain or excessive bleeding? | □ Yes | □ No | _____ |
| Do you have bleeding/spotting between menstrual periods? | □ Yes | □ No | _____ |
| Do you have bleeding/spotting after intercourse? | □ Yes | □ No | |
| Have you ever used contraception? | □ Yes | □ No | What kind(s)? _____ |
| Have you ever been diagnosed with: | | | |
| Polycystic Ovary Syndrome (PCOS) | □ Yes | □ No | _____ |
| Endometriosis | □ Yes | □ No | _____ |
| Uterine Fibroid(s) | □ Yes | □ No | _____ |
| Endometrial Polyp(s) | □ Yes | □ No | _____ |
| Ovarian Cyst(s) | □ Yes | □ No | _____ |
| Sexually Transmitted Infection | □ Yes | □ No | _____ |
| Pelvic Inflammatory Disease (PID) | □ Yes | □ No | _____ |
| Have you ever had an abnormal Pap smear? | □ Yes | □ No | Date of last Pap smear: _____ |

## SEXUAL HISTORY

| | Yes | No | |
|---|---|---|---|
| Are you sexually active? | □ | □ | |
| Is your partner male? | □ | □ | |
| Have you used over the counter ovulation kits to time intercourse? | □ | □ | |
| Do you use lubricants during intercourse? | □ | □ | If Yes, what types _____ |

## HISTORY OF FERTILITY THERAPY (Fill out if applicable)

Have you been treated for infertility previously? □ YES □ NO

If yes, who was your physician? _____

What cause of infertility was diagnosed? _____

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

□ Clomid (Serophene) □ Femera (letrozole) □ Antibiotics

□ Gonal F □ Progesterone □ baby Aspirin

□ Follistim □ Lupron □ Heparin

□ Steroids

Which of the following tests have you or your partner had performed? Please check all that apply and results, if known:

| | | |
|---|---|---|
| □ Hysterosalpingogram | When _____/_____/_____ | Results …… |
| □ Sonohysterogram | When _____/_____/_____ | Results …… |
| □ Laparoscopy, Hysteroscopy | When _____/_____/_____ | Results …… |
| □ Thyroid tests | When _____/_____/_____ | Results …… |
| □ Chromosomes | When _____/_____/_____ | Results …… |
| □ Genetic Screening | When _____/_____/_____ | Results …… |

Have you ever undergone Intrauterine Insemination (IUI) or In Vitro Fertilization (IVF)? □ YES □ NO

If yes, □ partner □ donor sperm #IUI's _____ #IVF cycle _____

## CONTRACEPTIVE USE

☐ **I have never used contraceptives**

| | Type | Start Date | End Date | Reason Discontinued |
|---|---|---|---|---|
| 1 | _____ | _____ | _____ | _____ |
| 2 | _____ | _____ | _____ | _____ |
| 3 | _____ | _____ | _____ | _____ |

**SURGICAL HISTORY** Please list all previous surgical procedures

☐ **I have never had surgery**

| | MM/YYYY | Surgical Procedure | Hospital | Surgeon | Complications |
|---|---|---|---|---|---|
| 1 | _____ | _____ | _____ | _____ | _____ |
| 2 | _____ | _____ | _____ | _____ | _____ |
| 3 | _____ | _____ | _____ | _____ | _____ |
| 4 | _____ | _____ | _____ | _____ | _____ |
| 5 | _____ | _____ | _____ | _____ | _____ |

**MEDICAL HISTORY**: Do you, or have you had, any of the following:

| | Current | Past | Never | | Current | Past | Never | | Current | Past | Never |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Serious Head Injury | □ | □ | □ | Abdominal Pain | □ | □ | □ | Thyroid Disease | □ | □ | □ |
| Headaches | □ | □ | □ | Indigestion | □ | □ | □ | Diabetes | □ | □ | □ |
| Fainting Spells | □ | □ | □ | Nausea / Vomiting | □ | □ | □ | Endocrine Disorder | □ | □ | □ |
| Dizziness | □ | □ | □ | Change in Bowel Habits | □ | □ | □ | Night Sweats | □ | □ | □ |
| Convulsions / Epilepsy | □ | □ | □ | Diarrhea | □ | □ | □ | | | | |
| Ringing in Ears | □ | □ | □ | Constipation | □ | □ | □ | Hot Flushes | □ | □ | □ |
| Deafness | □ | □ | □ | Hemorrhoids | □ | □ | □ | Vaginal Dryness | □ | □ | □ |
| Glaucoma | □ | □ | □ | | | | | Weight Change | □ | □ | □ |
| Eye Pain | □ | □ | □ | Bloody Stools | □ | □ | □ | Poor Appetite | □ | □ | □ |
| Disturbance of Vision | □ | □ | □ | Peptic Ulcers | □ | □ | □ | Excessive Weakness | □ | □ | □ |
| Nosebleeds | □ | □ | □ | Appendicitis | □ | □ | □ | Excessive Sweating | □ | □ | □ |
| | | | | Gall Bladder Disease | □ | □ | □ | Unwanted Hair Growth | □ | □ | □ |
| Anxiety | □ | □ | □ | Jaundice / Hepatitis | □ | □ | □ | Unwanted Hair Loss | □ | □ | □ |
| Depression | □ | □ | □ | Mononucleosis | □ | □ | □ | Blood Transfusion | □ | □ | □ |
| Thoughts of Suicide | □ | □ | □ | Hernia | □ | □ | □ | Anemia | □ | □ | □ |
| Sinusitis | □ | □ | □ | Bladder Infection | □ | □ | □ | Bleeding Disorder | □ | □ | □ |
| Asthma | □ | □ | □ | Kidney Infection | □ | □ | □ | Blood Disease | □ | □ | □ |
| Chronic Cough | □ | □ | □ | Kidney Stones | □ | □ | □ | | | | |
| Pneumonia | □ | □ | □ | Kidney Disease | □ | □ | □ | Cancer | □ | □ | □ |
| Chest Pain | □ | □ | □ | Blood in Urine | □ | □ | □ | Measles (Rubeola) | □ | □ | □ |
| Shortness of Breath | □ | □ | □ | Up to Urinate at Night | □ | □ | □ | Rubella | □ | □ | □ |
| Tuberculosis | □ | □ | □ | Urgent Urination | □ | □ | □ | Mumps | □ | □ | □ |
| COPD | □ | □ | □ | | | | | Chicken Pox | □ | □ | □ |
| | | | | Rheumatic Fever | □ | □ | □ | | | | |
| High Blood Pressure | □ | □ | □ | Heart Palpitations | □ | □ | □ | Birth Defects | □ | □ | □ |
| High Cholesterol | □ | □ | □ | Heart Murmur | □ | □ | □ | Genetic disorder | □ | □ | □ |
| Rapid / Irreg Heartbeat | □ | □ | □ | Heart Disease | □ | □ | □ | Other: _____ | | | |

Please Clarify any of the above: _____

_____

## SYSTEMIC REVIEW

WEIGHT _____ MAXIMUM WEIGHT _____ MINIMUM WEIGHT _____
HEIGHT _____

Have you participated in any significant dietary changes over the past 3 years? _____

Have you participated in any exercise programs over the past 3 years? _____

If so please document exercise: Type _____ Hours per week_____

Type _____ Hours per week _____

## MEDICATIONS

Please list all medications, including prescription, over the counter, vitamins, and herbs.

□ **I do not take any medications**

| | Medication | Dose | How Often | | Medication | Dose | How Often |
|---|---|---|---|---|---|---|---|
| 1 | | | | 6 | | | |
| 2 | | | | 7 | | | |
| 3 | | | | 8 | | | |
| 4 | | | | 9 | | | |
| 5 | | | | 10 | | | |

## ALLERGIES

Please list all allergies to medications, foods, or latex

□ **I have no known allergies**

| | Allergic to | Reaction | | Allergic to | Reaction |
|---|---|---|---|---|---|
| 1 | | | 4 | | |
| 2 | | | 5 | | |
| 3 | | | 6 | | |

## SOCIAL HISTORY

| | Yes | No | |
|---|---|---|---|
| Do you smoke? | □ | □ | If Yes, how much? _____ |
| Do you use alcohol? | □ | □ | If Yes, how much? _____ |
| Do you use recreational drugs? (ex. marijuana, cocaine, heroin, etc) | □ | □ | If Yes, please describe _____ |
| Do you use caffeine? (ex. coffee, tea, soda, etc) | □ | □ | If Yes, please describe _____ |
| Do you exercise? | □ | □ | If Yes, please describe _____ |

**FAMILY HISTORY**

Have your parents, grandparents, or siblings been diagnosed with or treated for the following? If Yes, please note relationship.

| | Yes | No | If yes, relation | | Yes | No | If yes, relation | | Yes | No | If yes, relation |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Cancer | □ | □ | _____ | Heart Disease | □ | □ | _____ | Thyroid Disease | □ | □ | _____ |
| Breast | □ | □ | _____ | High Blood Pressure | □ | □ | _____ | Diabetes | □ | □ | _____ |
| Ovarian | □ | □ | _____ | High Cholesterol | □ | □ | _____ | Endocrine Disorder | □ | □ | _____ |
| Infertility | □ | □ | _____ | Kidney Disease | □ | □ | _____ | Blood Disease | □ | □ | _____ |
| Recurrent Miscarriages | □ | □ | _____ | Kidney Stones | □ | □ | _____ | Muscular Disorders | □ | □ | _____ |
| Early Menopause | □ | □ | _____ | Epilepsy | □ | □ | _____ | Neurologic Disorders | □ | □ | _____ |
| Endometriosis | □ | □ | _____ | Anxiety / Depression | □ | □ | _____ | Glaucoma | □ | □ | _____ |
| Fibroids | □ | □ | _____ | Mental Illness | □ | □ | _____ | Lung Disease | □ | □ | _____ |
| PCOS | □ | □ | _____ | Suicide | □ | □ | _____ | Tuberculosis | □ | □ | _____ |

**ETHNICITY** * Data will be used for genetic testing recommendation purposes

□ Caucasian □ Hispanic □ Asian □ African American □ Other _____

**Genetic Screening:**

It is recommended that **all couples** attempting conception be offered cystic fibrosis and Spinal Muscular Atrophy screening. Cystic Fibrosis is a pulmonary disease affecting children and the most common genetic disease. The effectiveness of these tests varies dependent on your ethnic background. You may be offered additional screening based on you ethnicity. Please indicate if you are:

African American □ Yes □ No Ashkenazi Jewish □ Yes □ No

Mediterranean / Asian / French Canadian □ Yes □ No

**If you answered YES to any of these, please let your physician know at the visit, so that the additional genetic screening can be offered to you. If you have any specific genetic concerns and desire to see a geneticist, please let the physician know.**

I confirm that I have reviewed the above information

_____ _____

Patient's Signature Date