

**New Patient Demographic Form PART 1 of 2 (FEMALE Portion)**  
**Please Complete ALL Requested Information**

NAME: \_\_\_\_\_ Date: \_\_\_\_\_  
                     First                                    MI          Last                                    Maiden

ADDRESS: \_\_\_\_\_  
                     Street Address Line One

\_\_\_\_\_   
                     Street Address Line Two

\_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
                     City/Town                                    State          Zip Code                    +4

HOME #: (\_\_\_\_)-\_\_\_\_ - \_\_\_\_\_ WORK #: (\_\_\_\_)-\_\_\_\_ - \_\_\_\_\_ ext: \_\_\_\_\_ CELL #: (\_\_\_\_)-\_\_\_\_ - \_\_\_\_\_

EMAIL: \_\_\_\_\_ @ \_\_\_\_\_ FAX: (\_\_\_\_)-\_\_\_\_ - \_\_\_\_\_

OK TO SEND MEDICAL RECORDS BY EMAIL? ( Y / N )

PATIENT Date of Birth: \_\_\_\_\_ ANY ADDITIONAL NAME: \_\_\_\_\_

SS #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ RELIGION: \_\_\_\_\_

NEXT OF KIN / EMERGENCY CONTACT: \_\_\_\_\_

TELEPHONE: (\_\_\_\_)-\_\_\_\_ - \_\_\_\_\_ WORK: (\_\_\_\_)-\_\_\_\_ - \_\_\_\_\_ ext: \_\_\_\_\_

REFERRING PROVIDER NAME: \_\_\_\_\_

REFERRING PROVIDER ADDRESS: \_\_\_\_\_  
   Street Address Line One

\_\_\_\_\_   
   Street Address Line Two

\_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
                     City/Town                                    State          Zip Code                    +4

TELEPHONE: (\_\_\_\_)-\_\_\_\_ - \_\_\_\_\_ FAX: (\_\_\_\_)-\_\_\_\_ - \_\_\_\_\_ EMAIL: \_\_\_\_\_

PRIMARY CARE PHYSICIAN NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
                     Street Address Line One

\_\_\_\_\_   
                     Street Address Line Two

\_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
                     City/Town                                    State          Zip Code                    +4

TELEPHONE: (\_\_\_\_)-\_\_\_\_ - \_\_\_\_\_ FAX: (\_\_\_\_)-\_\_\_\_ - \_\_\_\_\_

EMAIL: \_\_\_\_\_ @ \_\_\_\_\_

PREFERRED PHARMACY NAME: \_\_\_\_\_

PREFERRED PHARMACY ADDRESS: \_\_\_\_\_

Street Address Line One

\_\_\_\_\_

Street Address Line Two

\_\_\_\_\_ - \_\_\_\_\_  
 City/Town State Zip Code +4

TELEPHONE: (\_\_\_\_)-\_\_\_\_ - \_\_\_\_\_ FAX: (\_\_\_\_)-\_\_\_\_ - \_\_\_\_\_

PRIMARY INSURANCE NAME: \_\_\_\_\_

PRIMARY INSURANCE ADDRESS: \_\_\_\_\_

Street Address Line One

\_\_\_\_\_

Street Address Line Two

\_\_\_\_\_ - \_\_\_\_\_  
 City/Town St. Zip Code +4

TELEPHONE: (\_\_\_\_)-\_\_\_\_ - \_\_\_\_\_ FAX: (\_\_\_\_)-\_\_\_\_ - \_\_\_\_\_

NAME OF POLICY HOLDER: \_\_\_\_\_

SS #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_

POLICY #: \_\_\_\_\_ GROUP #: \_\_\_\_\_ COPAY \$ \_\_\_\_\_

EMPLOYER NAME: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_

Street Address Line One

\_\_\_\_\_

Street Address Line Two

\_\_\_\_\_ - \_\_\_\_\_  
 City/Town State Zip Code +4

TELEPHONE: (\_\_\_\_)-\_\_\_\_ - \_\_\_\_\_ FAX: (\_\_\_\_)-\_\_\_\_ - \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**Personal Endocrine/Fertility Health Appraisal Intake Form--FEMALE:**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ yrs.

Occupation: \_\_\_\_\_ Height: \_\_\_\_\_ ins. Weight: \_\_\_\_\_ lbs.

Patients Race: \_\_\_\_\_ Are You Married: \_\_\_\_\_

Partners Name: \_\_\_\_\_ Partner's Occupation: \_\_\_\_\_

Why are you coming to see us? (check all that apply):

- Infertility    Recurrent miscarriage    Endometriosis    Pelvic pain  
 Assisted Reproduction (IVF, GIFT, et cetera)  
 Male-pattern hair growth    Polycystic Ovaries    Menopause/Hormone Replacement  
 Other (please specify): \_\_\_\_\_

In your words, what is the main reason that you are seeking consultation in our practice?

---



---

**PLEASE NOTE:** Insurance companies often require that consultative letters be provided to referring practitioners. In addition, we feel that it is ideal if all of your healthcare practitioners are aware of your total medical picture. It is our practice to routinely provide you, as well as your other healthcare providers with copies of your consultation letters.

Name, address, telephone and fax numbers of your other providers:

1. \_\_\_\_\_ Specialty: \_\_\_\_\_

---

 Telephone: (   )      FAX: (   )

2. \_\_\_\_\_ Specialty: \_\_\_\_\_

---

 Telephone: (   )      FAX: (   )

3. \_\_\_\_\_ Specialty: \_\_\_\_\_

---

 Telephone: (   )      FAX: (   )

How did you hear about our practice (check all that apply)?

Referral from your provider --- Name: \_\_\_\_\_

Referral from a friend/relative/acquaintance --- Name: \_\_\_\_\_

Yellow Pages     Radio Ad     Newspaper Ad     Internet Search Engine

IntegraMed Website     Insurance Company

**PLEASE COMPLETE:**

I hereby give Albany IVF permission to release copies of my consultative letters and laboratory results as appropriate to the practitioners listed above and/or on my registration sheets.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**PLEASE NOTE:** Most of our patients are seeking care for fertility and many questions in the health questionnaire relate to this chief complaint. If you are not seeking fertility care, please do not be offended by some of the questions, as you may feel that they do not apply to your circumstance. Nevertheless, we ask that you complete the form in its entirety. We will utilize the information to individualize your care.

## Personal Endocrine/Fertility Health Appraisal Intake Form -- FEMALE:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Is infertility your primary complaint?  YES  NO

Have you been pregnant with your current partner before?  YES  NO

How long (total time) have you had unprotected intercourse? \_\_\_\_\_ YEARS \_\_\_\_\_ MONTHS

Do you have any allergies to medicines or other substances?  YES  NO

(i.e., environmental, latex)

If yes, please list medication or substance, when taken last, and response (if unsure, state unsure):

\_\_\_\_\_

Are you currently taking any medications (including pain medications, Tylenol, aspirin, vitamins, herbal/naturopathic medicines)?  YES  NO

Medication

Reason for Taking

If yes, please list:

Prescribing Practitioner

\_\_\_\_\_

### A. LIFESTYLE

Marital status: Married \_\_\_\_\_ yrs. Single \_\_\_\_\_ Divorced \_\_\_\_\_ Plan Marriage \_\_\_\_\_ Separated \_\_\_\_\_

Widowed \_\_\_\_\_ Cohabiting \_\_\_\_\_

Do you smoke cigarettes?  YES  NO

If yes, how many packs per day? \_\_\_\_\_

Do you have any dietary restrictions?  YES  NO

If yes, please specify: \_\_\_\_\_

Do you eat a special diet?  YES  NO

If yes, please specify... \_\_\_\_\_

Do you ever crave non-food items (i.e., starch, clay, dirt)?  YES  NO

Do you vomit more than once per month?  YES  NO

Have you ever suffered from bulimia?  YES  NO

Have you ever suffered from anorexia?  YES  NO

Have you had a recent change in weight?  YES  NO

Gain or Loss of weight (circle): GAIN / LOSS

Was the weight change voluntary?  YES  NO

Do you know your average daily caloric intake?  YES  NO

Have you ever seen a nutritionist or similar provider?  YES  NO

Do you exercise regularly?  YES  NO

How often? (i.e., 1x/day; 3x/wk) \_\_\_\_\_

Type of exercise? \_\_\_\_\_

Do you know how many calories you burn during each workout?  YES  NO

If yes, how many, approximately? \_\_\_\_\_

Do you drink alcohol?  YES  NO

If yes, how many drinks? \_\_\_/d \_\_\_/wk \_\_\_/month

Ever experience DWI/DWAI?  YES  NO

Ever experience blackouts?  YES  NO

How much caffeine do you consume, in an average day?

Coffee, # ounces: \_\_\_\_\_

Tea, # ounces: \_\_\_\_\_

Caffeinated soda, # ounces: \_\_\_\_\_

Have you ever used recreational drugs?  YES  NO

(Circle: marijuana / cocaine / crack / speed / Ecstasy)

If yes, last time used. \_\_\_\_\_

Do you work with radiation or X-Rays?  YES  NO

Are you exposed to organic solvents regularly?  YES  NO

If yes, specify. \_\_\_\_\_

**B. OBSTETRIC AND REPRODUCTIVE HISTORY:** (Please list all pregnancies including abortions & miscarriages)

| Year of pregnancy | Infertility treatment needed to conceive? (if yes, type) | How Long To Conceive? | Did current Partner father the pregnancy? | Full-term, premature? Miscarriage/ Abortion? | Mode of Delivery (C-sec/vag'l) |
|-------------------|--|-----------------------|---|--|--------------------------------|
| _____             | _____  | _____                 | _____                                     | _____  | _____                          |
| _____             | _____  | _____                 | _____                                     | _____  | _____                          |
| _____             | _____  | _____                 | _____                                     | _____  | _____                          |

How old was your mother when she went through menopause? \_\_\_\_\_

History of your mother receiving DES (a drug to stop miscarriages) when she was pregnant with you?  YES  NO

Have you had any of the following?

One or more infants weighing more than 9 lbs. at birth?  YES  NO

One or more infants weighing less than 5-1/2 lbs. at birth?  YES  NO

One or more stillborn infants?  YES  NO

One or more neonatal deaths? (baby died before 1 month old)?  YES  NO

One or more infants requiring a stay in an intensive care nursery?  YES  NO

**C. GENERAL GYNECOLOGIC AND SEXUAL HISTORY**

Have you ever taken the birth control pill?  YES  NO

If yes, for how many years? \_\_\_\_\_

Have you ever used an IUD?  YES  NO

If yes, did you ever develop an infection or complication?

Describe. \_\_\_\_\_

When was the date of the first day of your last menstrual period? \_\_\_\_\_

Was it normal?  NO  YES

What was the date of your last PAP smear (f unsure state, unsure)? \_\_\_\_\_

Do you have a history of abnormal PAP smears?  YES  NO

If yes, have you ever had freezing, cautery, laser, LEEP or a cone biopsy of the cervix?

NO  YES If yes, when and what? \_\_\_\_\_

Number of sex partners within the last 10 yrs \_\_\_\_\_ 2 yrs \_\_\_\_\_

Have you or any of your sexual partners had: Year Treatment

Gonorrhea:  Self  Sexual Partner Details: (Year / Treatment): \_\_\_\_\_

Chlamydia:  Self  Sexual Partner Details: (Year / Treatment): \_\_\_\_\_

HPV (Warts):  Self  Sexual Partner Details: (Year / Treatment): \_\_\_\_\_

Herpes:  Self  Sexual Partner Details: (Year / Treatment): \_\_\_\_\_

Syphilis:  Self  Sexual Partner Details: (Year / Treatment): \_\_\_\_\_

Urethritis:  Self  Sexual Partner Details: (Year / Treatment): \_\_\_\_\_

Hepatitis:  Self  Sexual Partner Details: (Year / Treatment): \_\_\_\_\_

Have you ever been physically abused/assaulted?  YES  NO

If yes, did you receive supportive counseling?  YES  NO

If no, would you like us to assist you in finding counseling?  YES  NO

Are you satisfied with your level of sexual desire or libido?  YES  NO

If no, would you like us to assist you in improving this area of your life?  YES  NO

Are you satisfied with the quantity and quality of your sex life?  YES  NO

If no, what have you done to address this? \_\_\_\_\_

If no, would you be interested in getting information about sex therapy?  YES  NO

My sexual orientation is:  heterosexual  homosexual  bisexual

Are you comfortable with your sexual orientation/practice?  YES  NO

Is vaginal intercourse usually comfortable for you?  YES  NO

If no, is it painful with insertion?  YES  NO

If no, is it painful with deep penetration?  YES  NO

Do you use a lubricant (circle):  Never  Sometimes  Always

If yes, what type: \_\_\_\_\_

How often do you and your partner engage in sexual relations (# of times) \_\_\_\_\_/week \_\_\_\_\_/month

Do you try to increase sexual frequency when you think you are ovulating?  YES  NO

Do you experience orgasm?  YES  NO

**D. SURGICAL HISTORY**--Please list all surgeries in order (attach a separate sheet if needed)

| Date | Surgery type | Physician | Hospital | Diagnosis |
|------|--------------|-----------|----------|-----------|
|      |              |           |          |           |
|      |              |           |          |           |
|      |              |           |          |           |

**E. PERSONAL MEDICAL HISTORY**

Have you ever had a blood transfusion?  YES  NO

If yes, when? \_\_\_\_\_

Do you know your bloodtype and Rh Factor?  YES  NO

If yes, what is it? \_\_\_\_\_

***Do you have:***

If yes, give details:

|                       |                              |                             |       |
|-----------------------|------------------------------|-----------------------------|-------|
| Fibroids              | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Endometriosis         | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| High Blood Pressure   | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Frequent Headaches    | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Heart Disease         | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Diabetes              | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Birth Defects         | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Multiple Births       | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Mental Retardation    | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Mental Illness        | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Depression/Anxiety    | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Alcohol/Drug Abuse    | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Breast Lumps/cysts    | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Breast Cancer         | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Uterine Cancer        | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Cervical Cancer       | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Ovarian Cancer        | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Bowel Cancer          | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Thyroid Disease       | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Other Autoimmune      | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Osteoporosis          | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Obesity               | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Other cancers (list): |                              |                             | _____ |





I have had an endometrial biopsy within the last year.  YES  NO  
 If yes, when? \_\_\_\_\_ (please send pathology report)  
 Findings: \_\_\_\_\_

I have had a hysterosalpingogram (HSG) within the last year.  YES  NO  
 (please send radiology report, and bring/send films; see initial instructions page 3)  
 If yes, when? \_\_\_\_\_ Who did it? \_\_\_\_\_  
 Findings: \_\_\_\_\_

I have had a sonohysterogram (SHG) within the last year.  YES  NO  
 (please send report, and bring/send films; see initial instructions page 3)  
 If yes, when? \_\_\_\_\_ Who did it? \_\_\_\_\_  
 Findings: \_\_\_\_\_

I have had a hysteroscopy within the last year.  YES  NO  
 (please send operative report, and pathology report; see initial instructions page 3)  
 If yes, when? \_\_\_\_\_ Who did it? \_\_\_\_\_  
 Findings: \_\_\_\_\_

I have had a laparoscopy within the last 3 years.  YES  NO  
 (please send operative report, and pathology report; see initial instructions page 3)  
 If yes, when? \_\_\_\_\_ Who did it? \_\_\_\_\_  
 Findings: \_\_\_\_\_

I have had clomiphene citrate challenge test.  YES  NO  
 If yes, when? \_\_\_\_\_ What were the results?  
 Day 3 FSH \_\_\_\_\_ Day 10 FSH \_\_\_\_\_

**I. PREVIOUS FERTILITY THERAPY (if applicable)**

|                         | Dates | Dosage | # of Cycles | hCG used at midcycle? | IUI done? (Y/N) | Luteal support? (Y/N/Type)_____ |
|-------------------------|-------|--------|-------------|-----------------------|-----------------|---------------------------------|
| Clomiphene Citrate      | _____ |        |             |                       |                 |                                 |
| Injectable Drugs / Type | _____ |        |             |                       |                 |                                 |

Have you ever undergone assisted reproduction, such as IVF, GIFT/ZIFT/TET, or undergone therapy using donated sperm or eggs?  YES  NO  
 If yes, what, when, where, and what was the outcome?  
 \_\_\_\_\_

Please check if no male partner:  YES  NO

**If there is a male partner, please complete the attached male patient history form**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Partner: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Read each of the following 21 questions carefully and circle the number next to the answer that best describes how you have been feeling the past few days.** All information obtained from this document is confidential and will only be viewed by your Physician and/or their clinical staff. Albany IVF, Fertility and Gynecology will not release or disclose this information without written consent from the patient.

1. 0 I do not feel sad.  
1 I feel sad.  
2 I am sad all the time and can't snap out of it.  
3 I am so sad or unhappy that I can't stand it.
2. 0 I am not particularly discouraged about the future.  
1 I feel discouraged about the future.  
2 I feel I have nothing to look forward to.  
3 I feel that the future is hopeless and things cannot improve.
3. 0 I do not feel like a failure.  
1 I feel I have failed more than the average person.  
2 As I look back on my life, all I can see is a lot of failures.  
3 I feel I am a complete failure as a person.
4. 0 I get as much satisfaction out of things as I used to.  
1 I don't enjoy things the way I used to.  
2 I don't get real satisfaction out of anything anymore.  
3 I am dissatisfied or bored with everything.
5. 0 I don't feel particularly guilty.  
1 I feel guilty a good part of the time.  
2 I feel quite guilty most of the time.  
3 I feel guilty all of the time.
6. 0 I don't feel I am being punished.  
1 I feel I may be punished.  
2 I expect to be punished.  
3 I feel I am being punished.
7. 0 I don't feel disappointed in myself.  
1 I am disappointed in myself.  
2 I am disgusted with myself.  
3 I hate myself.
8. 0 I don't feel I am worse than anybody else.  
1 I am critical of myself for my weaknesses or mistakes.  
2 I blame myself all the time for my faults.  
3 I blame myself for everything bad that happens.
9. 0 I don't have any thoughts of killing myself.  
1 I have thoughts of killing myself, but I would not carry them out.  
2 I would like to kill myself.  
3 I would kill myself if I had the chance.

**Page 1 Total** \_\_\_\_\_

10. 0 I don't cry any more than usual.  
1 I cry more now than I used to.  
2 I cry all the time now.  
3 I used to be able to cry, but now I can't even cry even though I want to.
11. 0 I am no more irritated by things than I ever am.  
1 I am slightly more irritated now than usual.  
2 I am quite annoyed or irritated a good deal of the time.  
3 I feel irritated all the time now.
12. 0 I have not lost interest in other people.  
1 I am less interested in other people than I used to be.  
2 I have lost most of my interest in other people.  
3 I have lost all of my interest in other people.
13. 0 I make decisions about as well as I ever could.  
1 I put off making decisions more than I used to.  
2 I have greater difficulty in making decisions than before.  
3 I can't make decisions at all anymore.
14. 0 I don't feel that I look any worse than I used to.  
1 I am worried that I am looking old or unattractive.  
2 I feel that there are permanent changes in my appearance that make me look unattractive.  
3 I believe that I look ugly.
15. 0 I can work about as well as before.  
1 It takes an extra effort to get started at doing something.  
2 I have to push myself very hard to do anything.  
3 I can't do any work at all.
16. 0 I can sleep as well as usual.  
1 I don't sleep as well as I used to.  
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.  
3 I wake up several hours earlier than I used to and cannot get back to sleep.
17. 0 I don't get tired more than usual.  
1 I get tired more easily than I used to.  
2 I get tired from doing almost anything.  
3 I am too tired to do anything.
18. 0 My appetite is no worse than usual.  
1 My appetite is not as good as it used to be.  
2 My appetite is much worse now.  
3 I have no appetite at all anymore.
19. 0 I haven't lost much weight, if any, lately.  
1 I have lost more than five pounds.  
2 I have lost more than ten pounds.  
3 I have lost more than fifteen pounds.

- 20. 0 I am no more worried about my health than usual.
  - 1 I am worried about physical problems such as aches or pain, or upset stomach, or constipation.
  - 2 I am very worried about physical problems and it's hard to think of much else.
  - 3 I am so worried about my physical problems that I cannot think about anything else.
- 
- 21. 0 I have not noticed any recent change in my interest in sex.
  - 1 I am less interested in sex than I used to be.
  - 2 I am much less interested in sex now.
  - 3 I have lost interest in sex completely.

**Page 3 Total** \_\_\_\_\_

**Total Score** \_\_\_\_\_