

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.

Occupation: _____ Race: _____

Are you married? _____ Partner's Name: _____

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 NOHave 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 If yes, please list:Medication Reason for Taking 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 NODo you vomit more than once per month? YES NOHave you ever suffered from bulimia? YES NOHave you ever suffered from anorexia? YES NOHave you had a recent change in weight? YES NO

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

Was the weight change voluntary? YES NODo you know your average daily caloric intake? YES NOHave you ever seen a nutritionist or similar provider? YES NODo 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:	<input type="checkbox"/> Self	<input type="checkbox"/> Sexual Partner	Details: (Year / Treatment):	_____
Chlamydia:	<input type="checkbox"/> Self	<input type="checkbox"/> Sexual Partner	Details: (Year / Treatment):	_____
HPV (Warts):	<input type="checkbox"/> Self	<input type="checkbox"/> Sexual Partner	Details: (Year / Treatment):	_____
Herpes:	<input type="checkbox"/> Self	<input type="checkbox"/> Sexual Partner	Details: (Year / Treatment):	_____
Syphilis:	<input type="checkbox"/> Self	<input type="checkbox"/> Sexual Partner	Details: (Year / Treatment):	_____
Urethritis:	<input type="checkbox"/> Self	<input type="checkbox"/> Sexual Partner	Details: (Year / Treatment):	_____
Hepatitis:	<input type="checkbox"/> Self	<input type="checkbox"/> 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):			_____

Have you ever been tested as a carrier of:

If yes, give details:

Tay-Sachs Disease YES NO _____
 Sickle-Cell Disease YES NO _____
 Cystic Fibrosis YES NO _____
 Thalassemia YES NO _____
 Muscular Dystrophy YES NO _____
 HIV (AIDS) YES NO _____

What is the approximate date of your last mammogram? _____

Was it for screening? YES NO

Was it normal? YES NO

If ever abnormal, give details: _____

F. FAMILY HISTORY

Are there any known genetic diseases or conditions that run in your family? YES NO

If yes, please list: _____

Does anyone in your family have:

If yes, give details including, who:

Fibroids YES NO _____
 Endometriosis YES NO _____
 High Blood Pressure YES NO _____
 Frequent Headaches YES NO _____
 Heart Disease YES NO _____
 Diabetes YES NO _____
 Birth Defects YES NO _____
 Multiple Births YES NO _____
 Mental Retardation YES NO _____
 Mental Illness YES NO _____
 Depression/Anxiety YES NO _____
 Alcohol/Drug Abuse YES NO _____
 Breast Lumps/cysts YES NO _____
 Breast Cancer YES NO _____
 Uterine Cancer YES NO _____
 Cervical Cancer YES NO _____
 Ovarian Cancer YES NO _____
 Bowel Cancer YES NO _____
 Thyroid Disease YES NO _____
 Other Autoimmune YES NO _____
 Osteoporosis YES NO _____
 Obesity YES 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)_____
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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