

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

State

Zip Code

+4

TELEPHONE: (____)-____ - _____ FAX: (____)-____ - _____

EMAIL: _____ @ _____

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: (____)-____ - _____

EMAIL: _____ @ _____

Patient Signature _____ Date _____

Occupation: _____ Height: _____ ins. Weight: _____ lbs.

Partner's Name: _____ Occupation: _____

Are you married? _____

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

Infertility Recurrent miscarriage Assisted Reproduction (IVF, GIFT, et cetera)

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

PERSONAL ENDOCRINE/FERTILITY HEALTH APPRAISAL INTAKE FORM--MALE:

Have you achieved pregnancy with your your current partner? 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? NO YES
 If yes, please specify... _____

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

Do you vomit more than once per month? NO YES

Have you ever suffered from bulimia? NO YES

Have you ever suffered from anorexia? NO YES

Have you had a recent change in weight? NO YES
 Gain or Loss of weight (circle): GAIN / LOSS

Was the weight change voluntary? NO YES

Do you know your average daily caloric intake? NO YES

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

Do you exercise regularly? NO YES
 How often? (i.e., 1x/day; 3x/wk) _____

Type of exercise? _____

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

If yes, how many, approximately? _____

Do you drink alcohol? NO YES

If yes, how many drinks? ___/d ___ /wk ___ /month

Ever experience DWI/DWAI? NO YES

Ever experience blackouts? NO YES

How much caffeine do you consume, in an average day? 4 oz of coffee

Coffee, # ounces: _____

Tea, # ounces: _____

Caffeinated soda, # ounces: _____

Have you ever used recreational drugs? NO YES

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

If yes, last time used..._____

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

Are you exposed to organic solvents regularly? NO YES

If yes, specify..._____

B. REPRODUCTIVE HISTORY: (Please list all pregnancies you have fathered including abortions & miscarriages)

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

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

Have you had any of the following?

One or more stillborn infants? NO YES

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

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

C. GENERAL UROLOGIC AND SEXUAL HISTORY

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? NO YES

If yes, did you receive supportive counseling? NO YES

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

Are you satisfied with your level of sexual desire or libido? NO YES
 If no, would you like us to assist you in improving this area of your life? NO YES
 Are you satisfied with the quantity and quality of your sex life? NO YES

If no, what have you done to address this? _____

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

My sexual orientation is: heterosexual homosexual bisexual
 Are you comfortable with your sexual orientation/practice? NO YES
 Any problems with erections? If yes, give details: NO YES

Any problems with ejaculation (ex, premature ejaculation)? NO YES If yes, give details:

Any other problems with intercourse? NO YES If yes, give details:

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 experience intravaginal orgasm without difficulty? NO YES

Would you have any difficulty collecting a semen sample by masturbation? NO YES

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

Date	Surgery type	Physician	Hospital	Diagnosis
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E. PERSONAL MEDICAL HISTORY

Have you ever had a blood transfusion? NO YES
 If yes, when? _____

Do you know your bloodtype and Rh Factor? NO YES
 If yes, what is it? _____

Do you have: If yes, give details:

High Blood Pressure NO YES _____

Frequent Headaches NO YES _____

Heart Disease NO YES _____

Diabetes NO YES _____

Birth Defects NO YES _____

Mental Retardation NO YES _____

Mental Illness NO YES _____

Depression/Anxiety NO YES _____

Alcohol/Drug Abuse NO YES _____

Prostatic Cancer NO YES _____

Testicular Cancer NO YES _____

Bowel Cancer NO YES _____

Thyroid Disease NO YES _____

Other Autoimmune NO YES _____

Obesity NO YES _____

Other cancers (list): _____

Have you ever been tested as a carrier of: If yes, give details:

Tay-Sachs Disease NO YES _____

Sickle-Cell Disease NO YES _____

Cystic Fibrosis NO YES _____

Thalassemia NO YES _____

Muscular Dystrophy NO YES _____

HIV (AIDS) NO YES _____

F. FAMILY HISTORY:

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

If yes, please list: _____

Does anyone in your family have: If yes, give details including, who:

High Blood Pressure NO YES _____

Frequent Headaches NO YES _____

Heart Disease NO YES _____

Diabetes NO YES _____

Birth Defects NO YES _____

Mental Retardation NO YES _____

Mental Illness NO YES _____

Depression/Anxiety NO YES _____

Alcohol/Drug Abuse NO YES _____

Prostatic Cancer NO YES _____

Testicular Cancer NO YES _____

Bowel Cancer NO YES _____

Thyroid Disease NO YES _____

Other Autoimmune NO YES _____

Obesity NO YES _____

Other cancers (list): _____

H. PREVIOUS FERTILITY THERAPY *(if applicable)*

Have you ever taken clomiphene citrate therapy? NO YES
If yes, when taken last, and at what dosage?

Have you ever taken injectable fertility drugs? NO YES
If yes, when taken last, and at what dosage and what drugs?

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