Fertility New Patient Questionnaire

It is an honor to welcome you into our fertility enrichment program. For us to begin it is important that we have a good understanding of your health history and fertility journey. We understand the sensitivity of this journey and the challenges you may have already encountered. While this survey is lengthy and detailed we are asking that you be thorough with your answers to give us the clearest picture of how we can best assist you. Your answers will be held in the strictest confidence in accordance with HIPPA. If there are certain responses you would rather provide privately, please write "ask me" in that section for discussion when we meet. Please complete all of the sections of this questionnaire that are relevant to your situation.

Date: ____________________________

About You:

Name: ______________________________________ Date of Birth: ______________ Age: ______

Address: ____

Occupation: ____

Home Phone#: ______________________ ☐ (check if OK to leave voice mail)

Cell Phone#: ______________________ ☐ (Check if ok to leave voicemail)

Email: ____

Are you married or with a partner? ☐ Yes ☐ No

About your Spouse/Partner:

Name: ______________________________________ Date of Birth: ______________ Age: ______

Address: ____

Occupation: ____

Home Phone#: ______________________ ☐ (check if OK to leave voice mail)

Cell Phone#: ______________________ ☐ (Check if ok to leave voicemail)

Email: ____

Referred by:

Whom can we thank for referring you to SIMIO? ______________________

Current doctor: ______________________

Practice Name: ______________________

Address: ______________________

Phone#: ______________ Fax#: ______________

What concerns do you most want to discuss/resolve during your care in our office?

____

____

Medical History

Height: __________ Weight:__________ When was your last annual gyn exam? ____________

Do you have, or have you ever had (check all that apply):

- ☐ Endometriosis
- ☐ Cancer
- ☐ Unexplained weight loss
- ☐ Uterine fibroids
- ☐ Heart Disease
- ☐ Anorexia
- ☐ High Blood Pressure
- ☐ Bulimia
- ☐ Breast Discharge
- ☐ Chemotherapy
- ☐ Pelvic Infection
- ☐ Radiation therapy
- ☐ Poor Sense of Smell
- ☐ Gonorrhea
- ☐ Blood clots
- ☐ Seizures / Epilepsy
- ☐ Syphilis
- ☐ HIV/AIDS
- ☐ Chlamydia
- ☐ Appendicitis
- ☐ Herpes
- ☐ Thyroid problems
- ☐ Delayed Puberty
- ☐ Sickle cell disease
- ☐ Diabetes / Insulin Resistance
- ☐ Hepatitis ___A ____B ____C____
- ☐ Other ______________________

Have you ever been treated for substance abuse, depression, or other psychological problem?

☐ No ☐ Yes, please describe ______________________

Any Allergies? List: ______________________

Please list below any current prescription medications, Vitamins, over-the-counter medications, or nutritional supplements used on a regular basis.

Lifestyle

Do you or have you ever used (check all that apply):

☐ Alcohol: How many drinks per week usually? Wine _______ Beer ______ Cocktails ______

☐ Cigarette use: If yes, the average number smoked daily in the past 3 months (circle answer):

| < 1 | 1-3 | 4-6 | 7-9 | 10-20 | >20 | Number of years of smoking: ___________________

☐ Recreational Drugs: (Heroin, Marijuana, Cocaine, etc.) [If you would feel more comfortable not writing anything down, please discuss this directly with your Therapist] ____________________

Have you experienced a significant weight change (gain or loss) in the past 5 years? ☐ Yes ☐ No
If yes how much? ________ lb gain _________ lb loss

List any regular vigorous exercise (swimming, cycling, running, etc.). Please include frequency and duration.

Are you aware of the possible effect that weight (either under or overweight) may have on fertility?

☐ Yes ☐ Not at all ☐ Interested in knowing more

Would you like help adopting healthier lifestyle behaviors, such as:

☐ Weight management ☐ Healthier food choices ☐ Healthier eating patterns
☐ Stress management ☐ Fitness ☐ Other: ______________________

Would you like to make an appointment with our Nutritional Health Coach?

☐ Yes ☐ Not at this time, but I would like some more information

Menstrual History

Age at first period: _________ Date of LAST period: _________________
Are your periods regular? ☐ Yes ☐ No

What is the usual # of days from the start of one period to the next? Minimum ____ Maximum ___

What is the usual # of days your periods last? Minimum ________ Maximum_______

Do you bleed or spot between periods? ☐ Yes ☐ No.

Have you ever used an intrauterine device (IUD)? ☐ Yes ☐ No
If yes: What type: _______________________________________ For how long?______________

Have you ever had pelvic inflammatory disease (PID)? ☐ Yes ☐ No
Please describe: ____

Do you have PMS? (Premenstrual Syndrome) ☐ Yes ☐ No
If yes, is it: ☐ MILD ☐ MODERATE ☐ SEVERE

Do you have painful menses? ☐ Yes ☐ No If yes, is it: ☐ MILD ☐ MODERATE ☐ SEVERE

Is intercourse painful? ☐ Yes ☐ No If yes, is it: ☐ MILD ☐ MODERATE ☐ SEVERE

Do you use lubricants for intercourse? ☐ Yes ☐ No If yes, which brand? __________________

Do you douche before or after intercourse? ☐ Yes ☐ No

How many times per week do you and your partner have intercourse? __________

How many months have you been trying to get pregnant? __________

How many months have you had intercourse without contraception? __________

Did your mother have any difficulty with conception or pregnancy? ☐ Yes ☐ No ☐ Don't know

Did your mother take Diethylstilbestrol when she was pregnant with you? ☐ Yes ☐ No ☐ Don't know

At what age did your mother begin menopause? __________________

Have you tracked Basal Body Temperature (BBT)? ☐ Yes ☐ No.

If yes, what day did you see a temperature shift? __________________

Have you used an ovulation predictor kit (OPK)? ☐ Yes ☐ No

If yes, what day did you see a positive result? __________________

Have you been exposed to any toxins? ☐ Yes ☐ No If yes, which: __________________________

How many cups of coffee or caffeinated beverages do you drink each day? ___________________

Is there a family history of infertility? ☐ Yes ☐ No If yes, describe:

____

Is there a family history of birth defects? ☐ Yes ☐ No If yes, describe:

____

Is there a family history of recurring miscarriages? ☐ Yes ☐ No If yes, describe:

____

Is there a family history of cancer on either on the maternal and/or paternal side of your family?
☐ Yes ☐ No.

If yes, please note who was diagnosed, age at diagnosis, and type of cancer.

____

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____

Pregnancy History

Please provide a detailed outline of your pregnancy history in the space provided below.

Hospital/Surgical History

Have you had any surgeries / operation? ☐ No ☐ Yes (describe below).

Have you ever been surgically sterilized? ☐ No ☐ Yes

Have you been hospitalized for other than surgery? ☐ No ☐ Yes (describe below).

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Prior Fertility Testing

Have you been evaluated for infertility before? ☐ Yes ☐ No.

If yes, who was your physician? ____________________

Address: ____________________

____

Phone #: ____________________

Fax #: ____________________

What cause of infertility was diagnosed?

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Which of the following tests have you had performed? Check all that apply and results if known.

- ☐ 'Day 3' FSH, LH, Estradiol Date: ___/___/____ Results: _____________________
- ☐ AMH (anti-Mullerian hormone) Date: ___/___/____ Results: ______________________
- ☐ Hysterosalpingogram Date: ___/___/____ Results: ______________________
- ☐ Saline sonogram Date: ___/___/____ Results: ______________________
- ☐ Laparoscopy Date: ___/___/____ Results: ______________________
- ☐ Hysteroscopy Date: ___/___/____ Results: ______________________

Infertility Treatment History

Number of prior clomiphene (Clomid, Serophene) cycles: _________
Number of prior Letrozole (Femara) cycles: _________

Please provide specific details:

Date	Drug	Dose	#Follicles	Intrauterine Insemination (IUI)?	Pregnancy?
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No

Number of prior Gonadotropin Cycles: ___________

Please provide specific details:

Date	Drug	Dose	#Follicles	Intrauterine Insemination (IUI)?	Pregnancy?
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No

Number of prior Fresh In Vitro Fertilization (IVF) Cycles: __________

Number of prior Frozen IVF Cycles: __________

Date	1	2	3	4
IVF Center				
Fresh or Frozen Cycle				
Max. Starting dose				
# Eggs Retrieved				
# Eggs Fertilized	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
ICSI?				
# Ebryos Tranferred				
Embryo Age (Day 3 or 5)				
Pregnancy?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Delivery?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

What do you understand about the cause of your infertility and possible treatment options?

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Male Partner History (if applicable)

Marriage #: _________ Height:___________ Weight: __________
Urologist: ____
Address: ____

____
Phone #: ____
Fax #: ____
Number of pregnancies conceived with current partner: __________
Number of pregnancies conceived with previous partners: __________

Please give the dates and outcomes of Pregnancies with prior partners.

Date of Pregnancy	Delvered?	Aborted?	Miscarried?

Have you ever had a semen analysis (sperm count) performed? ☐ Yes ☐ No.

Date	Volume	Count (million/ML)	Motility (%)	Morphology (%)

Do you have any medical problems unrelated to your fertility?

Nature of Problem	Treatment	Physician

Have you had any surgeries / operation? ☐ No ☐ Yes (describe below).

Have you ever been surgically sterilized? ☐ No ☐ Yes

Have you been hospitalized for other than surgery? ☐ No ☐ Yes (describe below).

Please complete the chart about any prior surgeries or hospitalizations:

Year	Reason for surgery or Hospitalization	Procedure or Treatment	Physician

Within the last year, have you taken any prescription medications? Please chart below.

Medication	Diagnosis/Reason	Dosage	Frequency	Duration

Have you ever taken these medications:

☐ Sulfasalizine ☐ Allopurinol ☐ Colchicine

☐ Cimetadine (Tagamet) ☐ Anabolic steroids ☐ Androgen hormones

☐ Chemotherapy ☐ Interferon ☐ Antidepressants

☐ Calcium channel blockers (e.g., Norvasc, Procardia; any generic drug name ending in "-dipine")

Have you ever taken over the counter or been prescribed Testosterone? ☐ Yes ☐ No

Are you on it currently? ☐ Yes ☐ No If Yes, when was the last time?________________________

Do you or have you ever used (check all that apply):

☐ Alcohol: How many drinks per week usually? Wine ______ Beer ______ Cocktails ____

☐ Cigarette use: If yes, the average number smoked daily in the past 3 months (circle answer):

| < 1 | 1-3 | 4-6 | 7-9 | 10-20 | >20 | Number of years of smoking: _____________

☐ Recreational Drugs (Heroin, Marijuana, Cocaine, etc.) [If you would feel more comfortable not writing anything down, please discuss this directly with your physician]

Specify: ____

Do you or have you ever had any difficulties with (check all that apply):

☐ Erection: If yes, please explain: ____

☐ Ejaculation: If yes, please explain:____

Have your genitals ever been exposed to excessive heat? ☐ Yes ☐ No.

Have you had any serious injuries to your genitals? ☐ Yes ☐ No.

Have you had any infections of your penis, testicles or prostate gland? ☐ Yes ☐ No.

Is there any history of birth defects in your family? ☐ Yes ☐ No.

Is there any history of recurrent miscarriage in your family? ☐ Yes ☐ No.

Do you have any allergies to medications? ☐ Yes ☐ No.

If yes, please note:____

Consent to Use Electronic Records

Definitions: The following defined terms are utilized throughout the following document: SIMIO PHYSICAL THERAPY, PLLC and SIMIO HEALTH SERVICES, PLLC is referred to herein as "the Practice"

I acknowledge and agree that the Practice may convert some or all of my medical records into electronic format and thereafter maintain such medical records only in electronic format. I also acknowledge and agree that Consents (together with my signatures on all such Consents) that are obtained from me may be maintained by the Practice in electronic format. For purposes of obtaining my consent, I hereby consent to being required by the Practice to receive, recognize, accept, be bound by, and/or otherwise use electronic records and signatures as described herein. I hereby agree that such medical records and Consents and signatures of mine in electronic format are valid and will have the same validity as the hard paper copy thereof. Likewise, facsimiles or scanned images of any signed documents or consents shall have the same validity as the original. I acknowledge that I have carefully reviewed this Consent and understand its content.

Signature here: ____ Date _______________

Consent for Mutual Records

Definitions: The following defined terms are utilized throughout the following document: SIMIO PHYSICAL THERAPY, PLLC and SIMIO HEALTH SERVICES, PLLC is referred to herein as "the Practice"

During the course of treatment at the Practice there may be portions of my spouse or partner's Protected Health Information (PHI) that will be included in my medical records and portions of my PHI that will be included in my spouse or partner's medical records. I hereby give my express permission and consent for my PHI to be included in my spouse or partner's medical records and for my spouse or partner's PHI to be included in my medical records. I understand and agree that any disclosures that the Practice may make of my medical records or my spouse or partner's medical records will include my PHI and my spouse or partner's PHI.

Signature here: ____ Date _______________

Spouse or Partner's Name: _________________________________

Obligation to Pay

Definitions: The following defined terms are utilized throughout the following document: SIMIO PHYSICAL THERAPY, PLLC and SIMIO HEALTH SERVICES, PLLC is referred to herein as "the Practice"

I hereby make the assignment of all disability, surgical, medical, and major insurance benefits to the Practice and to release any medical information necessary to execute an assignment of benefits. I understand that regardless of any insurance coverage I might have, I am personally responsible for all charges to this or to my partner/spouse's account. I understand that I am responsible for services rendered and I agree to pay for services before the time of service. I understand that I am financially responsible to the Practice for any balance on my account or my partner/spouse's account. I/We understand and agree that any credit granted shall be paid promptly in accordance with terms and agreements and in the event of default to pay collection charges and/or attorney fees. I also understand that it is my responsibility to notify the Practice if I become no longer responsible for future balances incurred on my partner/spouse's account due to separation or divorce.

Signature here: ____ Date _______________

Spouse or Partner's Name: ________________________________

Authorization to Display Photos

Definitions: The following defined terms are utilized throughout the following document: SIMIO PHYSICAL THERAPY, PLLC and SIMIO HEALTH SERVICES, PLLC is referred to herein as "the Practice"

Due to new Federal privacy rules and regulations, we must have permission in writing to display any pictures you may send to us. By signing the authorization below, you are granting the Practice permission to display any pictures you may send. These pictures may be displayed in our offices or on bulletin boards in our office hallways. The pictures may be seen by all other Practice patients, all Practice staff, and Practice Business Associates. Such photos would be used to provide encouragement to patients currently undergoing treatment for infertility and to celebrate successful outcomes. Your authorization to display such photos could lead to further disclosure and thus the pictures would no longer be protected by federal privacy laws. It is always our intention to protect your privacy. All pictures that are received have all printed identifying information removed before they are displayed. ☐ Authorized ☐ Declined

Signature here: ____ Date _______________

Consent to use E-mail

Definitions: The following defined terms are utilized throughout the following document: SIMIO PHYSICAL THERAPY, PLLC and SIMIO HEALTH SERVICES, PLLC is referred to herein as "the Practice"

The Practice provides you the opportunity to communicate in certain circumstances with certain healthcare providers and administrative services by e-mail. Transmitting confidential patient information by e-mail, however, has a number of risks, both general and specific, that you should consider before using e-mail.

Risks
Among the risks:
- E-mail can be circulated, forwarded, and stored in numerous paper and electronic files.
- E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients.
- Recipients can forward e-mail messages to other recipients without the original sender's permission or knowledge.
- Users can easily misaddress an e-mail.
- E-mail is easier to falsify than handwritten or signed documents.
- Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.
- Employers and on-line services have a right to archive and inspect e-mails transmitted through their systems.
- E-mail can be used to introduce viruses into computer systems.
- E-mail can be used as evidence in court.
- E-mail containing information pertaining to your diagnosis and/or treatment must be included in your medical records here at the Practice. Thus, all individuals who have access to your medical record will have access to the e-mail messages.
- If you send or receive e-mail from your place of employment, you risk having your employer read the e-mail. Your employers or others, such as insurance companies, may read your e-mail and learn of medical treatment, particularly mental health, sexually transmitted diseases, or alcohol and drug abuse information.
- You cannot be sure how soon the Practice will respond to your e-mail. Although the Practice will endeavor to read and respond to e-mail promptly, we cannot guarantee that any particular e-mail message will be read and responded to within any particular period of time. Thus, patients should not use e-mail in a medical emergency.

Our Policy
The Practice will make all e-mail messages sent or received that concern your diagnosis or treatment part of your medical record, and will treat such email messages with the same degree of confidentiality as afforded other portions of the medical record. The Practice will use reasonable means to protect the security and confidentiality of e-mail information. Because of the risks outlined above, we cannot, however, guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is

not caused by the Practice intentional misconduct. Thus, you must consent to the use of e-mail for confidential medical information after having been informed of the above risks.

Consent to the use of e-mail includes agreement with the following conditions:
• The Practice may send (either directly or through a third party e-mail service) unsecured/ unencrypted e-mails to you to confirm appointments. These e-mails contain your e-mail address, as well as the date, time, and location of your appointment.
• All e-mails to or from you concerning diagnosis and/or treatment will be made a part of your medical record. As a part of the medical record, other individuals, such as other physicians, nurses, staff counselors, patient accounts personnel, and the like, and other entities, such as other health care providers and insurers, will have access to e-mail messages contained in medical Consent to use e-mail records.
• The Practice may forward e-mail messages internally to its staff or externally to its agents for diagnosis, treatment and other handling. The Practice will not, however, forward the e-mail outside to independent third parties without your prior written consent, except as authorized or required by law.
• The Practice may send you e-mails to provide updates or other notifications regarding your clinical care as well as financial matters.
• If you send an e-mail to the Practice (one of its physicians, another healthcare provider, or an administrative department), we will endeavor to read the e-mail promptly and respond promptly, if warranted. However, the Practice can provide no assurance that the recipient of a particular e-mail will read the e-mail message promptly. Because we cannot assure you that we will read e-mail messages promptly, do not use e-mail for situations, questions or conditions where a timely response is needed for diagnostic or treatment purposes or where time is of the essence, including, but not limited to a medical emergency.
• If your e-mail requires or invites a response from us, and you do not respond within a reasonable time, you are responsible for following up to determine whether the intended recipient received the e-mail and when the recipient will respond.
• Do not use e-mail for communications concerning diagnosis or treatment of AIDS/HIV infection; other sexually transmissible or communicable diseases, such as syphilis, gonorrhea, herpes, and the like; mental health or developmental disability; or alcohol and drug abuse.
• Because employees do not have a right of privacy in their employer's e-mail system, do not use your employer's e-mail system to transmit or receive confidential medical information.
• The Practice cannot guarantee that electronic communications will be private. The Practice is not liable for improper disclosure of confidential information not caused by the Practice gross negligence or wanton misconduct.
• You are responsible for protecting your password or other means of access to e-mail sent to or received from the Practice or the Lab to protect confidentiality. The Practice are not liable for breaches of confidentiality caused by you or any third party.
• It is your responsibility to follow up and/or schedule an appointment if warranted.
• Any use of e-mail by you that discusses diagnosis or treatment constitutes informed consent to the foregoing.
• Any use of email by you constitutes informed consent regarding this matter. Your signature on this consent acknowledges and accepts these risks and gives the Practice and the Lab permission to communicate via e-mail.

• You may withdraw consent to the use of e-mail at any time by e-mail or written communication to the Practice or the Lab, Attention: Administration Manager.

I hereby grant permission for the Practice staff to contact me by email. I have read and fully understand this consent form.

☐ Authorized ☐ Declined

Signature here: ____ Date _______________

Email Address: ____