Marin Fertility Center
1100 S. Eliseo Dr., Suite 107
Greenbrae, CA 94904
415.925.9404

Name: ______________________________ **Date of visit: _____/_____/_____**

Age: ______ Height: ______

New Patient History

Please note: All information is confidential and will only be used for the purpose of ensuring you the best treatment possible. Please answer all areas.

Why have you come to the office today?

Who referred you to our practice? **Self** **Friend** **Physician (List name) ________________**

Who is your usual Ob/Gyn? ___________________ Location: ________________________

Past Medical History (✓ if you have or have ever had)

	✓		✓		✓
Anemia/blood disease		Gall bladder disease		Prior Pulmonary Embolus (PE)	
Arthritis		Headaches/migraine		Prior blood clots (DVTs)	
Asthma		Heart disease/valve problems		Reflux/Hiatal Hernia	
Bladder problem / infections		High blood pressure		Skin disease	
Blood transfusion		Interstitial Cystitis		Stomach Ulcer	
Bowel disorder		Kidney disease		Thyroid disease	
Cancer		Leukemia		Tuberculosis	
Diabetes		Liver Disease/Hepatitis		Varicose veins/phlebitis	
Endometriosis		Lung disease		Weight loss/gain ≥ 10 lbs	
Epilepsy/Neurologic disease		PCOS (Polycystic Ovarian Syndrome)			

Other medical problems(list):____
Please expand on any problems you identified above:____
____

Surgeries/Operations (any procedure, including D&C's)

Type/Reason	Date	Location	Physician

Other Illnesses/ Hospitalizations

Type/Reason	Year

Current Medications

(Include any hormones, vitamins, herbs, over the counter and nonprescription medications)

	Dose

Allergies/Reactions

(list any drug or food allergy)

Please specify what happens to you:

Gynecologic History

First day of last menstrual period: / /	
Do you have regular monthly periods? Yes No Do you feel period coming before it starts? Yes No Which of the following do you experience before a period: ☐Breast tenderness ☐ Mood changes ☐Special food cravings	Have you ever had an abnormal Pap test? Yes No
Usual number of days from start of one period to start of the next:	Have you ever had a procedure on your cervix due to an abnormal pap test? (LEEP / Cryo / Cone) Yes No Year:
Any recent changes? Yes No Pain? Yes No Describe:	When was your last Pap test? What was the Pap result? Normal Abnormal
Number of days of bleeding:	Have you ever had a mammogram? Yes No Year of last: ________ Result: Normal Abnormal
Age periods began:	
Do you have problems with pelvic pain? Yes No When?:	**Present method of birth control:** (circle) None Pills-Patch-Ring Depo Provera IUD Diaphragm Rhythm Method Male Condom Withdrawl Implanon Female Sterilization (Tubal Ligation) Male Sterilization (Vasectomy)
Are you sexually active? Yes No	
Do you have pain with intercourse? Yes No	
Sexual partner(s) is/are: Men Women Both	
Have you ever had any of the following infections? (circle) Gonorrhea Chlamydia Herpes None HPV HIV PID Number of times: ______ Year(s): _____________	Weight at age 20: _________ Current Weight: _________ Have you ever used Birth Control Pills? Yes No Age when started birth control: ____ Age when last stopped: ____

Hirsutism (excessive hair growth) & Acne

Do you feel that you have problems with excessive hair growth? Yes No
If yes, circle all areas of concern: Face Chest/Breasts Back Stomach Arms Legs Thighs
Age that hair growth became noticeably worse? _______ Does this continue to worsen? Yes No
Prior Treatments: Waxing / Shaving / Plucking / Creams / Laser / Spironolactone (Aldactone) Treated how often? _____________________
Do you have problems with excessive acne? Yes No At what age did acne problems begin?
Does this continue to worsen? Yes No
Current acne treatment:

Obstetrical History

	Number
Total Number of Pregnancies	
Term Births (>37 wks)	
Premature (20-37 wks)	
Miscarriages (<20 wks)	
Ectopic (Tubal) Pregnancies	
Elective Abortions	
Living Children	

Immunizations

Type	Date		Date
Have you ever had Chicken Pox?	Yes / No	TB test	
Chicken Pox vaccine		Flu vaccine	
Hepatitis A vaccine		Pneumonia vaccine	
Hepatitis B vaccine		Other:	
Rubella/MMR vaccine			
HPV vaccine (Gardasil)			
Tetanus-Diptheria-Pertussis			

Obstetrical History: Please list all pregnancies in order

	Month /year	Outcome (Yes/No)				Delivery: Vag / C-section	Complications	Length of time To conceive	Required fertility Treatment?	Current partner?
		Live born	Miscarriage	Abortion	Ectopic					
1st										
2nd										
3rd										
4th										
5th										
6th										
7th										

Social History:

		Diet Restrictions?
Occupation:		
Status: Married / Single	Partner / No Partner	
Length of time with current partner (years): ______		No. of meals/day:
Routine Exercise? Yes No Hours per time: _____ Times/week: ___________________________ Type: _________________________________		Skip meals?
Routine exposures to chemicals? Yes No		

Currently Use:

Tobacco: Yes No	Packs/day: ____ Years: ____
Have you ever smoked >100 cigarettes? Yes No	
Alcohol: Yes No	Drinks/week: ________
Caffeine: Yes No (coffee, soda, tea)	Drinks/day:
Other drugs: Yes No (Including marijuana)	Type(s):

<u>Family History</u> **(Parents, Grandparents, Siblings, Aunts/Uncles)**

Illness	✓	List affected relative(s) and age at onset
Alcohol or drug addiction		
Birth defects / Mental retardation		What was cause?_______________
Bleeding disorders		
Blood clots in lungs or legs		
Breast cancer		
Cancer- Colon		
Cancer- Ovary		
Cancer- Uterus		
Diabetes		
Endometriosis		
Heart disease		
Hepatitis		
High blood pressure		
High cholesterol		
HIV		
Infertility		
Mental illness/depression		
Movement disorders (tremor)		
Osteoporosis (weak bones)		
Sickle Cell / Thalassemia		
Stroke		
Tuberculosis		
Any other genetic diseases		
Recurrent miscarriages?		List miscarriages for <u>both</u> your family's side <u>and</u> your partner's
Early menopause <40 years old. (Premature Ovarian Failure)		Age of mother at menopause if known:
Other:		

What is your ancestry? (Check mark)	African-American	East Asian/Pacific Islands	Hispanic/Latin Am.	South Asian
	American Indian	Caucasian	Northern European	Middle Eastern
	Ashkenazi Jewish	Eastern European	Other__________________________	

<u>Fertility History</u> (May STOP here if not being seen for fertility reasons)

<u>**Note**</u>**:** In order to help us more efficiently treat you, please obtain copies of your past fertility treatments, operative reports, IVF cycle, ultrasound reports, labs, <u>and hard copies</u> (<u>**films or on disk**</u>) of any

How long have you been actively trying to conceive? ___ yrs ___ mo.	Do you use lubricants? Yes No Type: ________

Hysterosalpingogram (HSG) (Xray test of your tubes) that you have had done. It is important that we review the HSG films that were previously done. <u>Please bring these records to your appointment with you</u>.

Number of times of intercourse per week? ______	Do you douche? Yes No
How long have you been off any birth control? _____ yrs ____ mo.	Frequency of intercourse near ovulation: _________

Prior Fertility Evaluation/Labs/Treatment

Treating physician and location:	Was a cause of infertility found?
Have you had an HSG Yes No (x-ray study of tubes)?	When? Result? Where was this performed?
Laparoscopy? Yes No Dates: ________________ Number of times: _______	When? Findings? Were they able to detect if your tubes were open? Yes No
Ovulation Testing? Yes No	Do you consistently ovulate? Checked by: **Temperature** / **Urine Ovulation Testing** / **Ultrasound** / **Blood**
Pelvic Ultrasound? Yes No Date: __________	Where done? Any abnormal findings?

Prior fertility treatments:	✓	**Please list dates, dosage, number of cycles:**
Clomiphene (Clomid)		
Letrozole (Femara)		
Intrauterine Insemination (IUI)		
Ovulation Induction with injectable fertility medications (Menopur, Bravelle, Repronex, Gonal-F, Follistim)		
In Vitro Fertilization (IVF)		
Frozen Embryo Transfer (FET)		

Male Partner History

Partner's Name:	Age:	Height:	Weight:
Medical problems:			

Take routine medications or supplements?	Medications or supplements:
Past surgeries:	Family History of diseases:
Has he had a semen analysis? Yes No When? Results?	History of hernia or testicular surgery Yes No History of injury to testicles Yes No
Has he seen a Urologist? Yes No Urologist's Name/Location:	Exposure to chemicals/radiation/toxins? Yes No Routine hot tub use: Yes No
Occupation?	Wears: Boxers / Briefs
Previously fathered a child? Yes No	Trouble with erections? Yes No
Age of children:	Trouble with ejaculation? Yes No
Does he currently smoke? Yes No Amount: Packs/day: Years:	Currently or has ever used any type of steroids? Yes No Length of time since last usage:
Use marijuana or other drugs? Yes No Last use:	Any illnesses/fevers in the past 3 months? Yes No
Alcohol use: Yes No Drinks/week:	History of sexually transmitted diseases? Yes No

What is your ancestry? (Check mark)	African-American	East Asian/Pacific Islands	Hispanic/Latin Am.	South Asian
	American Indian	Caucasian	Northern European	Middle Eastern
	Ashkenazi Jewish	Eastern European	Other ______________________	

Preconception Genetic Testing

Planning for a baby involves some very important decisions. Among those is whether to test yourself for certain genetic traits that can potentially cause disease in your offspring. While there are many rare inherited diseases, a few occur with enough frequency in certain populations to warrant screening for them before you become pregnant.

Screening for genetic diseases usually involves nothing more than a simple blood test. A “screening test” means that the test is designed to detect an abnormality in most affected individuals. In other words, **a negative result does not guarantee that you are not affected**. It does, however, dramatically reduce your risk.

A positive result from a genetic disease screening test may prompt further diagnostic testing and is normally followed by formal counseling about your reproductive options. Positive test results have implications for you, your offspring and your extended family members. Therefore, it is very important to consider how a positive screening test result would affect you before you complete the test.

The following is a list of currently-recommended genetic disease screening tests based on specific ethnic backgrounds.

African American

- Sickle Cell Anemia
- Beta-thalassemia

Asian

- Alpha-thalassemia
- Beta-thalassemia

Ashkenazi Jewish (Eastern European)

- Tay-Sachs
- Canavan Disease
- Familial Dysautonomia
- Cystic Fibrosis
- Fanconi Anemia, group C
- Gaucher disease, type 1
- Niemann-Pick, type A
- Bloom Syndrome
- Mucolipidosis IV

Caucasian

- Cystic fibrosis

Cajun/French Canadian

- Tay-Sachs

Hispanic

- Cystic fibrosis
- Sickle Cell Anemia
- Beta-thalassemia

Cystic Fibrosis

Cystic fibrosis (CF) is a hereditary disease that affects mainly the lungs and digestive system, causing progressive disability, recurrent infections, and usually early death. CF does not affect intelligence or appearance. Average life expectancy is around 37 years. Approximately 1 in 25 Caucasians carry this gene defect, as well as 1 in 46 Hispanics, 1 in 65 African Americans and 1 in 90 Asians. If you are a carrier, you have a 50% chance of your child being a carrier, which would not be affected. If your partner is also a carrier, you have a 25% chance of having a child with the disease. Current testing can determine if you carry the gene(s) responsible for this disease. Detection rates (the chance of picking up an affected gene if it exists) depend upon your ethnic background and vary from 30-97%. .

Sickle Cell Anemia/Alpha-thalassemia/Beta-thalassemia

These are a group of inherited blood disorders that causing varying degrees of anemia (low blood count) or episodes of body pain. In some cases, the genetic disease can be lethal. The chance of carrying one of these genes (in a population at risk) varies from 1/10 to 1/200.

Tay-Sachs/ Canavan Disease/Familial Dysautonomia
Fanconi Anemia, group C/Gaucher disease, type 1
Niemann-Pick, type A Bloom Syndrome/Mucolipidosis IV

Included in this group are disorders of the central nervous system (brain) and immune system. Many are lethal. The chance of carrying one of these genes (in a population at risk) varies from 1/13 to 1/100.

☐ I have read the above including specific risks related to my ethnic background and **DO** wish to pursue preconception genetic screening at this time.

☐ I have read the above including specific risks related to my ethnic background and **DO NOT** wish to pursue preconception genetic screening at this time.

__________________________ __________
Signature Date

____
Printed Name (Patient)

__________________________ __________
Signature Date

____
Printed Name (Partner)

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Patient Name: ________________________________ Date: ____/____/____

Address: ____
Street &/or Apt # City State Zip

Home Phone: (______)_______-__________ Cell Phone: (______)_______-_________ Other: (______)_______-__________

Email: ____ *Any restrictions for contacting you? ( ) No ( ) Yes
If yes explain restrictions for contacting: ________________________

Driver's License #:____ State:____________________

Birthdate: _______/_______/__________ Age: ______ Sex: ( ) Female ( ) Male SS#: ________-________-__________

Marital Status: ( ) Single ( ) Married to: _________________________________ ( )Other: ________________________________

Allergies: Foods:____ Drugs:____

Patient's Employer: ____ Occupation: __________________________________

Work Phone:(______)_______-__________ Ext.___________ *Is it okay to call you at work? ( )Yes ( )No

Address:____
Street &/or Apt # City State Zip

Emergency Contact:
(Not in your household) ____ Relationship: _________________________

Home Phone: (______) _______-__________ Cell Phone: (______) _______-_________ Other: (______) _______-__________

Address:____
Street &/or Apt # City State Zip

Primary Care Physician____ **Phone:** (______) _______-__________

Primary Health Insurance Company____

Insurance Claims Mailing Address____
Street &/or Apt # City State Zip

Policy #:______________________________ Group #:___________________________ Ins. Phone: (______) _______-__________

Referral Required? ( ) No ( ) Yes *Do you have a Co-pay? ( ) No ( ) Yes, $_______________________

Insured: Name:________________________________ DOB:______/______/________ Employer: ___________________________

Secondary Health Insurance Company____

Insurance Claims Mailing Address____
Street &/or Apt # City State Zip

Policy #:______________________________ Group #:___________________________ Ins. Phone: (______) _______-__________

Referral Required? ( ) No ( ) Yes *Do you have a Co-pay? ( ) No ( ) Yes, $_______________________

Insured: Name:________________________________ DOB:______/______/________ Employer: ___________________________

I understand that office visit charges are payable on the day of service is rendered. I authorize Napa Valley Fertility Center to bill my insurance company regardless of insurance coverage, I am responsible for all bills being paid in a timely manner.

Signature: ____ **Date:** ______/______/________

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CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Persuant to the requirements that are found in the *Health Insurance Portabilitiy* and *Accountability Act* of 1996 (*HIPPA*), the following is offered for your information and consent. Please be aware that it is this office's policy to require your reading and signing of this consent form prior to the provision of treatment or any other medical services. If you have any questions, please ask for the privacy official in this office.

I, ____, do hereby consent to use and disclosure of my individual identifiable health information (IIHI) by the **Marin Fertility Center** for the purpose of providing treatment to me, receiving payment from responsible parties for the health care services rendered by my physician, and/or engaging in the health care operations, such as office management, credentialing case management, and quality assessment.

I understand that **Marin Fertility Center's Notice of Privacy Practices** describes in more detail the types of uses of disclosure of health information involved in treatment, payment of health care operations, and that I have been given an opportunity to read this document prior to signing this consent. I also understand that I may receive a paper copy of this Notice upon request.

I understand that **Marin Fertility Center**, has the right to change its privacy practices and that I can obtain a copy of the revised Notice by writing to the physician.

I understand that if I chose to not sign this consent, my physician may withhold medical services, other than emergency services.

I understand that I have the right to request a restriction on my physician's use or disclosure of any and/or all health information to any/all locations, entities or persons. I further understand that my physician is not obligated to agree to the request. However, if my physician does agree to this request, the agreement will become binding.

I understand that I have the right to revoke this consent, in writing, at any time, except to the extent that my physician has relied on this consent, and that revocation will become effective on the date it has been received by the **Marin Fertility Center** and will apply to uses and disclosures of health information after the date of receipt.

Patient Signature:_______________________________________ Date:__________________