



Overlake Reproductive Health, Inc., P.S.

Welcome to Overlake Reproductive Health!

Thank you for entrusting your care to us.

Overlake Reproductive Health is a private medical practice specializing in the diagnosis and treatment of female reproductive disorders as well as male infertility. Our clinic is staffed by practitioners who have specialized in reproductive endocrinology and infertility. We provide a team approach to your care.

ORH's aim is to provide the most comprehensive and current diagnostic procedures and methods of treatment. While we cannot always promise success, we do strive to be supportive and professional in every case. Above all, our staff is interested in your well-being. We hope that your care here will be a positive and successful experience.

Please find enclosed in your new patient packet:

- registration forms
- medical history questionnaires for you and your partner
- a note from our billing service

The downloadable new patient packet as well as any appropriate health history forms can be found below. Please fill the forms out completely. The packet as well as all pertinent medical records must be received at least 72 hours prior to your appointment. Otherwise, your appointment is subject to cancellation and rescheduling.

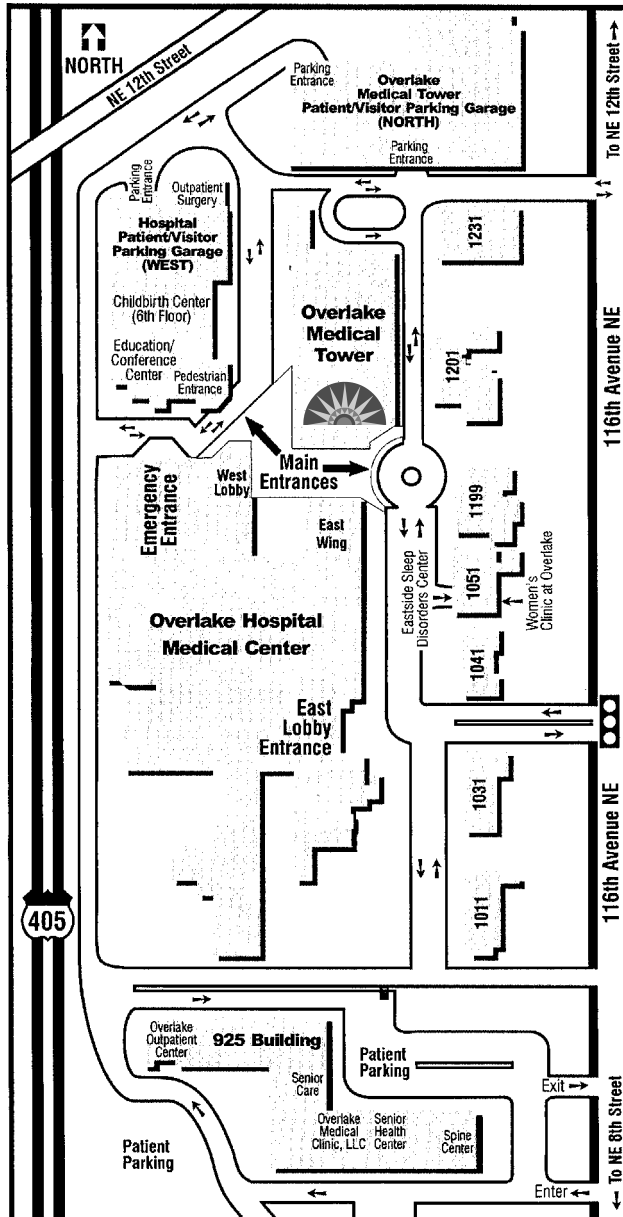
Your first visit will take approximately 90 minutes. If you cannot keep this appointment, please call the scheduling desk at (425) 646-4700 ext. 100 at least 48 hours in advance so that another couple may be given your appointment time; failure to follow this policy will incur a \$50 charge.

We appreciate your interest in our clinic and look forward to meeting you in person.

Sincerely,

Kevin M. Johnson, M.D.
Khurram Rehman, M.D.
Jo Overhouse Gray, A.R.N.P.

Driving Directions



Southbound

Exit I-405 at NE 8th St. eastbound. Merge to the left lane and turn left (north) at the first stoplight onto 116th Ave. NE. Turn left into the hospital campus.

Northbound

Exit I-405 at NE 4th St. Turn right on NE 4th St. and turn left onto 116th Ave. NE. Turn left into the hospital campus.

From the airport

Take I-5 northbound to I-405 northbound; then follow the directions for northbound.



OVERLAKE REPRODUCTIVE HEALTH

Overlake Medical Tower
1135 116th Ave NE, Suite 640
Bellevue, WA 98004
425 646-4700



www.fertileweb.com

PATIENT ACCOUNTS AND INSURANCE POLICY

To help you understand and anticipate any difficulties in insurance benefits you may encounter, please review this document.

Insurance coverage in this area of medicine is not as straightforward as in most other areas. For example,

- Many times there is coverage for testing to determine why you are infertile, but no coverage for treatment.
- Many times payment depends on why the service was performed. For instance, if we do an ultrasound of your ovaries to ensure that an ovarian cyst is shrinking, it will be paid, but if we do the ultrasound to track your response to fertility medications, it will often not be paid.
- Many times the information we get from your insurer over the phone is incorrect or incomplete.

To best serve you, we have developed this approach:

DETERMINATION OF INSURANCE BENEFITS

When you become a patient at ORH, we contact your insurance company to obtain information regarding the coverage you have for infertility care. We have developed a list of questions that we ask to get a picture of the nature and extent of your coverage. We will provide you a copy of this summary. Please review this information. If you think you have different coverage, or a different level of benefits, please notify us, so we that may clarify the information. We suggest that you call your insurance company directly for clarification.

Unfortunately, this 'verification' of benefits does not oblige insurers to pay. Insurance companies protect themselves by stating that verification of your insurance coverage by them is:

- Not a guarantee of payment, and is
- Not a guarantee of what is actually covered and not covered.

Because of this disclaimer, even when they have told you or us that a service is covered, there is no obligation for them to pay. The true determination as to whether a service is covered is made at the time the claim is received by the insurance company. Whether insurance will pay is dependent on whether:

- The service you received is covered by your plan
- The reason for the service (the diagnosis) is covered by your plan
- The appropriate deductibles and co-pays have been met
- "pre-existing condition" exclusions apply

Further complicating payment is that some plans require that:

- You have experienced infertility for a specified amount of time before services will be covered,
or
- The infertility is not due to prior elective sterilization, or
- Certain treatment steps should be taken before other treatment steps will be covered. This may not always be consistent with the course of treatment that we think is best for you. For instance, some companies will pay for IVF treatment, but only after 3 tries of gonadotropin cycles have failed.

There may be occurrences where your insurance company denies payment and deems that a service "is not consistent with the diagnosis" assigned to you.

Patient initial _____

CLAIMS FILING

For insurance companies/networks with which we are contracted

- We will be happy to file a claim for coverage of rendered services with your insurance company provided that you have insurance with a company with which we participate, if your plan provides benefits for the service provided for the reason it was provided, and if there are no other restrictions on covered services of which we are aware. We will collect any required co-payment at the time of your visit.
- If you have insurance with an insurer with which we participate, but your plan does not provide benefits for your diagnosis or for the procedures, then full payment for services rendered is required at each visit. We expect all balances to be settled on the day it occurs.
- Currently we participate in these networks:

<ul style="list-style-type: none">• Aetna• First Choice• First Health• Great West Healthcare• Pacificare of Washington	<ul style="list-style-type: none">• Premera• Premera Microsoft• Regence Blue shield• United Health Care
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For insurance companies/networks with which we are not contracted

If you have health insurance with an insurer with which we do not participate, then full payment for all services rendered is required at the time of your visit. As noted above, we require that each patient's balance be settled on the day it occurs. We will provide you with a statement that can be submitted to your insurance company for reimbursement directly to you.

OTHER ITEMS

• *All IVF Cycles*

Fees for all IVF cycles (IVF, Frozen embryo transfers, egg Recipient/Donor cycles, etc.) are collected in advance of the start of the cycle.

• *Surgery*

If you are having surgery, we will calculate an estimate of the charges you would be responsible to pay based on your "in" or "out" of network status and based on the information the insurance company provides to us. This payment is required prior to the surgery. We will also file the claim with our insurance company. If you are "in" network, you are responsible for any patient balance after insurance adjustments have been taken. If you are "out" of network, you are responsible for the difference between what we charge and what insurance pays.

• *Additional Services Rendered*

Occasionally, when the doctors review lab results, they determine that another test is needed to make a complete evaluation. When this occurs, the charges for the additional test will be posted to your account at the time test is ordered.

Occasionally, our audits detect that services were incorrectly posted to your account, resulting in overcharges or undercharges. When we identify such errors, we will correct your account, resulting in a credit or balance.

SETTLING BALANCES

As discussed prior, there are times when insurance companies process a claim in a manner different than expected. In these cases,

- A claim may be completely denied as not covered, with no payment being made, there by making you entirely responsible for the charge, or
- A claim may pay differently than was anticipated, also thereby making you responsible for a larger portion of the charge than expected.
- even though your insurance company communicated to us and we in turn communicated to you that a given service or set of services is covered, this Is NOT A GUARANTEE BY US of your insurance company's coverage for that service or set of services. If your insurance company denies coverage for any reason, you are responsible for full payment of the services billed. Because the insurance company states that the verbal information they provide is not a guarantee of payment nor can it be relied on as a guarantee of coverage, we are not responsible for any statement made by your insurance company, nor any statement made by us to you based on information given to us by your insurance company. It is very important for you to understand that the only TRUE representation of whether a given service is covered is when your insurance company actually processes the claim.

When this occurs, we will first try to understand why: Was the claim processed correctly? Were the appropriate diagnoses used? Were benefits incorrectly stated to us at verification? Typically an insurance company will send an EOB ("explanation of Benefits") that outlines what they paid and didn't pay and why. If we believe there are errors in the claim, we will resubmit. If you receive an EOB that processed your claim differently than you expected, please call your insurance company to clarify. If the insurance company states that they processed the claim incorrectly, please obtain the name of the person you spoke with, and call us with that information so we can note this in your account. If your insurance company reprocesses the claim, when you receive the corrected EOB showing payment was made to us, please call us to issue a refund to you.

If however there are no errors, we will make the corresponding adjustments to your account, determine the portion of the charge you are responsible for, and post this portion to your account.

As stated previously, there are times when an insurance company states that the test or procedure performed is not consistent with the diagnosis assigned to you. The practitioners at ORH perform or order services to be performed when they determine that they are important in the diagnosis and treatment of the patient for the particular circumstances of the patient. When your insurance company denies payment and renders the decision that the services are "not consistent with the diagnosis," it has decided otherwise.

When services have been performed by/ordered by an ORH practitioner, and your insurance deems the services to be "inconsistent with the diagnosis," your practitioner has deemed them to be important in your diagnosis and treatment and for your particular circumstances. Your signature below acknowledges your agreement that you will be responsible for the payment for these services, should your insurance company deny payment and state that these services are "inconsistent with the diagnosis" assigned to you.

Credit Card Authorizations

There are instances of charges being generated or recognized on days when there is no office visit scheduled. With the very busy lives of our patients, it is difficult to reach patients to come in and settle balances as they arise. Therefore, it is our offices' policy to require a credit card authorization be maintained on file so that your balances can be settled as they occur. Our patients find this convenient.

Patient initial _____

When these cases arise:

- We will call you before making any charge in excess of \$500.
- We will call you before making any charges to a debit card, regardless of amount
- We will call you before making any charge for a service provided more than 6 months ago.
- We will mail you a copy of your credit card receipt and your statement on the day the charge is made.
- An authorization form will be supplied to you and your spouse for your signatures.

Outside Laboratories

Outside labs may be used for necessary testing. You will receive a statement from that lab which you will be responsible for paying.

Insurance company Look Back Periods

Insurance companies often perform audits of paid claims. These audits can be performed for up to two years from the latter of the following (a) the date of service, (b) the receipt of the claim, (c) the payment of the claim, or (d) the receipt of an appeal. When an insurance company performs an audit and determines that claims were paid in error and should not have been, the insurance company contacts us for a refund of the monies they paid. They then direct us to collect for these services from the patient. Unfortunately this may mean that for a period of up to two years after any one of the above listed events your insurance company may reverse their decision. If this should occur we will than contact you for payment of these services.

Interest on Unpaid Balances

Should you have an outstanding balance on you account that is your responsibility and that is greater than 60 days old, we reserve the right to assess simple interest on the unpaid balance at the rate of 1.5%/month. This represents an annual interest rate of 18%

Administrative Billing when your Co-Pay, Co-Insurance or Patient Responsibility Balance is not paid at the Time of Service.

When your co-pay, co-insurance or patient responsibility balance for the day's visit is not paid at the time of service delivery, we will assess a \$25.00 administrative billing fee and subsequently bill you for the unpaid amount.

Account Representative

We understand that infertility is a challenging problem. Unfortunately, managing insurance benefits is often troublesome in this area. We have Patient Account Representatives who are trained to help you navigate these often troubled waters. Feel free to work with them by dialing Washington Medical Billing at (253) 833-3255

PATIENTS ATTESTATION:

I fully understand Overlake Reproductive Health's Patient Accounts and Insurance Policy described above. I understand that I am responsible for any balance not covered by or paid by insurance for any reason.

Signature

Date

Signature (significant other)

Date

Signature (witness)

Date



BILLING AUTHORIZATION FORM

By checking this box, I would like to pay for this and future visits with Visa/Mastercard/American Express, please keep this information on file. I give permission for Overlake Reproductive Health, Inc. PS and Laboratory, LLC to charge my credit card for any patient balance due on my account. If I have insurance coverage, my card will be charged AFTER my insurance has paid their portion.

Name:	Address:
City:	State/Zip:
(Office only) Patient Account Number:	

SELECT PAYMENT METHOD

VISA	MASTERCARD	DEBIT(VISA or MC)
Name on Card:	Exp Date:	
Bankcard Statement Address:		
Bankcard Statement ZIP Code:		
Account Number:		
Key Code:		

- We will call you to inform you of a charge to your card, and will seek permission on a charge in excess of \$500.
- We will call you before making any charges to a debit card, regardless of amount.
- We will call you before making any charge for a service provided more than 6 months ago.
- We will mail you a copy of your credit card receipt and your statement on the day the charge is made.

I authorize and request Overlake Reproductive Health, Inc PS (ORH) & Overlake Reproductive Health Laboratory LLC to process my payments through my bankcard as noted above. I also understand I may discontinue this authorization at any time by giving written notice to ORH. I realize this information will be used solely for the purpose of consumer withdrawal.

Signature _____ Date _____

Overlake Reproductive Health, Inc., P.S. / Overlake Reproductive Health Laboratory (& Surgical Services), LLC
PATIENT REGISTRATION FORM

Dates Reviewed & Updated: _____

PLEASE PRINT

PT. NAME _____ Last First MI DRIVER'S LICENSE # _____ ADDRESS _____ CITY/STATE _____ ZIP _____ HOME PHONE (_____) _____ SPOUSE'S NAME _____ DOB _____ REFERRED BY _____	M ___ F ___ DOB _____ AGE _____ SS# _____ MARITAL STATUS _____ OCCUPATION _____ EMPLOYER _____ ADDRESS _____ WORK PHONE (_____) _____ PRIMARY CARE PHYSICIAN _____
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PRIMARY INSURANCE _____ Insured _____ DOB _____ Employer _____ Relationship to Patient _____ Insured ID No. _____ Group No. _____ If Labor and Industries: Claim # _____ Date of Injury _____ Employer at time of injury _____	SECONDARY INSURANCE _____ Insured _____ DOB _____ Employer _____ Relationship to Patient _____ Insured ID No. _____ Group No. _____ If Labor and Industries: Claim # _____ Date of Injury _____ Employer at time of injury _____
Does your insurance require preauthorization before hospitalization or procedures? YES <input type="checkbox"/> No <input type="checkbox"/>	
If YES, phone number to call: _____	

BILLING: If person responsible for bill is other than above patient , please complete.	
NAME _____ Last First MI Relationship to Patient _____ ADDRESS _____ CITY/STATE _____ ZIP _____ HOME PHONE (_____) _____	SS# _____ OCCUPATION _____ EMPLOYER _____ ADDRESS _____ CITY/STATE _____ ZIP _____ WORK PHONE (_____) _____

EMERGENCY INFORMATION: Person to contact in case of emergency, not living at the above address.	
NAME _____ ADDRESS _____ CITY/STATE _____ ZIP _____	Relationship to Patient _____ PHONE (_____) _____

Please read the following statement carefully before signing.

I authorize treatment of the person named above and agree to pay all fees for such treatment. I hereby authorize all benefits to which my dependents or I are entitled to under my health insurance plan. In addition, I will not withhold or delay payment if my insurance denies payment of any of my charges. I have also been informed of the \$35.00 fee (per RCW 62A.3-515&520) on checks returned from my bank NSF. The undersigned agrees that whether he/she signs as an agent, that he/she is obligated to pay for the account. Should the balance of the account exceed an amount the undersigned is able to pay in full, an agreed payment plan can be established with 1% interest per month (per RCW 19.52) on the unpaid balance.

PATIENT'S SIGNATURE _____ DATE _____

PARTNER'S SIGNATURE _____ DATE _____

PARTNER

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	DRIVER'S LICENSE #	BIRTHDATE	SEX
STREET OR ROUTE #			APT #	HOME PHONE (INCLUDING AREA CODE)	
CITY/STATE/ZIP CODE			WORK PHONE (INCLUDING AREA CODE)		
SOCIAL SECURITY #		EMPLOYER			
NAME YOU WISH TO BE CALLED		MARITAL STATUS M S D W	EMPLOYMENT STATUS <input type="checkbox"/> PART <input type="checkbox"/> FULL TIME	STUDENT Y N	TIME/STATUS <input type="checkbox"/> PART <input type="checkbox"/> FULL
REFERRING SOURCE (i.e. MD, PHONE BOOK, OTHER-PLEASE SPECIFY)			EMERGENCY CONTACT - RELATIONSHIP		PHONE NUMBER
RELATIVE NOT LIVING WITH YOU		CITY/STATE			PHONE NUMBER
SPOUSE'S NAME					

RESPONSIBLE PARTY INFORMATION

If the person responsible for the account is someone other than the patient, please complete this section.

LAST NAME	FIRST NAME	MIDDLE INITIAL	BIRTHDATE
STREET OR ROUTE #		APT #	HOME PHONE (INCLUDING AREA CODE)
CITY/STATE/ZIP CODE		WORK PHONE (INCLUDING AREA CODE)	
SOCIAL SECURITY #		EMPLOYER	

INSURANCE INFORMATION

PRIMARY (INCLUDES MEDICARE, DSHS, L & I)		SECONDARY (INCLUDES MEDICARE OR DSHS)	
NAME OF INSURANCE COMPANY		NAME OF INSURANCE COMPANY	
GROUP # OR L & I CLAIM NUMBER		GROUP #	
EMPLOYER		EMPLOYER	
ID # OF SUBSCRIBER	EFFECTIVE DATE	ID # OF SUBSCRIBER	EFFECTIVE DATE
NAME OF SUBSCRIBER	BIRTHDATE	NAME OF SUBSCRIBER	BIRTHDATE
ADDRESS IF DIFFERENT		ADDRESS IF DIFFERENT	
DATE OF INJURY	PLACE OF INJURY		

MEDICAL RELEASE

I hereby authorize my insurance benefits to be paid directly to the clinic. I am financially responsible for any balance due. I authorize the clinic to release any information necessary to process an insurance claim, including industrial injury. Signature acknowledges understanding and consent to all of the above information.

Signature _____ Date _____

We keep a record of the health care services we provide you. You may ask us to see and copy that record. You may also ask us to correct that record. We will not disclose your records to others unless you direct us to do so or unless the law authorizes us or compels us to do so. You may see your record or get more information about it at the clinic.

Thank You



Overlake Reproductive Health, Inc., P.S.

Patient Name: _____ Date: _____

Some infertility tests and services are considered experimental, investigational, or are not covered by your insurance company. Because the above procedures are of medical necessity in determining a diagnosis of male/female infertility or are necessary to infertility treatment, Overlake Reproductive Health will balance bill the patient. This is in accordance with our contract with your insurance company. Failure to sign this document will result in exclusion of treatments not specifically covered by your insurance company.

PATIENT'S SIGNATURE _____

PARTNER'S SIGNATURE _____

WITNESS _____

TO BE PLACED WITH PATIENT CHART



Overlake Reproductive Health

AUTHORIZATION FOR DISCLOSURE OF HEALTH RECORDS AND INFORMATION

I, _____ Birthdate: ___/___/___ Authorize

(Person/Facility)

Street Address

City/State

Zip

Release records to **OVERLAKE REPRODUCTIVE HEALTH, Inc., P.S.**
1135 116th Ave NE, Suite 640
Bellevue, WA 98004
Phone: 425.646.4700 Fax: 425.646.1076

The following information:

Personal health records during the period of: _____

_____ All medical records Chart #: _____
_____ Lab results
_____ X-ray results X-ray#: _____
_____ Original x-rays*

*any original X-rays so released will be promptly returned as soon as possible if necessary.

This consent _____ INCLUDES _____ EXCLUDES Release of information pertaining to (check in each area):
_____ INCLUDES _____ EXCLUDES Drug or alcohol abuse diagnosis or treatment
_____ INCLUDES _____ EXCLUDES HIV (AIDS) testing/treatment
_____ INCLUDES _____ EXCLUDES Psychiatric care/mental illness
_____ INCLUDES _____ EXCLUDES Confirmed STD test results and/or treatment

I understand that records are protected under confidentiality regulations, and any records that contain information regarding drug and/or alcohol abuse that are created by an alcohol abuse or drug abuse prevention program are protected under federal confidentiality laws (42 CFR Part 2) and state law. I understand that said records containing information about the diagnosis, treatment, or referral of alcohol and drug abuse problems cannot be disclosed without my written consent, and that those receiving this information are prohibited from re-disclosing these records unless expressly permitted by my written consent. I understand that any records that contain information regarding HIV and or confirmed STD tests or treatment are protected by state confidentiality laws (RCW 70.24). I understand that and HIV and/or confirmed STD tests or treatment records cannot be disclosed without my written consent unless permitted by State law, and that those receiving this information are prohibited from re-disclosing these records without my further written consent.

This consent may be revoked by me at any time unless action has been taken in reliance on it. If not previously revoked, this consent will terminate in 90 days.

Signature

Print Name

Witnessed

Date



Overlake Reproductive Health

PATIENT TELEPHONE CONSENT

I, _____, give my permission for Overlake
(Print your full name)

Reproductive Health to leave medical information at the following number:

Home: _____ Cell: _____

I understand that a message will be left only if I am unavailable to answer when called.

I give permission for Overlake Reproductive Health to leave a detailed message regardless of the nature of the information being shared with me. I understand that the clinic will leave only the minimum information necessary to convey the message. This information may include but is not limited to laboratory results and instructions for follow-up.

I understand that by giving my consent, I give permission to have normal test results, abnormal test results and next step follow-ups left on voice mail.

Patient initials ____/____

OR

I do not give my consent, I understand that it will be **my responsibility** to call the clinic to obtain this information, if I am not available when called.

Patient initials ____/____

This consent is initialed today, ____/____/____

This consent is in effect until I advise Overlake Reproductive Health in writing of its discontinuance.

Signature _____ Date _____

Witness _____

This notice will be maintained in the medical record

Overlake Reproductive Health ~ Notice of Privacy Practices Acknowledgment

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the Practice Administrator.

Our *Notice of Privacy Practices* describes in more detail how your health information may be used and disclosed, and how you can access your information. The ORH ~ Notice of Privacy Practices can be found at our website: www.overlakereproductivehealth.com (bottom of each page).

By my signature below I acknowledge the availability of the ORH ~ Notice of Privacy Practices.

Patient or legally authorized individual signature _____ Date _____ Time _____

Printed name if signed on behalf of the patient _____ Relationship (parent, legal guardian, personal representative) _____

ORH Staff Witness _____

Office Use Only:

I attempted to obtain the patient's signature on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below.

Date	Staff Member Signature	Reason

This form will be retained in your medical record.



Overlake Reproductive Health

NEW FERTILITY PATIENT QUESTIONNAIRE

IDENTIFYING INFORMATION:

Date: ____/____/____ (of first visit)

Name: _____

Age: _____ yrs Birth date: ____/____/____

Partner's Name: _____

Age: _____ yrs Birth date: ____/____/____

Address: _____

City/State/Zip: _____

Telephone (day): (____) _____ (evening): (____) _____

Occupation: _____ Company: _____

Reason for visit: _____

What are your expectations for this visit? _____

What questions do you want answered at this visit? _____

How did you hear about us? (Please be as specific as possible)

Physician

Name _____ Phone (____) _____

Address _____

Former Patient/Friend _____

Web Site _____ Advertisement _____

Insurance (Name of Insurance) _____

Who is your OB/GYN?

Name _____ Phone (____) _____

Address _____

Who is your Primary Care Physician?

Name _____ Phone (____) _____

Address _____

ETHNICITY: [See Genetics Table](#)

Are you of Caucasian ancestry? yesno

If yes, have you been tested as a carrier of Cystic Fibrosis? yesno

Results: carrier non-carrier

Are you of French Canadian ancestry? yesno

If yes, have you been tested for Tay Sachs disease? yesno

Results: carrier non-carrier

Are you of Jewish ancestry? yesno

If yes, (info at www.jewishgeneticscenter.org/what/) have you been tested as a carrier of the following:

—Tay Sachs disease? carrier non-carrier

—Gaucher’s disease? carrier non-carrier

—Nieman-Pick? carrier non-carrier

—Canavan’s disease? carrier non-carrier

—Fanconi Anemia? carrier non-carrier

—Bloom Syndrome? carrier non-carrier

—Dysautonomia ? carrier non-carrier

Are you of Black ancestry? yesno

If yes, have you been tested for Sickle Cell disease? yesno

Results: carrier non-carrier

Are you of Mediterranean (Greek or Italian) ancestry? yesno

Are you of Asian ancestry? yesno

Are you of Middle Eastern ancestry? yesno

Are you of Caribbean, Mexican, or Central American ancestry? yesno

If yes to any of the above 4 questions, have you been tested as a carrier of Thalassemia?

..... yesno

Results: carrier non-carrier

I do not wish to proceed with further testing. _____

The appropriate available prenatal screens have been discussed (initial) _____

**I. FERTILITY HISTORY:
FEMALE: (Menstrual and Pregnancy History)**

How long have you been having intercourse without using contraception? _____

How long have you been "working" at becoming pregnant? _____

When did you first see a doctor for infertility? _____

Total # of all pregnancies: _____

Please list all pregnancies (include all miscarriages, abortions, tubals, etc)

Date Pregnancy ended or delivered	Length of Pregnancy	How long to conceive	Result	Infertility Therapy?	Current Partner?
1.	wks				<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	wks				<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	wks				<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	wks				<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	wks				<input type="checkbox"/> Yes <input type="checkbox"/> No

Were there any complications or problems during, including high blood pressure, preeclampsia, intrauterine growth retardation, or gestational diabetes?

- Explain:
1. _____
 2. _____
 3. _____
 4. _____

Did you require? (circle pregnancies that apply):

- C-section 1 2 3 4 5
- Surgery 1 2 3 4 5
- Blood transfusion 1 2 3 4 5
- Antibiotics 1 2 3 4 5
- D & C 1 2 3 4 5
- Other 1 2 3 4 5

- Explain:
1. _____
 2. _____
 3. _____
 4. _____

Patient Name _____

Age at first period _____yrs.

Age when you first noticed: Breast development ___yrs Pubic hair ___yrs Underarm hair ___yrs

Date of the first day of your last period ____/____/____

If your menstrual cycles are regular, what is the usual number of days from the first day of one period to the first day of the next? _____

How many days does your menstrual flow last? _____

Do you consider your menstrual flow abnormal? Yes No
(circle): light heavy short long painful other _____

Do you have severe cramping or pelvic pain with your periods?
Yes: ___ Always ___ Sometimes ___ Recently ___ In the past No

Do you have pain with intercourse? Yes No

Do you spot or bleed between periods? Yes No

Do you have pelvic pain between periods? (If it is a significant problem, please complete pelvic pain questionnaire)
Yes No

Do you have premenstrual symptoms other than cramps? Yes No

Do you need medication to bring on a period? Yes No

Are your periods now, or have they ever been irregular or unpredictable? Yes No

If yes:

1. When _____
2. Average # of periods in a year _____
3. Shortest time in between periods _____
4. Longest time spent without menstruating _____

(M.D. use only) _____

Do you have acne or oily skin? Yes No

Do you have a breast discharge? Yes No

Are you currently breast feeding? Yes No

Do you have extra body hair? Yes: Where? _____ No

What has been your maximum weight? _____ When? _____

What has been your minimum adult weight? _____ When? _____

Have you ever had a sudden weight change? Yes: When? _____ No

Do you feel that you are underweight? Yes No

Do you feel that you are overweight? Yes No

Patient Name _____

How many meals do you usually eat per day? _____

Do you follow a particular food diet or have any special dietary habits? Yes No

Have you ever been diagnosed with an eating disorder, such as anorexia or bulimia? Yes No

Have you ever used self-induced vomiting to control overeating? Yes No

Do you regularly participate in any vigorous exercise? Yes No

What: _____

Number of hours _____/week Number of miles _____/week

FEMALE: (Contraceptive History)

Have you ever taken oral contraceptives ("Pill")?

Name _____ From _____ To _____

Name _____ From _____ To _____

Name _____ From _____ To _____

Did you or your doctor note any problems? Yes No

Explain _____

Was it stopped because of a problem? Yes No

Explain _____

Were there any problems with your cycles after stopping the "pills"? Yes No

Explain _____

Have you ever used injectable contraception (Depo-Provera®, Lunelle™, etc.)?

Yes: Dates of use _____ Complications? _____ No

Have you ever used an IUD? Yes No

Name _____; From _____ To _____

Name _____; From _____ To _____

Did you note any problems? Yes No

(Circle) Pain Bleeding Fever Infection

Was it removed because of a problem? Yes No

Explain _____

Have you had tubal sterilization procedure (tubes tied)? Yes: _____ Date (mnth/yr) No

If yes, have you had a tubal reversal (tubes untied)? Yes: _____ Date (mnth/yr) No

FEMALE: (Uterine, Tubal, Pelvic)

Have you ever had any of the following sexually transmitted diseases or pelvic infections?

				Yes (check all that apply)	No
<input type="checkbox"/> Chlamydia: date _____	<input type="checkbox"/> Gonorrhea: date _____	<input type="checkbox"/> Herpes: date _____	<input type="checkbox"/> Genital warts/HPV: date _____		
<input type="checkbox"/> Syphilis: date _____	<input type="checkbox"/> HIV/AIDS: date _____	<input type="checkbox"/> Hepatitis: date _____	<input type="checkbox"/> Other _____: date _____		

Have you had your appendix removed? Yes No
 (Circle one): Uncomplicated Ruptured Complicated Infection

Did your mother take any hormones when she was pregnant with you? Yes No

Have you ever had a D&C for an abortion, to end a miscarriage, following childbirth, or for abnormal bleeding? Yes No

Explain: _____

FEMALE: (Testing and Treatment)

Please indicate the tests you have had to check for ovulation and a normal cycle. Also briefly indicate the test results.

TEST	RESULTS
_____ Basal Temperatures	_____
_____ Urine L.H. Tests (ovulation predictor)	_____
_____ Follicle Ultrasound	_____
_____ Progesterone Level	_____
_____ Endometrial Biopsy	_____
_____ Post-Coital Test	_____

Have you ever had any of the following?

Procedure	Dates	Results
Hysterosalpingogram:		
Hysteroscopy:		
Laparoscopy:		
Tubal Surgery:		
Abdominal Surgery:		
Other Pelvic Surgery:		

Patient Name _____

Have you ever been noted to have or been treated for endometriosis? Yes No

Treatment: _____

Prior Treatment:

Have you ever taken any of the following medications to induce ovulation or normalize your cycle? (circle)

Clomid	Serophene	Parlodel	Repronex	HCG
Letrozole	Progesterone	Bravelle	Pergonal	GNRH
Prednisone	Lupron	Other		

Dates	Medication	Dose	Results	Comments
-------	------------	------	---------	----------

Prior Treatment: Check all that apply:

	# of cycles	Dates (mo/yr) (mo/yr)	Outcome
<input type="checkbox"/> Intrauterine insemination:	_____	From ___/___ to ___/___	___Pregnant: ___Delivered ___Ectopic ___Miscarriage ___Not Pregnant
<input type="checkbox"/> Clomiphene citrate with timed intercourse: Maximum # tablets/day? _____	_____	From ___/___ to ___/___	___Pregnant: ___Delivered ___Ectopic ___Miscarriage ___Not Pregnant
<input type="checkbox"/> Clomiphene citrate with insemination: Maximum # tablets/day? _____	_____	From ___/___ to ___/___	___Pregnant: ___Delivered ___Ectopic ___Miscarriage ___Not Pregnant
<input type="checkbox"/> Daily fertility drug injections with insemination: Maximum # vials/day? _____	_____	From ___/___ to ___/___	___Pregnant: ___Delivered ___Ectopic ___Miscarriage ___Not Pregnant
<input type="checkbox"/> Completed in vitro fertilization cycle(s):			___Pregnant: ___Delivered ___Ectopic ___Miscarriage ___Not Pregnant
1. #eggs___ #embryos transferred___#frozen___	_____	_____/____/_____	___Pregnant: ___Delivered ___Ectopic ___Miscarriage ___Not Pregnant
2. #eggs___ #embryos transferred___#frozen___	_____	_____/____/_____	___Pregnant: ___Delivered ___Ectopic ___Miscarriage ___Not Pregnant
3. #eggs___ #embryos transferred___#frozen___	_____	_____/____/_____	___Pregnant: ___Delivered ___Ectopic ___Miscarriage ___Not Pregnant
4. #eggs___ #embryos transferred___#frozen___	_____	_____/____/_____	___Pregnant: ___Delivered ___Ectopic ___Miscarriage ___Not Pregnant
<input type="checkbox"/> Frozen embryo transfers:			___Pregnant: ___Delivered ___Ectopic ___Miscarriage ___Not Pregnant
1. #embryos transferred_____	_____	_____/____/_____	___Pregnant: ___Delivered ___Ectopic ___Miscarriage ___Not Pregnant
2. #embryos transferred_____	_____	_____/____/_____	___Pregnant: ___Delivered ___Ectopic ___Miscarriage ___Not Pregnant
3. #embryos transferred_____	_____	_____/____/_____	___Pregnant: ___Delivered ___Ectopic ___Miscarriage ___Not Pregnant
4. #embryos transferred_____	_____	_____/____/_____	___Pregnant: ___Delivered ___Ectopic ___Miscarriage ___Not Pregnant
Cancelled in vitro fertilization attempt(s):	_____		
Any other prior treatment (describe): _____			

Additional Information/Complications: _____

MALE FACTORS

Partner's Name: _____ Age: _____

Occupation: _____

ETHNICITY OF PARTNER: [See Genetics Table](#)

Is your partner of Caucasian ancestry? yesno

If yes, has he been tested as a carrier of Cystic Fibrosis? yesno

Results: carrier non-carrier

Is he of French Canadian ancestry? yesno

If yes, has he been tested for Tay Sachs disease? yesno

Results: carrier non-carrier

Is he of Jewish ancestry? yesno

If Yes, (info at www.jewishgeneticscenter.org/what/) has he been tested as a carrier of the following:

—Tay Sachs disease? carrier non-carrier

—Gaucher's disease? carrier non-carrier

—Nieman-Pick? carrier non-carrier

—Canavan's disease? carrier non-carrier

—Fanconi Anemia? carrier non-carrier

—Bloom Syndrome? carrier non-carrier

—Dysautonomia ? carrier non-carrier

Is he of Black ancestry? yesno

If yes, has he been tested for Sickle Cell disease? yesno

Results: carrier non-carrier

Is he of Mediterranean (Greek or Italian) ancestry? yesno

Is he of Asian ancestry? yesno

Is he of Middle Eastern ancestry? yesno

Is he of Caribbean, Mexican, or Central American ancestry? yesno

If yes to any of the above 4 questions, has he been tested as a carrier of Thalassemia? .

..... yes no

Results: carrier non-carrier

My partner does not wish to proceed with further testing (initial) _____

The appropriate prenatal screens have been discussed (initial) _____

Has your partner previously conceived with another woman? Yes - how many times? ___ No

If no, was birth control used? Yes No

Has your partner had a semen analysis? Yes No

Dates **Results**

Has your partner been seen by a urologist? Yes No

Dates **Results**

Patient Name _____

Has your partner had difficulty with erections? Yes No
 Does he have retrograde ejaculation of sperm into the bladder? Yes No
 Has he had any of the following sexually transmitted diseases or pelvic infections?
 Yes (check all that apply) No

Chlamydia: date _____ Gonorrhea: date _____ Herpes: date _____ Genital warts/HPV: date _____
 Syphilis: date _____ HIV/AIDS: date _____ Hepatitis: date _____ Other _____: date _____

Has your partner had a history of undescended testicles? Yes - one side ___ both ___ No
 Does he have scrotal or testicular pain? Yes No
 Did he have the mumps after puberty? Yes No
 Has he had prior injury to his testicles requiring hospitalization? Yes No

Has your partner been diagnosed with any of the following diseases?
 Yes (check all that apply) No
 Diabetes Mellitus Prostatic Infections Cancer
 Multiple Sclerosis Urinary Infections Other neurologic problems
 High Blood Pressure - if yes, any medications: _____

Has your partner had any fever in the last 3 months? Yes No
 Has he had a vasectomy? Yes - date _____ No
 If yes, has he had a vasectomy reversal? Yes - date _____ No
 Has he had surgery for varicocele repair? Yes No
 Has he had hernia surgery? Yes No
 Did your partner undergo any bladder or penis surgery as a child? Yes No
 Is he exposed to prolonged heat in the workplace? Yes No
 Is he exposed to any radiation or harmful chemicals in the workplace? Yes No
 Has he had chemotherapy for cancer? Yes No

Is he allergic to any medications? Yes (please list and describe reactions) No

List his current medications: _____

List any current medical problem(s): _____

Has your partner had treatment to improve his fertility? Yes No

Dates	Results

How many caffeinated beverages does he drink per day? _____ None

Does he use or has he ever used:

- | | | |
|--|-----|----|
| 1. Alcohol, (# of glasses per week) | Yes | No |
| Wine _____ Beer _____ Cocktails _____ | | |
| 2. Cigarettes, (present _____ prior _____) | Yes | No |
| # packs per day _____ # of years _____ | | |
| 3. Illicit or recreational drugs (specify) | Yes | No |
| _____ | | |
| _____ | | |

Have you or your partner ever been in a program for limiting or discontinuing use of drugs or alcohol? Yes No

Does your partner use herbal medicines/vitamins or health food store supplements? Yes (describe) _____ No

Are you aware of any radiation/toxic materials exposure? Yes No

Does your partner use hot tubs regularly? Yes No

Did his mother take DES during pregnancy to prevent miscarriage? Yes No

Have any of his immediate family members had difficulty conceiving a child? Yes (describe) _____ No

COUPLE FACTORS

How frequently do you have sexual intercourse?

- More than once a day _____
- Daily or almost daily _____
- 3-5 times a week _____
- 1-2 time a week _____
- Less than once a week _____
- Irregularly _____

Which of the following best describes how you feel about your sex life?

- Very satisfied _____
- Fairly satisfied _____
- Fairly unsatisfied _____
- Very unsatisfied _____

Which of the following best describes how you think your partner feels about your mutual sex life?

- Very satisfied _____
- Fairly satisfied _____
- Fairly unsatisfied _____
- Very unsatisfied _____

Patient Name _____

Do any of these statements describe sex with your partner?

- It is sometimes difficult _____
- It is almost always difficult _____
- It is sometimes painful _____
- It is almost always painful _____
- It is sometimes unpleasant _____
- It is almost always unpleasant _____
- It is sometimes enjoyable _____
- It is almost always enjoyable _____

Do you or your partner have problems with initiating or completing sexual intercourse?

Yes No

Do you plan intercourse for a specific time of your cycle?

Yes No

When: _____

Do you use lubricant for intercourse?

Yes No

Do you douche before or after intercourse?

Yes No

Do you feel that your fertility problem is:

- 1. Causing personal stress Yes No
- 2. Causing stress between you and your husband Yes No
- 3. Interfering with a satisfactory sex life Yes No

II. FAMILY HISTORY: MALE FAMILY HISTORY

Relative	Alive/Dead	Age
Mother _____	A/D _____	_____
Father _____	A/D _____	_____
Sisters/Brothers:		
1. S / B _____	A/D _____	_____
2. S / B _____	A/D _____	_____
3. S / B _____	A/D _____	_____
4. S / B _____	A/D _____	_____

Patient Name _____

Have any of your partner's relatives ever had the diseases or conditions listed below?

Condition	Mother	Father	Brother/Sister	Other
Alcoholism	M	F	S	O
Anemia	M	F	S	O
Diabetes	M	F	S	O
Cancer	M	F	S	O
Bleeding disorders	M	F	S	O
Heart disease	M	F	S	O
High blood pressure	M	F	S	O
Kidney disease	M	F	S	O
Stroke	M	F	S	O
Blood clots	M	F	S	O
Thyroid disease	M	F	S	O
Excess hair growth	M	F	S	O
Epilepsy	M	F	S	O
Birth defects	M	F	S	O
Muscular dystrophy	M	F	S	O
Cystic fibrosis	M	F	S	O
Mental retardation	M	F	S	O
Physical retardation	M	F	S	O
Downs syndrome	M	F	S	O
Other chromosome defects	M	F	S	O
Obesity	M	F	S	O
Psychiatric problems	M	F	S	O

Do any hereditary diseases or abnormal conditions run in his family? Yes No

FEMALE FAMILY HISTORY

Relative	Alive/Dead	Age
Mother _____	A/D _____	_____
Father _____	A/D _____	_____
Sisters/Brothers:		
1. S / B _____	A/D _____	_____
2. S / B _____	A/D _____	_____
3. S / B _____	A/D _____	_____
4. S / B _____	A/D _____	_____

Have any of your blood relatives ever had the diseases or conditions listed below?

Condition	Mother	Father	Brother/Sister	Other
Alcoholism	M	F	S	O
Anemia	M	F	S	O
Diabetes	M	F	S	O
Cancer	M	F	S	O
Bleeding disorders	M	F	S	O
Heart disease	M	F	S	O
High blood pressure	M	F	S	O
Kidney disease	M	F	S	O
Stroke	M	F	S	O
Blood clots	M	F	S	O
Thyroid disease	M	F	S	O
Excess hair growth	M	F	S	O
Epilepsy	M	F	S	O
Birth defects	M	F	S	O
Muscular dystrophy	M	F	S	O
Cystic fibrosis	M	F	S	O
Mental retardation	M	F	S	O
Physical retardation	M	F	S	O
Downs syndrome	M	F	S	O
Other chromosome defects	M	F	S	O
Frequent miscarriages	M	F	S	O
Stillbirths	M	F	S	O
Twins	M	F	S	O
Early menopause (before age 40)	M	F	S	O
Endometriosis	M	F	S	O
Infertility	M	F	S	O
Irregular periods	M	F	S	O
Obesity	M	F	S	O
Psychiatric problems	M	F	S	O

Do any hereditary diseases or abnormal conditions run in your family (including breast, bowel or ovarian cancer)? Yes No

III. FEMALE MEDICAL HISTORY:

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

- | | | |
|------------------|----------------------|-----------------------|
| Scarlet fever | High blood pressure | Neurological problems |
| Rheumatic fever | Gallbladder problems | Seizures |
| Tuberculosis | Liver problems | Epilepsy |
| Hepatitis | Ulcers | Dizziness |
| Heart murmur | Appendicitis | Loss of balance |
| Pelvic infection | Colitis | Chronic headaches |
| Chicken pox | Anemia | Vaginitis |
| Thyroid problems | Arthritis | Pneumonia |
| Cancer | Breast lump | Parasites |
| Kidney infection | Breast problems | Ovarian cysts |
| Heart disease | Breast discharge | Other _____ |

Comments _____

Patient Name _____

PAP SMEAR HISTORY

When was your last pap smear? (month/year) ____/____ Normal Abnormal

When was your last abnormal pap smear? ____/____ Not applicable

Have you undergone any procedures as a result of an abnormal pap smear?

Yes (check all that apply) No

Colposcopy Cryosurgery (freezing) Laser treatment Conization LEEP procedure

BREAST SCREENING HISTORY

Have you ever had a mammogram?

Yes - date _____ Result: normal abnormal - explain _____ No

Do you perform breast self exams? Yes No

Have you ever had Rubella (German measles)? Yes No

Have you received Rubella immunization? Yes No

Have you ever undergone surgery? Yes No

Date	Type	Hospital

Were there:

Complications? Yes No

Anesthesia problems? Yes No

Bleeding problems? Yes No

Comments _____

Are you allergic to any medication, drugs, foods, metals, other? Yes (list and describe reactions) No

Do you regularly take medications? Yes No

1. Over the counter (list) Yes No

2. Prescriptions (list) Yes No

3. Are you taking any now (list) Yes No

Do you use or have you ever used:

1. Alcohol, (# of glasses per week) Wine ____ Beer ____ Cocktails ____ Yes No

2. Cigarettes, (present _____ prior _____)
packs per day _____ # of years _____ Yes No

3. Illicit or recreational drugs (specify) Yes No

_____ **Past / Present (circle)**

IV. REVIEW OF SYSTEMS

General:

- Recent weight gain or loss
- Anorexia/Bulimia
- Lack of energy
- Fever/Chills
- Other _____
- none

Endocrine/Hormonal:

- Diabetes Hair loss
- Thyroid gland problems
- Rapid weight gain or loss
- Excessive hunger/thirst
- Temperature intolerance - hot flashes or feeling cold
- Other _____
- none

Gastrointestinal:

- Nausea/Vomiting Ulcers
- Hepatitis Diarrhea
- Blood in your stools Constipation
- Irritable Bowel Syndrome
- Change in bowel habits
- Colitis (Ulcerative or Crohn's)
- Other _____
- none

Musculoskeletal:

- Unusual muscle weakness
- Decreased energy/stamina
- Rheumatoid arthritis
- Lupus Erythematosus
- Myasthenia gravis
- Other _____
- none

Mental Health Problems:

- Depression Anxiety disorder
- Schizophrenia
- Other _____
- none

Head, Eyes, Ears, Nose and Throat:

- Dizziness Loss of sense of smell
- Headaches Chronic nasal congestion
- Blurred vision Ringing ears
- Hearing loss/deafness
- Other _____
- none

Breasts:

- Discharge: clear ___ bloody ___ milky ___
- Lumps Pain Cancer
- Abnormal mammogram
- Reduction
- Augmentation/Breast implants
Saline ___ Silicone ___
- Other _____
- none

Genito-Urinary:

- Bladder infections
- Kidney infections
- Vaginal infections
- Frequent urination Leaking urine
- Blood in the urine
- Herpes
- Other _____
- none

Hematologic:

- Blood clotting disorder/Blood clot
- Sickle Cell Anemia Thrombophlebitis
- Easy bruising
- Swollen glands/lymph nodes
- Blood transfusions (dates/reasons _____)
- Other _____
- none

Respiratory:

- Shortness of breath
- Asthma Bronchitis
- Pneumonia Tuberculosis
- Bloody cough
- Other _____
- none

Neurological Problems:

- Weakness/Loss of balance
- Seizures/Epilepsy
- Headaches
- Migraine headaches
- Numbness
- Memory loss
- Other _____
- none

Skin/Extremities:

- Unexplained rash/inflammation
- Acne
- Skin cancer
- Burn injury
- Moles changing in appearance
- Excess hair growth
- Other _____
- none

Cardiovascular:

- Palpitations/Skipped beats
- Chest pain Heart attack
- Stroke Murmurs
- High blood pressure
- Rheumatic fever
- Mitral valve prolapse (need antibiotics before dental procedures? Yes ___ No ___)
- Other _____
- none

Physician Notes (for office use only) _____

V. PHYSICAL EXAM:**Office Use Only**

Height _____ Weight _____ Pulse _____ B.P. _____

Stature _____ Race _____

General Appearance: Well developed Well nourished Normal mood/affect Oriented x3
 No acute distressSkin: Acne XS Sebum Hirsutism (facial, chest, back, areolar, abd., thigh)
 No lesions No abnormal molesNeck: Supple Without massesThyroid: WNL No masses Without thyromegalyBreast: No dominant masses No skin changes No nipple dischargeLungs: Clear to auscultation bilaterally Normal respiratory effortHeart: Regular rhythm and rate No murmurs/gallopsAbdomen: Soft, non-distended No masses/HSM No herniasBack: No CVA tendernessLymphatic: No neck No axillary No groin lymphadenopathyExtremities: Without varicosities Without edema Nontender calvesPelvic Exam: Normal external genitalia Adnexa NTUrethral meatus/urethra: Without lesions, tenderness or prolapseBladder: Without masses, tenderness Well supportedVagina: Well supported No lesions No abnormal dischargeCervix: Without lesions No CMTUterus Position: Normal size & shape Nontender Without descentAdnexa: Normal size No adnexal masses No tendernessAnus/Perineum: No lesionsRectal: Normal sphincter tone No hemorrhoids No tenderness

Other Findings:

The above was discussed with the patient at the New Patient Consultation.

Signed: _____ Date: _____

**WHAT OTHER GROUPS OF PEOPLE
HAVE SPECIFIC GENETIC DISEASES?**

It is estimated that we all carry 6 - 8 disease-producing genes which would be harmful if passed on to our children by both mother and father.

Many other racial and ethnic groups have "their own" genetic disorders - disorders which are not unique to the group, but which are more common in the group.

Ancestry	Disease	Carrier Frequency	Disease Incidence
Blacks	Sickle Cell Anemia	1 in 12.....	1 in 600
Ashkenazi Jews	Tay-Sachs disease	1 in 30.....	1 in 3,600
Ashkenazi Jews	Canavan disease	1 in 35 - 40	1 in 6,000
Greeks, Italians.....	beta-thalassemia.....	1 in 30.....	1 in 3,600
SE Asians, Chinese	alpha-thalassemia	1 in 25.....	1 in 2,500
N. Europeans.....	Cystic fibrosis	1 in 25.....	1 in 2,500