AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE
Infertility History Form

FOR OFFICE USE ONLY

IMPORTANT:
Please complete this form and return it to our office at least one week prior to your appt.
This form was developed by the American Society for Reproductive Medicine to assist physicians and patients in obtaining a complete infertility history. It consists of three parts:

Part I: Contact information
Part II: Your medical history
Part III: Your spouse/male partner's medical history (if applicable)

PART I: CONTACT INFORMATION

First Name _____ **Middle Initial** _____ **Last Name** _____ **Age** _____

Date of Birth (MM/DD/YY) ____/____/____ Occupation _____

Home Street Address _____

City _____ State _____ Zip/Postal Code _____ Country _____

Indicate which number to call or leave messages.
☐ Home Telephone ( ) _____ ☐ Cell Phone ( ) _____ ☐ Email _____

Are you married? ☐ Yes ☐ No ☐ Divorced ☐ _____

Spouse/Male Partner
First Name _____ **Middle Initial** _____ **Last Name** _____ **Age** _____
☐ Not Applicable

Date of Birth (MM/DD/YY) ____/____/____ Occupation _____

Home Street Address _____

City _____ State _____ Zip/Postal Code _____ Country _____

Indicate which number to call or leave messages.
☐ Home Telephone ( ) _____ ☐ Cell Phone( ) _____ ☐ Email: _____

Who referred you?
☐ Physician
Name _____
Address _____ Phone ( ) _____
☐ Former Patient/Friend _____
☐ Web Site _____
☐ Insurance (Name of Insurance) _____

Who is your Ob/Gyn?
Name _____
Address _____ Phone ( ) _____

Who is your Primary Care Physician?
Name _____
Address _____ Phone ( ) _____

Physician Notes
(for office use only)

PART II: FEMALE HISTORY AND INFORMATION

Reason for Visit: ☐ Infertility Evaluation ☐ Sperm Insemination ☐ Other _____

What are your expectations for this visit? _____

What questions do you want answered at this visit? _____

_____

Do you have any **personal, ethical or religious objections** to any of our tests or treatments, such as insemination, in vitro fertilization, egg donation, sperm donation, masturbation to collect a semen sample, etc.? ☐ No ☐ Yes _____

How many months have you been having intercourse without using any form of birth control? _____

Pregnancy Summary

* Total Number of ALL Pregnancies: _____ * Number of miscarriages (less than 20 weeks): _____
* Number of Ectopic/Tubal Pregnancies: _____ * Number of Elective Terminations (Abortions): _____
* Number of Full Term Deliveries: _____ Of these, how many were live births? _____ How many were stillborn? _____
* Any Pregnancies with Birth Defects? ☐ No ☐ Yes – explain _____

Date Pregnancy Ended or Delivered	Months to Conception	Treatments to Conceive	Delivery Type/D&C/ Complications	Current Partner?
1. _____	_____	_____	_____	Y N
2. _____	_____	_____	_____	Y N
3. _____	_____	_____	_____	Y N
4. _____	_____	_____	_____	Y N
5. _____	_____	_____	_____	Y N
6. _____	_____	_____	_____	Y N

Menstrual History

* Menstrual cycle pattern (check all that apply): ☐ Regular periods ☐ Irregular periods ☐ Spotting before periods ☐ No periods ☐ Heavy periods ☐ Light periods ☐ Bleeding between periods
* Number of days between the start of one period to the start of the next period: _____ days
* How many days of bleeding do you have? _____ days
* Dates of the 1st day of your last 2 menstrual periods: ____/____/____; ____/____/____
* Age when you had your first period: ____ years old
* Age when you first noticed: Breast development: ____ years old; Pubic hair: ____ years old; Underarm hair: ____ years old
* How many periods do you have per year? _____
* Do you need medication to bring on a period? ☐ Yes – what type? _____ ☐ No
* If you do not have periods, at what age did you stop having them? _____ years old
* Do you have severe cramping or pelvic pain with your periods? ☐ Yes: __Always __Sometimes __Recently __In the Past ☐ No

Contraceptive History

☐ None ☐ Condoms – dates of use_____ ☐ Diaphragm – dates of use_____ ☐ IUD – dates of use_____
☐ Birth control pills – dates of use_____-complications? _____ ☐ Never used birth control pills
☐ Injectable contraception (Depo-Provera®, Lunelle™, etc.) – dates of use_____-complications? _____
☐ Skin patch – dates of use_____-complications? _____ ☐ Foam or jelly
☐ Tubal sterilization procedure (tubes tied) – date (month/year) ____/____ ☐ Tubes untied – date (month/year) ____/____

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

Sexual History

* How many times do you have intercourse per week? ____times per week ☐ None ☐ Not applicable
* Have you used over-the-counter ovulation kits to time intercourse? ☐ Yes ☐ No
* Do you have pain with intercourse? ☐ Yes ☐ No
* Do you use lubricants (K-Y Jelly®, etc) during intercourse? ☐ Yes-what types? _____ ☐ No

Have you 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_____

Pap Smear History

* When was your last pap smear (month and 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? ☐ No ☐ Yes – date_____ Result: ☐ normal ☐ abnormal – explain_____
Do you perform breast self exams? ☐ Yes ☐ No

Medical History

* Are you allergic to any medications? ☐ No ☐ Yes (Please list and describe reactions) _____

* Are you allergic to any foods (peanuts, eggs, etc.)? ☐ No ☐ Yes (Please list and describe reactions) _____

* List any medications you are currently taking, including over-the-counter medicines: _____

* Do you take any herbal medicines/vitamins or health food store supplements? ☐ No ☐ Yes (Please list) _____

* Do you have any medical problem(s)? ☐ No ☐ Yes (Please list type, dates and treatments.)
(1)_____
(2)_____
(3)_____
(4)_____
(5)_____

* Did you have either of these childhood illnesses? ☐ Chickenpox (Varicella) ☐ German Measles (Rubella) ☐ Don't know
Other childhood diseases: _____

Vaccinations

* Chickenpox (Varicella):	☐ No	☐ Yes (dates_____)	☐ Don't know
* MMR – Measles, Mumps and Rubella (German Measles):	☐ No	☐ Yes (dates_____)	☐ Don't know
* BCG (Tuberculosis):	☐ No	☐ Yes (dates_____)	☐ Don't know
* Hepatitis B:	☐ No	☐ Yes (dates_____)	☐ Don't know
* Polio:	☐ No	☐ Yes (dates_____)	☐ Don't know
* Hepatitis A:	☐ No	☐ Yes (dates_____)	☐ Don't know
* Tetanus:	☐ No	☐ Yes (dates_____)	☐ Don't know
* Influenza:	☐ No	☐ Yes (dates_____)	☐ Don't know

Social History

* How many caffeinated beverages (coffee, tea, soda) do you drink every day?_____ ☐ None
* Do you smoke cigarettes: ☐ No ☐ Yes How many/day?_____ How many years?_____ ☐ Quit – when?_____
* Do you drink alcohol? ☐ No ☐ Yes
☐ Beer - # per week_____ ☐ Wine - # per week ☐ Liquor - # per week
* Do you use marijuana, cocaine, or any other similar drug? ☐ No ☐ Yes (describe_____)
* Do you exercise? ☐ No ☐ Yes (describe_____)
* Are you aware of any radiation exposures other than X-rays? ☐ No ☐ Yes (describe_____)

Physician Notes (for office use only)_____

Surgical History

* Have you had any surgeries? ☐ No ☐ Yes (List all surgeries in chronologic order.)

Year	Reason and Type of Surgery
_____	(1)_____
_____	(2)_____
_____	(3)_____
_____	(4)_____
_____	(5)_____
_____	(6)_____
_____	(7)_____

*Did you have any anesthesia problems? ☐ No ☐ Yes (describe_____)

Physical Symptoms

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
- ☐ Excessive 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?) Y N
- ☐ Other_____
- ☐ None

Physician Notes (for office use only) _____

Family History

	Living	Cause of Death/Age at Death	Relationship to You
* Mother	☐ Yes – age___ ☐ No		
* Father	☐ Yes – age___ ☐ No		
* Brother (s)	☐ Yes – age___ ☐ No		
* Sister(s)	☐ Yes – age___ ☐ No		
* Maternal Grandmother	☐ Yes – age___ ☐ No		
* Maternal Grandfather	☐ Yes – age___ ☐ No		
* Paternal Grandmother	☐ Yes – age___ ☐ No		
* Paternal Grandfather	☐ Yes – age___ ☐ No		

Disorders in Your Family

* Breast cancer	☐ Yes	☐ No	☐ Don't Know
* Ovarian cancer	☐ Yes	☐ No	☐ Don't Know
* Colon cancer	☐ Yes	☐ No	☐ Don't Know
* Other cancer	☐ Yes	☐ No	☐ Don't Know
* Diabetes	☐ Yes	☐ No	☐ Don't Know
* Thyroid problems	☐ Yes	☐ No	☐ Don't Know
* Heart disease	☐ Yes	☐ No	☐ Don't Know
* Blood clots	☐ Yes	☐ No	☐ Don't Know
* Obesity	☐ Yes	☐ No	☐ Don't Know
* Psychiatric problems	☐ Yes	☐ No	☐ Don't Know
* Tuberculosis	☐ Yes	☐ No	☐ Don't Know
* Endometriosis	☐ Yes	☐ No	☐ Don't Know
* Infertility	☐ Yes	☐ No	☐ Don't Know
* Menopause before age 40	☐ Yes	☐ No	☐ Don't Know
* Birth defects	☐ Yes	☐ No	☐ Don't Know
* Cystic Fibrosis	☐ Yes	☐ No	☐ Don't Know
* Tay-Sachs disease	☐ Yes	☐ No	☐ Don't Know
* Canavan disease	☐ Yes	☐ No	☐ Don't Know
* Bloom syndrome	☐ Yes	☐ No	☐ Don't Know
* Gaucher disease	☐ Yes	☐ No	☐ Don't Know
* Niemann-Pick disease	☐ Yes	☐ No	☐ Don't Know
* Fanconi Anemia	☐ Yes	☐ No	☐ Don't Know
* Familial Dysautonia	☐ Yes	☐ No	☐ Don't Know
* Muscular Dystrophy	☐ Yes	☐ No	☐ Don't Know
* Neurologic (brain/spine)	☐ Yes	☐ No	☐ Don't Know
* Neural Tube Defects	☐ Yes	☐ No	☐ Don't Know
* Bone/Skeletal Defects	☐ Yes	☐ No	☐ Don't Know
* Dwarfism	☐ Yes	☐ No	☐ Don't Know
* Developmental delay	☐ Yes	☐ No	☐ Don't Know
* Learning problems	☐ Yes	☐ No	☐ Don't Know
* Polycystic kidney disease	☐ Yes	☐ No	☐ Don't Know
* Heart defect from birth	☐ Yes	☐ No	☐ Don't Know
* Down syndrome	☐ Yes	☐ No	☐ Don't Know
* Other chromosome defects	☐ Yes	☐ No	☐ Don't Know
* Marfan syndrome	☐ Yes	☐ No	☐ Don't Know
* Hemophilia	☐ Yes	☐ No	☐ Don't Know
* Sickle Cell Anemia	☐ Yes	☐ No	☐ Don't Know
* Thalassemia	☐ Yes	☐ No	☐ Don't Know
* Galactosemia	☐ Yes	☐ No	☐ Don't Know
* Deafness/Blindness	☐ Yes	☐ No	☐ Don't Know
* Color Blindness	☐ Yes	☐ No	☐ Don't Know
* Hemochromatosis	☐ Yes	☐ No	☐ Don't Know

☐ None of the above

☐ Other (Specify_____)

What is your ancestry?

____ African-American

____ American Indian/Native American

____ Ashkenazi Jewish

____ Asian-American

____ Cajun/French Canadian

____ Caucasian

____ Eastern European

____ Hispanic/Caribbean

____ Northern European

____ Southern European

____ Other (specify_____)

Would you like to be screened for:

____ Cystic Fibrosis: __Yes __No

____ Sickle Cell Anemia: __Yes __No

____ Tay-Sachs Disease: __Yes __No

____ Thalassemia: __Yes __No

PRIOR INFERTILITY TESTING AND TREATMENT

* Have you had prior infertility testing or treatment elsewhere? ☐ Yes ☐ No

Prior Tests (check all that apply): ☐ Basal body temperature chart (date_____/results_____)
☐ Thyroid test (date_____/results_____) ☐ Ovulation test kit (date_____/results_____)
☐ Day 3 blood test for FSH level (date_____/results_____) ☐ Hysterosalpingogram (HSG) (date_____/results_____)
☐ Laparoscopy surgery (date_____/results_____) ☐ Hysteroscopy surgery (date_____/results_____)
☐ Progesterone blood test (date_____/results_____) ☐ Prolactin blood test (date_____/results_____)

Prior Treatment (check all that apply):

	# of cycles	Dates (mo/yr) (mo/yr)	Outcome
☐ Intrauterine insemination:	_____	From__/___ to __/___	__Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant
☐ Clomiphene citrate with timed intercourse: Maximum # tablets per day?_____	_____	From__/___ to __/___	__Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant
☐ Clomiphene citrate with insemination: Maximum # tablets per day?_____	_____	From__/___ to __/___	__Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant
☐ Daily fertility drug injections with insemination?: Maximum # vials per day?_____	_____	From__/___ to __/___	__Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant
☐ Completed in vitro fertilization cycle(s): 1. # eggs___ # embryos transferred__ # frozen___ 2. # eggs___ # embryos transferred__ # frozen___ 3. # eggs___ # embryos transferred__ # frozen___ 4. # eggs___ # embryos transferred__ # frozen___	_____	_____/_____ _____/_____ _____/_____ _____/_____	__Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant __Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant __Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant __Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant
☐ Frozen embryo transfers: 1. # embryos transferred _____ 2. # embryos transferred _____ 3. # embryos transferred _____ 4. # embryos transferred _____	_____	_____/_____ _____/_____ _____/_____ _____/_____	__Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant __Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant __Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant __Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant
Canceled in vitro fertilization attempt(s):	_____		
☐ Any other prior treatment (describe):			

* Additional Information/Complications: _____

EMOTIONAL STATUS

On a scale of 1-10 (10 being the worst), estimate the level of stress you feel due to infertility and other pressures: _____
Do you see a counselor? ☐ No ☐ Yes – For how long? _____ How often? _____
List any antidepressant/antianxiety medications you are currently taking: _____
Describe any emotional, marital or sexual problems caused by your infertility. _____

PATIENT'S SIGNATURE _____ DATE _____

I confirm that I have reviewed the information above.

PHYSICIAN'S SIGNATURE _____ DATE _____

Complete with your male partner, if applicable.

* Have you been evaluated by a urologist? ☐ Yes ☐ No
* Have you previously conceived with another woman? ☐ Yes: How many times? ____ ☐ No: Birth control used? Yes___ No___
* Have you had a semen analysis? ☐ Yes ☐ No
* Do you have difficulty with erections? ☐ Yes ☐ No
* Do you have retrograde ejaculation of sperm into the bladder? ☐ Yes ☐ No
* Have you 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_____
* Have you had a history of undescended testicles? ☐ Yes – One side____ Both____ ☐ No
* Do you have scrotal or testicular pain? ☐ Yes ☐ No
* Did you have mumps after puberty? ☐ Yes ☐ No
* Have you had prior injury to your testicles requiring hospitalization? ☐ Yes ☐ No

*Have you been diagnosed with any of the following diseases?
☐ Diabetes Mellitus – Yes___ No___ ☐ Cancer – Yes___ No___
☐ Multiple Sclerosis – Yes___ No___ ☐ Other neurologic problems – Yes___ No___
☐ Prostatic infections – Yes___ No___ ☐ Urinary infections – Yes___ No___
☐ High Blood Pressure – Yes___ No___ If yes, any medications?_____

* Have you had any fever in the last 3 months? ☐ Yes ☐ No
* Have you had a vasectomy? ☐ Yes (date_____) ☐ No
If yes, have you had a vasectomy reversal? ☐ Yes (date_____) ☐ No
* Have you had surgery for varicocele repair? ☐ Yes ☐ No
* Have you had hernia surgery? ☐ Yes ☐ No
* Did you undergo any bladder or penis surgery as a child? ☐ Yes ☐ No
* Are you exposed to prolonged heat in the workplace? ☐ Yes ☐ No
* Are you exposed to any radiation or harmful chemicals in the workplace? ☐ Yes ☐ No
* Have you had chemotherapy for cancer? ☐ Yes ☐ No
* Are you allergic to any medications? ☐ No ☐ Yes (Please list and describe reactions)_____

List your current medications: _____

List any current medical problem(s)_____

* How many caffeinated beverages do you drink per day?_____ ☐ None
* Do you smoke cigarettes? ☐ No ☐ Yes How many/day? How many years?____ ☐ Quit – when?_____
* Do you drink alcohol? ☐ No ☐ Yes
  ☐ Beer - # per week___ ☐ Wine - # per week___ ☐ Liquor - # per week___
* Do you use marijuana, cocaine or any other similar drug? ☐ No ☐ Yes (describe_____)
* Do you use herbal medicines/vitamins or health food store supplements? ☐ No ☐ Yes (describe_____)
* Are you aware of any radiation/toxic materials exposure? ☐ Yes ☐ No

* Do you use hot tubs regularly? ☐ Yes ☐ No
* Did your mother take DES during pregnancy to prevent miscarriage? ☐ Yes ☐ No ☐ Don't Know
* Have any of your immediate family members had difficulty conceiving a child? ☐ Yes ☐ No
If yes, please describe_____

Physician Notes (for office use only)

Disorders in Your Family

		Relationship to You		
* Cystic Fibrosis	☐ Yes	_____	☐ No	☐ Don't Know
* Tay-Sachs disease	☐ Yes	_____	☐ No	☐ Don't Know
* Canavan disease	☐ Yes	_____	☐ No	☐ Don't Know
* Bloom syndrome	☐ Yes	_____	☐ No	☐ Don't Know
* Gaucher disease	☐ Yes	_____	☐ No	☐ Don't Know
* Niemann-Pick disease	☐ Yes	_____	☐ No	☐ Don't Know
* Fanconi Anemia	☐ Yes	_____	☐ No	☐ Don't Know
* Familial Dysautonia	☐ Yes	_____	☐ No	☐ Don't Know
* Muscular Dystrophy	☐ Yes	_____	☐ No	☐ Don't Know
* Neurologic (brain/spine)	☐ Yes	_____	☐ No	☐ Don't Know
* Neural Tube Defects	☐ Yes	_____	☐ No	☐ Don't Know
* Bone/Skeletal Defects	☐ Yes	_____	☐ No	☐ Don't Know
* Dwarfism	☐ Yes	_____	☐ No	☐ Don't Know
* Developmental delay	☐ Yes	_____	☐ No	☐ Don't Know
* Learning problems	☐ Yes	_____	☐ No	☐ Don't Know
* Polycystic kidney disease	☐ Yes	_____	☐ No	☐ Don't Know
* Heart defect from birth	☐ Yes	_____	☐ No	☐ Don't Know
* Down syndrome	☐ Yes	_____	☐ No	☐ Don't Know
* Other chromosome defects	☐ Yes	_____	☐ No	☐ Don't Know
* Marfan syndrome	☐ Yes	_____	☐ No	☐ Don't Know
* Hemophilia	☐ Yes	_____	☐ No	☐ Don't Know
* Sickle Cell Anemia	☐ Yes	_____	☐ No	☐ Don't Know
* Thalassemia	☐ Yes	_____	☐ No	☐ Don't Know
* Galactosemia	☐ Yes	_____	☐ No	☐ Don't Know
* Deafness/Blindness	☐ Yes	_____	☐ No	☐ Don't Know
* Color Blindness	☐ Yes	_____	☐ No	☐ Don't Know
* Hemochromatosis	☐ Yes	_____	☐ No	☐ Don't Know

☐ None of the above

☐ Other (Specify_____)

What is your ancestry?

____ African-American
____ American Indian/Native American
____ Ashkenazi Jewish
____ Asian-American
____ Cajun/French Canadian
____ Caucasian
____ Eastern European
____ Hispanic/Caribbean
____ Northern European
____ Southern European
____ Other (specify_____)

Would you like to be screened for:

____ Cystic Fibrosis: __Yes __No
____ Sickle Cell Anemia: __Yes __No
____ Tay-Sachs Disease: __Yes __No
____ Thalassemia: __Yes __No

SPOUSE/MALE PARTNER'S SIGNATURE_____ **DATE**_____

I confirm that I have reviewed the information above.

PHYSICIAN'S SIGNATURE_____ **DATE**_____

Physician Notes (for office use only) _____

West Virginia
FERTILITY INSTITUTE

Acknowledgement Regarding Precautions During Coronavirus (COVID-19)

This Acknowledgement of risks regarding COVID-19 ("***Acknowledgement***") applies to all physicians, nurses, embryologists and other practitioners, physician practices, fertility laboratories, tissue storage repositories and management services organizations owned, directly or indirectly, managed by, or otherwise affiliated with, **CAROLINAS FERTILITY INSTITUTE** ("***Provider***"). Both the patient and the patient's partner, as applicable, are parties to this Agreement and are referred to as "**I**". This Acknowledgement lays out the legal terms and conditions that apply to all treatment(s), procedure(s) or service(s) (referred to in this document as "***Services***") I will receive from any Provider.

I understand that information regarding COVID-19 and the medical communities' understanding of this disease is rapidly evolving and that risk(s) may come to light of which we are presently not aware. I acknowledge that guidance from the Center for Disease Control ("***CDC***"), the American Society for Reproductive Medicine ("***ASRM***"), American College of Obstetrics and Gynecology ("***ACOG***") and the World Health Organization ("***WHO***") may change at any time based on new information regarding COVID-19. I further understand that the CDC, ASRM and the ACOG have not determined what risks, known or unknown or if any, the virus that causes COVID-19 might have on patients undergoing infertility treatment or patients who become pregnant.

I understand that there may be risks associated with contracting COVID-19 during pregnancy. Although there is no current evidence of maternal-fetal transmission of COVID-19, prior data with other illnesses support that a febrile illness of any kind in pregnancy may pose risks including miscarriage, stillbirth, and preterm birth. Furthermore, the impact of the medications used to treat COVID-19 have not been studied in pregnancy.

For patients undergoing oocyte retrieval or Intrauterine Insemination (IUI), I understand that if I test positive for COVID-19 during the course of ovarian stimulation leading to my oocyte retrieval or IUI, the cycle will be cancelled and I will incur the financial implications.

I understand that I might have been or may become exposed to COVID-19 prior to or while receiving Services by the Provider. I understand that despite the measures that Provider is taking I may become exposed to COVID-19 during my/our treatment with Provider or on account of such treatment. I understand that I may have the option to be tested for COVID 19 before my cycle. If I choose to be tested, I understand and agree that I must discuss these results with the Provider prior to any treatment. I understand that COVID-19 tests are not 100% accurate. I understand that these tests have varying levels of false negatives, and positive antibody tests may not result in immunity from COVID-19. If I demonstrate symptoms, my provider may cancel my cycle even if I have been tested negative.

I further understand that should I be directly exposed to COVID-19, be diagnosed with COVID-19, or become symptomatic with any illness which could possibly be COVID-19 (even in the absence of a positive COVID-19 test), Provider may elect to postpone, reschedule, terminate or modify the manner in which Provider renders its Services, depending on the clinical circumstances.

West Virginia
FERTILITY INSTITUTE

I understand that it is my obligation to inform the clinic if I am not feeling well, have a fever, shortness of breath or any other symptoms associated with COVID-19, or if I have reason to believe that I have been exposed to COVID-19. I understand that should any of the forgoing apply to me, the clinic may elect to reschedule my appointment, visit, or any Services to a later date.

I further understand that there may come a point where the Provider may not be able to support continued Services (e.g, illness of doctors or laboratory staff which would prevent Provider from rendering services or clinic being required to pause operations) and if this occurs the Services may be postponed or cancelled.

I understand that prior to and during my treatment that I should continue to practice preventive measures, i.e. physical distancing, handwashing, use of personal protective equipment (PPE- i.e. masks and gloves, hand sanitizer) and all current CDC recommendations to reduce the risks of infection.

I understand that the Provider may be under a Stay at Home or Shelter in Place Ordinance that may restrict my ability to travel in my local community. I agree that I will familiarize myself with all such applicable orders. I acknowledge that I am leaving my home for medical treatment and that I should and will take precautions to remain isolated during my travel to not increase the chance of infection to myself or others. I agree to wear a mask, either fabric or medical, for the duration of my commute to the Provider's office, and to sanitize my hands upon arriving at the Provider.

I understand that the Provider is taking extra precautions to limit the chance of spreading COVID-19, including prescreening for fever and social distancing practices during my treatment. I agree to comply with these efforts, and I understand that my failure to do so may result in the cancellation of my appointment. I acknowledge that despite these efforts it is still possible that I could become infected with COVID-19 during my travel to and from the clinic or while at the clinic. I agree to hold the clinic, physicians, and staff harmless in the event that I am infected with COVID-19.

The risks, potential benefits of and alternatives to this treatment or procedure have been explained to me by the Provider. I understand the explanation that has been given to me. I have had the opportunity to ask any questions I may have about the Services and this Acknowledgement and those questions have been answered to my satisfaction.

Patient Signature: _____

Name: _____

Date: _____

Witness Name: _____

Signature: _____

Spouse/Partner Signature: _____

Name: _____

Date: _____

Witness Name: _____

Signature: _____

West Virginia Fertility Institute Inc. Authorization for Information Release – Compound Release

Name of Patient: _____ **Date of Birth:** _____

West Virginia Fertility Institute is authorized to release protected health information about the above named patient in the following manner and/or to selected persons.

Check each person/entity approved to receive information.	Check type of information that can be given to person/entity on the left in the same section.
_____ Voice Mail	_____ Results of lab tests/ultrasounds _____ Other_____
_____ Other person (s) (provide name and phone number)	_____ Financial _____ Medical
_____ Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	_____ Financial _____ Medical _____ Appointment reminders _____ Breach notification
_____ Text communication -Provide number * _____ *For text communication to occur, accept the disclosure below:	_____ Appointment reminder _____ Other: _____
_____ For email and/or text communication I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	
_____ Photo of patient received by patient or legal guardian _____ Photo taken by staff (Example: pre/post procedure) _____ Other	_____ May be posted in office _____ May be posted on website _____ Other

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____ _____

Signature of Patient or Personal Representative Date

*Description of Personal Representative's Authority (attach necessary documentation)

Revised May 2020

West Virginia
FERTILITY INSTITUTE

WEST VIRGINIA FERTILITY INSTITUTE INC.
FINANICAL RESPONSIBIILTY AND ASSINGMENT OF BENEFITS

Pre-certification & Financial Responsibility: I/we understand that WVFI may contact my insurer to provide information about anticipated courses of treatment. If the insurer determines that the treatment plan is medically necessary and issues certification, my benefits will be paid according to my/our policy terms. *However, if certification is denied, benefits may be withheld.*

I/we also understand that some services do not require preauthorization and may be considered covered when WVFI inquires on behalf of the patient. **Benefit payment may be denied, however, based upon the diagnosis code(s) chosen by the provider. I/we understand that diagnosis codes are determined by the medical provider, and I/we are responsible for payment of any claims denied if the insurer determines they are uncovered.**

I/we also understand that I/we are financially responsible for any and all charges incurred as a result of this treatment plan should the insurer either refuse to pre-certify the treatment or retrospectively determine that a service was inappropriate. I understand that to protect myself from unnecessary personal financial obligations with my insurance company and referring physician in advance of my appointment.

I have read and understand the above consents _____ / _____ (Initials)

Assignment of Benefits: I/we hereby assign and transfer to West Virginia Fertility institute Inc., all medical provider benefits payable under my insurance policies, and direct the insurance company to pay all such benefits to WVFI. I/we understand that this assignment does not relieve us of any responsibility I/we may have for payment of charges not paid by the insurance company.

I have read and understand the above consents _____ / _____ (Initials)

I (WE) HAVE READ AND FULLY UNDERSTAND THE AUTHORIZATIONS, CONSENTS, ASSIGNMENTS AND REALESES PRINTED ON THIS FORM AND FULLY ACCEPTED AND CONSESNT TO EACH OF THEM.

Date: _____ Print Name(s): _____, _____

Signature of responsible parties: _____, _____

This notice describes how information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.

West Virginia Fertility Institute Inc.
P.O. Box 25804
Winston-Salem, NC 27114-5804
(336) 448-9100

NOTICE OF PRIVACY PRACTICES

1. West Virginia Fertility Institute Inc. may use and disclose protected health information for treatment, payment and healthcare operations. Examples of these include, but are not limited to, requested preschool, or sports physicals, foster care homes, home health agencies and/or referral to other providers for treatment. Payment examples include, but are not limited to, insurance companies for claims including coordination of benefits with other insurers, collection agencies. Healthcare operations include, but are not limited to, internal quality control and assurance including auditing of records.
2. West Virginia Fertility Institute Inc. is permitted or required to use or disclose protected health information without the individual's written consent or authorization in certain circumstances. Two examples of such are for public health requirements or court orders.
3. West Virginia Fertility Institute Inc. will not use or disclose PHI for marketing purposes and/or disclosures constituting a sale of PHI without the individual's Authorization.
4. West Virginia Fertility Institute Inc. will not sell or make any other use or disclosure of a patient's protected health information without the individual's written authorization. Such authorization may be revoked at any time. Revocation must be written.
5. West Virginia Fertility Institute Inc. will abide by the terms of this notice currently in effect at the time of the disclosure.
6. West Virginia Fertility Institute Inc. reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information that it maintains. West Virginia Fertility Institute Inc. will provide each patient with a copy of any revisions of its Notice of Information Practices at the time of their next visit, or at their last known address if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at our offices.
7. Any patient, guardian or personal representative has the right to object to the use of their health information for directory purposes.
8. Any patient, guardian or personal representative has the right to inspect and obtain copies of their medical record. The records will be provided within 30 days of the request, and a reasonable charge may be assessed for any copies after the first request in a 12-month period. If West Virginia Fertility Institute Inc. is unable to act within the required period, West Virginia Fertility Institute Inc., may provide the patient with

written notice of the reason for delay and expected date of completion of the request. This extension of time will not exceed 30 days.

9. Any patient, guardian or personal representative has the right to request amendments be made to their medical record.
10. Any patient, guardian or personal representative has the right to request a 6-year accounting of all disclosures of their medical record. The history will be provided within 30 days of the request and a reasonable charge may be assessed for any copies after the first requested in a 12-month period. If West Virginia Fertility Institute Inc. is unable to act within the required period, West Virginia Fertility Institute Inc. may provide the patient/person with written notice of the reason for delay and expected date of completion of the request. This extension of time will not exceed 30 days.
11. Any patient, guardian or personal representative has the right to request restrictions as to how their health information may be used or disclosed to carry out treatment, payment or healthcare operations. West Virginia Fertility Institute Inc. is not required to agree to the restrictions requested, but if West Virginia Fertility Institute Inc. does agree, West Virginia Fertility Institute Inc. must abide by those restrictions.
12. Any patient, guardian or personal representative has the right to restrict disclosure of certain Personal Health Information to a health plan for payment or health care operation purposes, but not for treatment purposes, for items or services that have been paid in full and out-of-pocket.
13. Any person/patient has the right to be notified by the West Virginia Fertility Institute Inc. Security Officer following a breach of unsecured Personal Health Information of the affected individual. West Virginia Fertility Institute Inc. may use email to notify the person/patient of a breach.
14. Any person/patient may file a complaint to West Virginia Fertility Institute Inc. and to the U.S. Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with the Practice, please contact the Privacy Officer at the following address and/or phone number, West Virginia Fertility Institute Inc., P.O. Box 25804, Winston-Salem, NC 27114-5804, telephone (336) 448-9100. All complaints will be addressed, and the results will be reported to the Privacy Officer.
15. It is the policy of West Virginia Fertility Institute Inc. that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.

I have read the above Notice of Privacy Practices and understand it or had the opportunity to ask questions about any part of it that I did not understand.

Effective Date:_____

Name of Patient:_____

Signature of Patient or Legal Guardian:_____

Date:_____