

BUFFALO INFERTILITY & IVF ASSOCIATES

4510 MAIN STREET · SNYDER, NEW YORK · 14226 · OFFICE 716-839-3057 · FAX 716-839-1477

PATIENT PERSONAL INFORMATION – ALL INFORMATION IS STRICTLY CONFIDENTIAL

Date: _____
Patient Name: _____
Date of Birth: _____ Age: _____
Marital Status: _____
Address: _____
City: _____ State: _____ Zip: _____
Email: _____
Social Security Number: _____
Employer: _____
Employer Address: _____
City: _____ State: _____ Zip: _____

Preferred contact number(s) OK to leave voicemail
(please rank order of preference) with medical results?
Cell Phone: _____ ☐ Yes ☐ No
Home Phone: _____ ☐ Yes ☐ No
Work Phone: _____ ☐ Yes ☐ No

In case of Emergency, please notify (other than spouse/partner):
Name: _____
Phone #: _____
Relationship: _____

INSURANCE INFORMATION – PRIMARY (SELF)

Plan Name: _____
Policy Number: _____
Group Number: _____
Effective Date of Insurance: _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____, and assign directly to Infertility & IVF Medical Associates of WNY all medical benefits. If any, otherwise payable to us for services rendered I understand that I am financially responsible for all charges whether or not paid by insurance, including 35% collection costs and 50% attorney fees. I hereby authorize the doctor to release all information necessary to secure the payment of benefits and authorize the use of this signature on all submissions.

Signature of Insured: _____ Date: _____

MEDICARE AUTHORIZATION

I, the undersigned, request that payment of authorized Medicare benefits be made directly to Infertility & IVF Medical Associates of WNY for any services rendered to me. I authorize any medical information about me to be released to the Health Care Administration and its agents and to any other health insurance or on approved claim forms or electronically submitted claims. I understand my signature requests payments to be made. In Medicare assigned cases, Infertility & IVF Medical Associates of WNY agrees to accept Medicare charge determination and I am responsible only for the deductible, coinsurance and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.

Beneficiary's Signature: _____ Date: _____

Referred by: _____
Spouse/Partner's Name: _____
Date of Birth: _____ Age: _____
Marital Status: _____
Address: _____
City: _____ State: _____ Zip: _____
Email: _____
Social Security Number: _____
Employer: _____
Employer Address: _____
City: _____ State: _____ Zip: _____

Preferred contact number(s) OK to leave voicemail
(please rank order of preference) with medical results?
Cell Phone: _____ ☐ Yes ☐ No
Home Phone: _____ ☐ Yes ☐ No
Work Phone: _____ ☐ Yes ☐ No

PREFERRED PHARMACY

Name _____
Phone # _____

SECONDARY INSURANCE / ADDITIONAL COVERAGE (SPOUSE)

Does patient have other health insurance? ☐ Yes ☐ No

If yes, name of policy holder: _____

Plan Name: _____
Policy Number: _____
Group Number: _____
Effective Date of Insurance: _____

MEDICAL HISTORY: Do you, or have you had, any of the following:

	Current	Past	Never		Current	Past	Never		Current	Past	Never
Serious Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea / Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Change in Bowel Habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions / Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fevers or Chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hot Flushes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deafness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anal Fissures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weight Change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bloody Stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disturbance of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Peptic Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Sweating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gall Bladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unwanted Hair Growth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sores in Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice / Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unwanted Hair Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dentures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
								Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lump(s) in Breast(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pus in Urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lump(s) in Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sugar in Urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lump(s) in armpit/groin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Up to Urinate at Night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leg Cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Urgent Urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain / Swelling of Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin Sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rapid / Irreg Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Heart Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Measles (Rubeola)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Worry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rubella	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nightmares	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thoughts of Suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MEDICATIONS Please list all medications, including prescription, over the counter, vitamins and herbs

☐ I do not take any medications

	Medication	Dose	How Often		Medication	Dose	How Often
1	_____	_____	_____	6	_____	_____	_____
2	_____	_____	_____	7	_____	_____	_____
3	_____	_____	_____	8	_____	_____	_____
4	_____	_____	_____	9	_____	_____	_____
5	_____	_____	_____	10	_____	_____	_____

CONTRACEPTIVE USE

☐ I have never used contraceptives

	Type	Start Date	End Date	Reason Discontinued
1				
2				
3				

ALLERGIES Please list all allergies to medications, foods, or latex

☐ I have no known allergies

	Allergic to	Reaction		Allergic to	Reaction
1			4		
2			5		
3			6		

SURGICAL HISTORY Please list all previous surgical procedures

☐ I have never had surgery

	MM/YYYY	Surgical Procedure	Hospital	Surgeon	Complications
1					
2					
3					
4					
5					

FAMILY HISTORY Have your parents, grandparents, siblings, or children been diagnosed or treated for the following?

	Yes	No	If yes, relation		Yes	No	If yes, relation		Yes	No	If yes, relation
Cancer	<input type="checkbox"/>	<input type="checkbox"/>		Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>		Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Breast	<input type="checkbox"/>	<input type="checkbox"/>		High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>		Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Ovarian	<input type="checkbox"/>	<input type="checkbox"/>		High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>		Endocrine Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Infertility	<input type="checkbox"/>	<input type="checkbox"/>		Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>		Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Recurrent Miscarriages	<input type="checkbox"/>	<input type="checkbox"/>		Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>		Muscular Disorders	<input type="checkbox"/>	<input type="checkbox"/>	
Early Menopause	<input type="checkbox"/>	<input type="checkbox"/>		Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>		Neurologic Disorders	<input type="checkbox"/>	<input type="checkbox"/>	
Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>		Anxiety / Depression	<input type="checkbox"/>	<input type="checkbox"/>		Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	
Fibroids	<input type="checkbox"/>	<input type="checkbox"/>		Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>		Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	
PCOS	<input type="checkbox"/>	<input type="checkbox"/>		Suicide	<input type="checkbox"/>	<input type="checkbox"/>		Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	

SOCIAL HISTORY

	Yes	No	
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, how much? _____
Do you use alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, how much? _____
Do you use recreational drugs? (ex. marijuana, cocaine, heroin, etc)	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, please describe _____
Do you use caffeine? (ex. coffee, tea, soda,etc)	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, please describe _____
Do you exercise?	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, please describe _____

OBSTETRICAL HISTORY Please list all previous pregnancies☐ **I have never been pregnant**

#	MM/YYYY	Duration of Pregnancy (# weeks, miscarriage, full term)	If Delivered, Method of Delivery (vaginal, C-Section)	If Miscarriage, was a procedure required (D&C)?	If Live Birth, Sex, Weight	Complications
1	_____	_____	_____	_____	_____	_____
2	_____	_____	_____	_____	_____	_____
3	_____	_____	_____	_____	_____	_____
4	_____	_____	_____	_____	_____	_____
5	_____	_____	_____	_____	_____	_____
6	_____	_____	_____	_____	_____	_____

GYNECOLOGIC HISTORY

		Comments
Do you menstruate?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Date that your last period began:	_____	_____
Date that your previous period began:	_____	_____
At what age did you have your first period?	_____	_____
My periods are:	<input type="checkbox"/> Regular <input type="checkbox"/> Irregular	_____
Average number of days between periods:	_____	_____
Average number of days that you have bleeding:	_____	Menstrual flow is: <input type="checkbox"/> Scant <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy <input type="checkbox"/> Excessive
Do you pass clots with your periods?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Do you have pain with your periods?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Do you have pain during/after intercourse?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Have you ever missed school or work due to pain or excessive bleeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Do you have bleeding/spotting between menstrual periods?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Do you have bleeding/spotting after intercourse?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Have you ever used contraception?	<input type="checkbox"/> Yes <input type="checkbox"/> No	What kind(s)? _____
Have you ever been diagnosed with:		_____
Polycystic Ovary Syndrome (PCOS)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Endometriosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Uterine Fibroid(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Endometrial Polyp(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Ovarian Cyst(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Sexually Transmitted Infection	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Pelvic Inflammatory Disease (PID)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Have you ever had an abnormal Pap smear?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last Pap smear: _____

SEXUAL HISTORY

	Yes	No
Are you sexually active?	<input type="checkbox"/>	<input type="checkbox"/>
Is your partner male?	<input type="checkbox"/>	<input type="checkbox"/>
Have you used over the counter ovulation kits to time intercourse?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use lubricants during intercourse?	<input type="checkbox"/>	<input type="checkbox"/> If Yes, what types _____

SYSTEMIC REVIEW

WEIGHT _____

MAXIMUM WEIGHT _____

MINIMUM WEIGHT _____

HEIGHT _____

Do / have you participated in any significant dietary changes over the past 3 years? _____

Do/ have you participated in any exercise programs over the past 3 years? _____

If so please document exercise Type _____ Hours per week _____

Type _____ Hours per week _____

*The effect of being overweight on fertility therapies have been well documented.

*Please speak with your physician regarding weight loss attempts and ideal weight range for your height

*Obesity does not usually cause infertility but it may have a significant impact on treatment responses & may have multiple negative effects on both you & fetus

ETHNICITY * Data will be used for genetic testing recommendation purposes

☐ Caucasian ☐ Hispanic ☐ Asian ☐ African American ☐ Other _____

Do you or anyone in either family have?

☐ Neural tube defects /spina
bifidal /anencephaly

☐ Cystic fibrosis

☐ Tay- Sachs disease

☐ Chromosomal disorder

☐ Muscular dystrophy

☐ Sickle Cell disease or trait

☐ Genetic / inherited disorder

☐ Thalassemia

☐ Huntington chorea

☐ Hemophilia

☐ Baby with birth defects

☐ Down Syndrome

☐ Mental retardation/ fragile X

☐ Hormonal disorder

☐ Infertility

☐ Hydrocephalus

☐ Epilepsy or seizures

☐ Kidney Disease

☐ Mental illness

☐ Stillbirth

☐ Phenylketonuria

☐ Neurofibromatosis

☐ Myotonic dystrophy

☐ 3 or more miscarriages

☐ Diabetes

☐ **Any birth defects?**

☐ **Any inherited disorders?**

Please explain a "Yes" answer to any of the above _____

Genetic Screening:

It is recommended that **all couples** attempting conception be offered cystic fibrosis screening. Cystic Fibrosis is a pulmonary disease affecting children and the most common genetic disease. The effectiveness of the test varies dependent on your ethnic background. You may be offered additional screening based on you ethnicity. Are you:

African American ☐ Yes ☐ No Ashkenazi Jewish ☐ Yes ☐ No

Mediterranean / Asian / French Canadian ☐ Yes ☐ No

If you answered YES to any of these, please let your physician know at the visit, so that the additional genetic screening can be offered to you.
If you have any specific genetic concerns and desire to see a geneticist, please let the physician know.

HISTORY OF FERTILITY THERAPY (Fill out if applicable)Have you been treated for infertility previously? ☐ YES ☐ NO

If yes, who was your physician? _____

What cause of infertility was diagnosed? _____

What drugs have you taken for infertility? Please check all that apply:

- | | | |
|---|---|--|
| <input type="checkbox"/> Clomid (Serophene) | <input type="checkbox"/> hCG Profasi | <input type="checkbox"/> Antibiotics |
| <input type="checkbox"/> Gonal F | <input type="checkbox"/> Progesterone | <input type="checkbox"/> baby Aspirin |
| <input type="checkbox"/> Follistim | <input type="checkbox"/> Lupron | <input type="checkbox"/> Heparin |
| <input type="checkbox"/> Repronex | <input type="checkbox"/> Microdose Lupron | <input type="checkbox"/> Steroids |
| <input type="checkbox"/> Pergonal | <input type="checkbox"/> Antagon | <input type="checkbox"/> Oral Contraceptives |
| <input type="checkbox"/> Fertinex | <input type="checkbox"/> Parlodel | <input type="checkbox"/> Other |

Which of the following tests have you or your partner had performed? Please check all that apply and results, if known:

- | | | |
|--|---------------------|---------------|
| <input type="checkbox"/> Hysterosalpingogram | When ____/____/____ | Results |
| <input type="checkbox"/> Sonohysterogram | When ____/____/____ | Results |
| <input type="checkbox"/> Laparoscopy, Hysteroscopy | When ____/____/____ | Results |
| <input type="checkbox"/> Thyroid tests | When ____/____/____ | Results |
| <input type="checkbox"/> Chromosomes | When ____/____/____ | Results |
| <input type="checkbox"/> Genetic Screening | When ____/____/____ | Results |

Have you ever undergone Artificial Insemination (IUI) or In Vitro Fertilization (IVF)? ☐ YES ☐ NOIf yes, ☐ partner ☐ donor sperm #IUI's ____ #IVF cycle ____**PRESENT COMPLAINT** Please state briefly what you would like to address during your visit

Patient's Signature_____
Date

I confirm that I have reviewed the above information

Physician's Signature_____
Date

BUFFALO INFERTILITY & IVF ASSOCIATES

4510 MAIN STREET · SNYDER, NEW YORK · 14226 · OFFICE 716-839-3057 · FAX 716-839-1477

PATIENT PERSONAL INFORMATION – ALL INFORMATION IS STRICTLY CONFIDENTIAL

MALE HISTORY FORM

Date: _____

Name: _____ Date of Birth: _____ Age: _____

MEDICAL HISTORY Do you have , or have you had, any of the following:

	Current	Past	Never		Current	Past	Never		Current	Past	Never
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Serious injury / accident	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis / liver disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colitis / enteritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rubella	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prostatic infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recent immunization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urinary infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Any Medical problem not listed above (please list type, dates, treatments)

1. _____
2. _____

MEDICATIONS Please list all medications, including prescription, over the counter, vitamins and herbs

☐ I do not take any medications

	Medication	Dose	How Often		Medication	Dose	How Often
1	_____	_____	_____	4	_____	_____	_____
2	_____	_____	_____	5	_____	_____	_____
3	_____	_____	_____	6	_____	_____	_____

ALLERGIES Please list all allergies to medications, foods, or latex

☐ I have no known allergies

	Allergic to	Reaction		Allergic to	Reaction
1	_____	_____	4	_____	_____
2	_____	_____	5	_____	_____
3	_____	_____	6	_____	_____

SURGICAL HISTORY Please list all previous surgical procedures☐ I have never had surgery

	MM/YYYY	Surgical Procedure	Hospital	Surgeon	Complications
1	_____	_____	_____	_____	_____
2	_____	_____	_____	_____	_____
3	_____	_____	_____	_____	_____
4	_____	_____	_____	_____	_____
5	_____	_____	_____	_____	_____

FAMILY HISTORY have your parents, grandparents, siblings, or children been diagnosed or treated for the following:

	Yes	No	If Yes, Relation		Yes	No	If Yes, Relation		Yes	No	If Yes, Relation
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breast	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ovarian	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____	Endocrine Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Infertility	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Recurrent Miscarriages	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	_____	Muscular Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Early Menopause	<input type="checkbox"/>	<input type="checkbox"/>	_____	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____	Neurologic Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Anxiety / Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fibroids	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	_____	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
PCOS	<input type="checkbox"/>	<input type="checkbox"/>	_____	Suicide	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____

SOCIAL HISTORY

	Yes	No	
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, how much? _____
Do you use alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, how much? _____
Do you use recreational drugs? (ex. marijuana, cocaine, heroin, etc)	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, please describe _____
Do you use caffeine? (ex. coffee, tea, soda, etc)	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, please describe _____
Do you exercise?	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, please describe _____

PREGNANCY HISTORY (that you have been responsible for)☐ I have never initiated a pregnancy

Date MM/YY	Miscarriage?	Elective Abortion?	Months to Conceive?	Infertility Treatment?	Weight and Sex?	Complications?
1.						
2.						
3.						

HISTORY OF FERTILITY THERAPY (Fill out if applicable)		
Have you been treated for infertility previously? <input type="checkbox"/> YES <input type="checkbox"/> NO		
If yes, who was your physician? _____		
What cause of infertility was diagnosed? _____		
What medications have you taken for infertility? _____		
Which of the following tests have you or your partner had performed? Please check all that apply and results, if known:		
<input type="checkbox"/> Semen Analysis	When ____/____/____	Results
<input type="checkbox"/> Chromosomes	When ____/____/____	Results
<input type="checkbox"/> Genetic screening	When ____/____/____	Results
<input type="checkbox"/> Other _____	When ____/____/____	Results

UROLOGIC HISTORY (if applicable)
Have you been evaluated by an urologist? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you able to ejaculate inside your partner’s vagina? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have retrograde ejaculation of sperm into the bladder? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had any of the following sexually transmitted disease or severe testicular pain?
<input type="checkbox"/> Yes (check all that apply) <input type="checkbox"/> 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
Have you had a history of undescended testicles? <input type="checkbox"/> Yes One side _____ Both _____ <input type="checkbox"/> No
Have you ever had torsion / twisting of the testicles? <input type="checkbox"/> Yes <input type="checkbox"/> No
Did you have mumps after puberty? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had injury to your testicles requiring an ER visit or hospitalization? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had a fever (>101°F) in the past 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had a vasectomy? <input type="checkbox"/> Yes – date _____ <input type="checkbox"/> No
If yes, have you had a vasectomy reversal? <input type="checkbox"/> Yes – date _____ <input type="checkbox"/> No
Have you had varicocele surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had hernia surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had other surgery to the scrotum or groin area? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you exposed to prolonged heat in the workplace? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you exposed to harmful chemicals or fumes in the workplace? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use hot tubs regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have any of your immediate family members had difficulty conceiving a child? <input type="checkbox"/> Yes <input type="checkbox"/> No

ETHNICITY * Data will be used for genetic testing recommendation purposes

☐ Caucasian ☐ Hispanic ☐ Asian ☐ African American ☐ Other _____

Do you or anyone in either family have?

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Neural tube defects /spina | <input type="checkbox"/> Cystic fibrosis | <input type="checkbox"/> Tay- Sachs disease | <input type="checkbox"/> Chromosomal disorder bifidal /anencephaly |
| | <input type="checkbox"/> Muscular dystrophy | <input type="checkbox"/> Sickle Cell disease or trait | <input type="checkbox"/> Genetic / inherited disorder |
| <input type="checkbox"/> Thalassemia | <input type="checkbox"/> Huntington chorea | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Baby with birth defects |
| <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Mental retardation/ fragile X | <input type="checkbox"/> Hormonal disorder | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Hydrocephalus | <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Stillbirth | <input type="checkbox"/> Phenylketonuria | <input type="checkbox"/> Neurofibromatosis | <input type="checkbox"/> Myotonic dystrophy |
| <input type="checkbox"/> 3 or more miscarriages | <input type="checkbox"/> Diabetes | | |
| <input type="checkbox"/> Any birth defects? | <input type="checkbox"/> Any inherited disorders? | | |

Please explain a “Yes” answer to any of the above _____

Genetic Screening:

It is recommended that **all couples** attempting conception be offered cystic fibrosis screening. Cystic Fibrosis is a pulmonary disease affecting children and the most common genetic disease. The effectiveness of the test varies dependent on your ethnic background. You may be offered additional screening based on you ethnicity. Are you:

African American ☐ Yes ☐ No Ashkenazi Jewish ☐ Yes ☐ No
Mediterranean / Asian / French Canadian ☐ Yes ☐ No

**If you answered YES to any of these, please let your physician know at the visit, so that the additional genetic screening can be offered to you.
If you have any specific genetic concerns and desire to see a geneticist, please let the physician know.**

Partner’s Signature

Date

I confirm that I have reviewed the above information

Physician’s Signature

Date

Notice of Privacy Practices

PURPOSE:

This notice describes how your medical information may be used, disclosed and how you can have access to this information. Please review carefully.

This notice takes effect January 1, 2003 and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law requires us to:

- Keep your medical information private
- Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information
- Follow the terms of the notice that is now in effect We have the right to:
- Change the privacy practices and the terms of this notice at any time, provided that the changes are permitted by law
- Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes

Notice of change to privacy practices:

- Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. For each kind of use or disclosure, we will explain that we mean and give an example. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

For Treatment:

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students or other people who are taking care of you.

We may also share medical information about you to your other health care providers to assist them in treating you.

We may disclose your medical information for payment purposes.

For Health Care Operations:

We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

Additional Uses and Disclosures:

In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Disaster Relief: Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim, or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be a risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Health Oversight Activities: We may disclose information to an agency providing health oversight for activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reported by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

4. YOUR INDIVIDUAL RIGHTS

You have the right to:

1. Look at or get copies of your medical information. You may request that we provide copied in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you \$.75 for each page, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use of disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in case of emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to contact the person listed at the end of this notice.
5. Request that we change medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept

your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.

6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.

We may leave messages at the phone numbers & addresses that are on file, as provided by you. It is your responsibility to notify us of any changes.

QUESTIONS AND COMPLAINTS

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Colleen Savage, Office Manager
(716)839-3057

If you think that we may have violated your privacy rights, contact the person above. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint to the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

KRYSTENE B. DIPAOLO, M.D.
ADAM M. GRIFFIN, M.D.
MICHAEL W. SULLIVAN, M.D.



Notice of Privacy Practices

Buffalo Infertility & IVF Associates may leave messages at the phone numbers listed below & use the address that is on file.

It is the patient's responsibility to notify Buffalo IVF & Infertility of any changes.

Phone numbers:

Home: _____

Cell: _____

Work: _____

Other: _____

E-Mail:

Acknowledgement Form

I have had the opportunity to review the Notice of Privacy Practices that is posted on BuffaloIVF.com or have requested a copy to review.

Name: _____ Date of Birth: _____

Signature: _____

Date: _____