BUFFALO INFERTILITY & IVF ASSOCIATES
4510 MAIN STREET · SNYDER, NEW YORK · 14226 · OFFICE 716-839-3057 · FAX 716-839-1477

PATIENT INFORMATION – ALL INFORMATION IS STRICTLY CONFIDENTIAL

FEMALE PATIENT FORMS

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**

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: ______________________

PREFERRED PHARMACY

Name ______________________

Address: ______________________

Phone # ______________________

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**

Cell Phone: ______________ ☐ Yes ☐ No

Home Phone: ______________ ☐ Yes ☐ No

Work Phone: ______________ ☐ Yes ☐ No

INSURANCE INFORMATION – PRIMARY (SELF)

Group Number: ______________________

Plan Name: ______________________

Name of Policy Holder: ______________________

Date of Birth: ______________

ID Number: ______________ Suffix ____

Employer: ______________________

Member ID (Self) ______________ Suffix ____

Relationship: ______________________

Insurance Effective Date: ______________________

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: ______________

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

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

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	☐	☐		Heart Disease	☐	☐		Thyroid Disease	☐	☐	
Breast	☐	☐		High Blood Pressure	☐	☐		Diabetes	☐	☐	
Ovarian	☐	☐		High Cholesterol	☐	☐		Endocrine Disorder	☐	☐	
Infertility	☐	☐		Kidney Disease	☐	☐		Blood Disease	☐	☐	
Recurrent Miscarriages	☐	☐		Kidney Stones	☐	☐		Muscular Disorders	☐	☐	
Early Menopause	☐	☐		Epilepsy	☐	☐		Neurologic Disorders	☐	☐	
Endometriosis	☐	☐		Anxiety / Depression	☐	☐		Glaucoma	☐	☐	
Fibroids	☐	☐		Mental Illness	☐	☐		Lung Disease	☐	☐	
PCOS	☐	☐		Suicide	☐	☐		Tuberculosis	☐	☐	

SOCIAL HISTORY

	Yes	No	
Do you smoke?	☐	☐	If Yes, how much? ____
Do you use alcohol?	☐	☐	If Yes, how much? ____
Do you use recreational drugs? (ex. marijuana, cocaine, heroin, etc)	☐	☐	If Yes, please describe ____
Do you use caffeine? (ex. coffee, tea, soda, etc)	☐	☐	If Yes, please describe ____
Do you exercise?	☐	☐	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?	□ Yes	□ 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:	□ Regular	□ Irregular	
Average number of days between periods:			
Average number of days that you have bleeding:			Menstrual flow is: □ Scant □ Moderate □ Heavy □ Excessive
Do you pass clots with your periods?	□ Yes	□ No	
Do you have pain with your periods?	□ Yes	□ No	
Do you have pain during/after intercourse?	□ Yes	□ No	
Have you ever missed school or work due to pain or excessive bleeding?	□ Yes	□ No	
Do you have bleeding/spotting between menstrual periods?	□ Yes	□ No	
Do you have bleeding/spotting after intercourse?	□ Yes	□ No	
Have you ever used contraception?	□ Yes	□ No	What kind(s)?
Have you ever been diagnosed with:			
Polycystic Ovary Syndrome (PCOS)	□ Yes	□ No	
Endometriosis	□ Yes	□ No	
Uterine Fibroid(s)	□ Yes	□ No	
Endometrial Polyp(s)	□ Yes	□ No	
Ovarian Cyst(s)	□ Yes	□ No	
Sexually Transmitted Infection	□ Yes	□ No	
Pelvic Inflammatory Disease (PID)	□ Yes	□ No	
Have you ever had an abnormal Pap smear?	□ Yes	□ No	Date of last Pap smear:

SEXUAL HISTORY

	Yes	No	
Are you sexually active?	□	□	
Is your partner male?	□	□	
Have you used over the counter ovulation kits to time intercourse?	□	□	
Do you use lubricants during intercourse?	□	□	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:

◻ Clomid (Serophene)	◻ hCG Profasi	◻ Antibiotics
◻ Gonal F	◻ Progesterone	◻ baby Aspirin
◻ Follistim	◻ Lupron	◻ Heparin
◻ Repronex	◻ Microdose Lupron	◻ Steroids
◻ Pergonal	◻ Antagon	◻ Oral Contraceptives
◻ Fertinex	◻ Parlodel	◻ Other ....

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

◻ Hysterosalpingogram	When ____/____/____	Results ....
◻ Sonohysterogram	When ____/____/____	Results ....
◻ Laparoscopy, Hysteroscopy	When ____/____/____	Results ....
◻ Thyroid tests	When ____/____/____	Results ....
◻ Chromosomes	When ____/____/____	Results ....
◻ Genetic Screening	When ____/____/____	Results ....

Have you ever undergone Artificial Insemination (IUI) or In Vitro Fertilization (IVF)? ◻ YES ◻ NO

If 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