

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 PATIENT FORM

Date: _____

Patient Name: _____

Date of Birth: _____ Age: _____

Marital Status: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Social Security Number: _____

Employer: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

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: _____

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: _____

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: _____

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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							
<input type="checkbox"/> 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			
<input type="checkbox"/> I have no known allergies			
	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? YES 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? Yes No

Are you able to ejaculate inside your partner's vagina? Yes No

Do you have retrograde ejaculation of sperm into the bladder? Yes No

Have you had any of the following sexually transmitted disease or severe testicular pain?

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

Have you ever had torsion / twisting of the testicles? Yes No

Did you have mumps after puberty? Yes No

Have you had injury to your testicles requiring an ER visit or hospitalization? Yes No

Have you had a fever (>101°F) in the past 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 varicocele surgery? Yes No

Have you had hernia surgery? Yes No

Have you had other surgery to the scrotum or groin area? Yes No

Are you exposed to prolonged heat in the workplace? Yes No

Are you exposed to harmful chemicals or fumes in the workplace? Yes No

Do you use hot tubs regularly? Yes No

Have any of your immediate family members had difficulty conceiving a child? Yes 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"/> Thalassemia | <input type="checkbox"/> Muscular dystrophy | <input type="checkbox"/> Sickle Cell disease or trait | <input type="checkbox"/> Genetic / inherited disorder |
| <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Huntington chorea | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Baby with birth defects |
| <input type="checkbox"/> Hydrocephalus | <input type="checkbox"/> Mental retardation/ fragile X | <input type="checkbox"/> Hormonal disorder | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Stillbirth | <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> 3 or more miscarriages | <input type="checkbox"/> Phenylketonuria | <input type="checkbox"/> Neurofibromatosis | <input type="checkbox"/> Myotonic dystrophy |
| <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