

BUFFALO INFERTILITY & IVF ASSOCIATES

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: _____

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 been diagnosed or treated for the following? If yes, note the relationship.

	Yes	Relation		Yes	Relation		Yes	Relation
Cancer	<input type="checkbox"/>		Heart Disease	<input type="checkbox"/>		Thyroid Disease	<input type="checkbox"/>	
Breast	<input type="checkbox"/>		High Blood Pressure	<input type="checkbox"/>		Diabetes	<input type="checkbox"/>	
Ovarian	<input type="checkbox"/>		High Cholesterol	<input type="checkbox"/>		Endocrine Disorder	<input type="checkbox"/>	
Infertility	<input type="checkbox"/>		Kidney Disease	<input type="checkbox"/>		Blood Disease	<input type="checkbox"/>	
Recurrent Miscarriages	<input type="checkbox"/>		Kidney Stones	<input type="checkbox"/>		Muscular Disorders	<input type="checkbox"/>	
Early Menopause	<input type="checkbox"/>		Epilepsy	<input type="checkbox"/>		Neurologic Disorders	<input type="checkbox"/>	
Endometriosis	<input type="checkbox"/>		Anxiety / Depression	<input type="checkbox"/>		Glaucoma	<input type="checkbox"/>	
Fibroids	<input type="checkbox"/>		Mental Illness	<input type="checkbox"/>		Lung Disease	<input type="checkbox"/>	
PCOS	<input type="checkbox"/>		Suicide	<input type="checkbox"/>		Tuberculosis	<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
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

GYNECOLOGIC HISTORY

	Yes	No	Comments
Do you menstruate?	<input type="checkbox"/>	<input type="checkbox"/>	_____
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? 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
- 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

What kind(s)?

last Pap smear:

SEXUAL HISTORY

Are you sexually active?	Yes	No	
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?

<input type="checkbox"/> Neural tube defects /spina bifidal /anencephaly	<input type="checkbox"/> Cystic fibrosis	<input type="checkbox"/> Tay- Sachs disease	<input type="checkbox"/> Chromosomal disorder
<input type="checkbox"/> Thalassemia	<input type="checkbox"/> Muscular dystrophy	<input type="checkbox"/> Sickle Cell disease or trait	<input type="checkbox"/> Genetic / inherited
<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"/> Kidney Disease	<input type="checkbox"/> Infertility
<input type="checkbox"/> Stillbirth	<input type="checkbox"/> Epilepsy or seizures	<input type="checkbox"/> Neurofibromatosis	<input type="checkbox"/> Mental illness
<input type="checkbox"/> 3 or more miscarriages	<input type="checkbox"/> Phenylketonuria	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Myotonic dystrophy
<input type="checkbox"/> Any birth defects?	<input type="checkbox"/> Any inherited disorders?	<input type="checkbox"/> Hormonal Disorder	

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"/> Gonadotropin (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"/> Fertilinex | <input type="checkbox"/> Parlodel |

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 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