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: _____

Gender Identity:_____

Address: _____

City: _____ State: _____ Zip: _____

Email:_____

Social Security Number: _____

Employer: _____

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

Spouse/ Partner OR Emergency Contact

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: _____

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

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:

□ Semen Analysis When _____/_____/_____ Results ……

□ Chromosomes When _____/_____/_____ Results ……

□ Genetic screening When _____/_____/_____ Results ……

□ Other _____ When _____/_____/_____ Results ……

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.						

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

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

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

1. _____
2. _____

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	_____	_____	_____	_____	_____

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	_____	_____

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 _____

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	☐	☐	
Birth Defects	☐	☐		Genetic Disorders	☐	☐					

ETHNICITY * Data will be used for genetic testing recommendation purposes

□ Caucasian □ Hispanic □ Asian □ African American □ Other _____

Genetic Screening:

It is recommended that **all couples** attempting conception be offered cystic fibrosis and Spinal Muscular Atrophy screening. Cystic Fibrosis is a pulmonary disease affecting children and the most common genetic disease. The effectiveness of these tests varies dependent on your ethnic background. You may be offered additional screening based on you ethnicity. Please indicate if you are:

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.

I confirm that I have reviewed the above information

_____ _____

Patient's Signature Date