Directions to Fertility & Endocrine Associates & Louisville Reproductive Center

Dr. Robert Homm
Kit Devine, DNP, APRN
Miriam S. Krause, MD FACOG
4123 Dutchman’s Lane
Suites 414 and 416
Louisville, KY 40207
502-897-2144

From Interstates 64 and 71 take the Watterson Expressway West (264 W) to Breckenridge Lane North exit.
From Interstate 65 take the Watterson Expressway East (264 E) to Breckenridge Lane North exit.

Turn right off exit onto Breckenridge Lane.
Once on Breckenridge Lane you will turn right at the first light which is Dutchman’s Lane.

Proceed through three lights. After the third light you will see Norton Suburban Hospital and the Women’s Pavilion on your left. Turn left into the entrance and park in the Plaza III parking garage directly in front of you. Our office is on the fourth floor, suites 414 and 416. If you are able to park on the fourth level you will enter the building where you will find our office is the second door on your right (Suite 414).
For your appointment:

☐ Bring pertinent medical records *(it’s a good idea to make a copy to keep for yourself prior to your appointment).*

☐ Bring a list of your current medications and supplements.

☐ Bring a photo ID.

☐ Bring documentation of your insurance benefits.

☐ If your insurance requires a referral, make certain your referring provider has obtained a referral and forwarded a copy to our office.

☐ Please call 502-897-2144 if you have questions about your financial responsibility.

Quite often patients experiencing infertility have an underlying medical condition that must be addressed before pursuing fertility treatment. Typically the underlying condition is covered by insurance. If there is *no* underlying medical condition and you have *no* coverage for fertility, we will collect for all services rendered. Otherwise, we will collect your copay.
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law.

Treatment:
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment:
Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:
We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and abide by the same HIPAA Privacy standards as outlined in this Notice of Privacy Practice.

Other Permitted Uses and Disclosures Requiring Your Written Authorization

Unless noted above in our Use and Disclosures, all other permitted uses and disclosures of your protected health information will be made only with your consent, authorization or opportunity to object unless required by law. This includes:

- Most uses and disclosure of psychotherapy notes
- Uses and disclosure for marketing purposes
- Disclosures that constitute a sale of your protected health information.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS
The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form.

We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to receive a Breach Notification. You have the right to receive a notification upon a breach of any of your unsecured Protected Health Information.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying “Acknowledgment” form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.
Acknowledgement of Receipt of Privacy Notice And Disclosure Statement

I have been presented with a copy of Fertility & Endocrine Associates’ Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Our office, at the discretion of the medical staff, routinely discloses information such as, but not limited to, appointment time and date, laboratory results, account information (financial), and medication information to family members (i.e.: spouse, parent, or sibling).

Please indicate below should you wish information shared or restricted:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Share appointment information with spouse</td>
<td>□</td>
</tr>
<tr>
<td>Share appointment information with family members</td>
<td>□</td>
</tr>
<tr>
<td>Share treatment information with spouse</td>
<td>□</td>
</tr>
<tr>
<td>Share treatment information with family members</td>
<td>□</td>
</tr>
<tr>
<td>Share medication information with spouse</td>
<td>□</td>
</tr>
<tr>
<td>Share medication information with family members</td>
<td>□</td>
</tr>
<tr>
<td>Share financial information with spouse</td>
<td>□</td>
</tr>
</tbody>
</table>

Other allowed disclosure or restriction: ______________________________________________________

__________________________________________________________

Patient Name (Printed): ___________________________________________
Signed: ___________________________ Date: __________

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: ________________ Witnessed by: ________________

Note: the patient may change this information and/or restriction at anytime.

Internal Use Only:
If patient or patient’s representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time): ____________________________

By: (name and title): ____________________________
FERTILITY AND ENDOCRINE ASSOCIATES
PATIENT REGISTRATION

Robert J. Homm, MD, FACOG       Kit S. Devine, DNP, APRN       Miriam S. Krause, MD, FACOG

Date: __________________

PATIENT: ________________________________________________________

(Last name)                                   (First name)                             (Middle initial)

ADDRESS: __________________________________________________________________________
Street/P.O. Box        City        State/Zip

HOME PHONE: __________________________ CELL PHONE: __________________________

DAY PHONE: __________________________     Email:______________________________

DATE OF BIRTH: ____ - ____ - ____    SS#: _______ - _______ - _______

EMPLOYER OR SCHOOL: ___________________________________________________________

EMPLOYER PHONE: ________________ OCCUPATION: _________________________________

MARITAL STATUS: Single ____ Married ____ Separated ____ Divorced ____ Widowed ____

SPOUSE: _____________ _______________________________________________________
            Last          First          Middle

DATE OF BIRTH: ____ - ____ - ____    SS#: _______ - _______ - _______

EMPLOYER OR SCHOOL: ________________________________CELL PHONE: ________________

EMPLOYER PHONE #: ______________________ OCCUPATION: _________________________

REFERRED BY:  ____HEALTHCARE PROVIDER     ____WEBSITE     ____FRIEND
 ____PHONE BOOK    ____MAGAZINE/NEWSPAPER AD

PHARMACY:_______________________________PHARMACY TELEPHONE:______________

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IF PERSON RESPONSIBLE FOR BILL IS OTHER THAN THE ABOVE PATIENT,
PLEASE COMPLETE THIS PORTION

GUARANTOR: ________________________________
            Last          First          Middle

ADDRESS: __________________________________________________________________________
Street        City        State/Zip

HOME PHONE: __________________________ DATE OF BIRTH: ____ - ____ - ____

CELL PHONE: __________________________ SS#: _______ - _______ - _______

EMPLOYER: ________________________________
Patient Name: ___________________________ DOB ____________

PRIMARY CARE PHYSICIAN: ______________________________________________________

OFFICE PHONE #: ________________________

ADDRESS: __________________________________________________________
Street/P.O. Box City State/Zip

REFERRING PHYSICIAN: ________________________________________________

OFFICE PHONE #: ________________________

ADDRESS: __________________________________________________________
Street/P.O. Box City State/Zip

NEAREST RELATIVE NOT LIVING WITH YOU: ________________________________
Last First

ADDRESS: __________________________________________________________
Street City State/Zip

HOME PHONE #: ________________________ DAY PHONE #: ________________________

RELATIONSHIP: ________________________________________________________

*******************************************************************************

PRIMARY INSURANCE COMPANY: ____________________________
Name of company

______________________________
Street/P.O. Box City State/Zip

ID#: ___________________________ GROUP #: ___________________________

POLICY HOLDER: __________________________________________________________
Last First Middle

SECONDARY INSURANCE COMPANY: __________________________
Name of company

______________________________
Street/P.O. Box City State/Zip

ID#: ___________________________ GROUP #: ___________________________

POLICY HOLDER: __________________________________________________________
Last First Middle
FERTILITY AND ENDOCRINE ASSOCIATES
PATIENT REGISTRATION

I hereby grant permission to Robert J. Homm, M.D., Kit S. Devine, DNP, APRN and Miriam S. Krause, M, FACOG or any designated health care provider(s) to administer medication and/or perform needed medical treatment. I also give permission for any laboratory testing, including HIV, to be completed that is necessary in conjunction with my care.

I understand I am responsible for obtaining a prior approved referral from my primary care physician and that I am responsible for any service provided without an appropriate referral for each office visit while being treated at this office.

I understand the health care providers do not discuss financial issues. Any questions regarding charges and/or payments can be discussed with Mary Mallick, our Business Manager.

I give permission for release of my medical records and financial information (by verbal, mail or fax transmission) for purposes of insurance filing of claims. I hereby assign all benefits payable to Fertility and Endocrine Associates and understand that the balance not paid by my insurance company and/or predetermined not to be covered by my insurance carrier will be my responsibility. I understand I am responsible for all co-insurance, deductibles and non-covered services. I also understand when surgery is necessary, that I will receive separate bills from the assistant surgeon, the hospital, and the anesthesiologist. I also understand that I will receive a separate bill for laboratory charges.

SIGNED: ___________________________________________ DATE: ____________
Patient

SIGNED: ___________________________________________ DATE: ____________
Spouse

SIGNED: ___________________________________________ DATE: ____________
Guarantor if other than patient or spouse
Very Important!!!!

If you are being seen for infertility care, it is essential that you bring a copy of your insurance policy plan’s documentation of benefits. You may obtain this from either your policy manual or from your insurance company’s website. If you know that you do not have infertility benefits, sign the bottom of this form and bring it with you to your consultation.

Verification of Insurance Exclusion of Benefits

I am aware that I do not have infertility benefits paid by my insurance company and that fees for care and services related to infertility will be my responsibility. I understand that payment will be due prior to or at the time that the services are rendered.

_________________________________________  _______________
Patient                                      Date
Patient Payment Policy

Thank you for choosing our medical practice. We are committed to providing the best possible medical care. The following information is provided to avoid any confusion regarding payment for professional medical services. Please sign below that you have read and agree to this policy.

New Patient Deposit

Fertility and Endocrine Associates requires a $50 deposit prior to scheduling a new patient appointment. This deposit is credited toward any copay, co-insurance or non-covered charge that may occur during your treatment and is refundable at cancellation only if you notify our office within 48 hours of your scheduled appointment.

Payment Policy

Payment for service is due in full at the time of service.
- We accept cash, check, Visa and MasterCard
- All fees are based on the type of service provided for your care and related services. Our fees are competitive for this region.
- If the patient is a minor (18 years and younger), the parent or guardian is responsible for payment of the account, in accordance with the policies outlined above.
- For any surgical services, all co-payments, deductibles and/or estimated fees are due prior to your surgery
- If your account is more than 120 days overdue, it will be referred to a collection agency. This is a last resort and done reluctantly, after we have exhausted efforts for voluntary payment. Costs of collection/court costs will be added to the patient’s account should this become necessary.

Referrals

It is your responsibility to bring any required referrals for treatment at, or prior to, the time of your visit. If you do not have a referral, your visit will be rescheduled, or you may be financially responsible.

Acknowledgement and Authorization

I have read, understand, and agree to the above Payment Policy. I understand that charges not covered by my insurance company, as well as co-payments and deductibles, are my responsibility.

I authorize my insurance benefits to be paid directly to Fertility & Endocrine Associates.

I authorize Fertility & Endocrine Associates to release any medical or other information to my insurance company when requested.

__________________________________                                     ______________
Signature                                      Date
AUTHORIZATION FOR RELEASE OF INFORMATION

NOTE: We only need your signature. We will fill in the top.

To:

Physician/Medical Group: ________________________________

Patient Name: ________________________________

Date of Birth: _______________ Social Security Number: _____-___-_____

I hereby authorize (provider name) ________________________________ to release all medical information relative to my visits, hospitalization, and/or outpatient treatment during the period of ________________ to ________________.

This authorization is effective through (check one):

☐ ______/_____/____ or

☐ NO Expiration, unless revoked or terminated by the patient or the patient's personal representative.

Please send the above records to:

Fertility & Endocrine Associates
4123 Dutchmans Ln. Suite 414
Louisville, KY 40207
Phone: (502)-897-2144
Fax (502)-897-1773

Information requested:

☐ Semen Analysis Report
☐ Operative Report
☐ Outpatient Notes
☐ Lab Reports
☐ Pathology Report
☐ X-Ray Report/films
☐ Other (Specify below)

☐ All Records

________________________________________  __________________________
Signature of patient  Signature of parent/guardian if a minor

________________________________________  __________________________
Relationship to patient  Witness

________________________________________
Date

Please sign here
Date of appointment: _____/_____/______
Patient name: ___________________________ date of birth _____/_____/______ Age: _______
Who referred you? ___________________________ Country of birth_________ Religion_________
Reason for your visit: ________________________________________________________________
Allergies: ________________________________________________________________________
What medications are you currently taking: ____________________________________________

Past medical history: Have you ever had (CIRCLE ALL THAT APPLY AND APPROXIMATE YEAR):
Measles ______ Mumps _______ Swollen glands ______ Chickenpox _______ Chronic/recurrent diarrhea__________
TB _________ Anemia _______ German Measles _______ Back Problems______ Rapid/irregular heartbeat_______
Infections ____ Pneumonia _______ Bladder trouble_______ Convulsions ___________ Other rectal problems__________
Bruising ______ Frequent colds ___ Hemorrhoids _______ Sinus Problems_________ Frequent sore throat _______
Hernia ______ Poliomyelitis ___ Eye Injury/disease ______ Cancer _________ Chronic Constipation________
Heart Murmur ___ Hepatitis _______ Emotional Problems____ Eating Disorder ________ Yellow jaundice _______
Chest Pain____ Arthritis _______ Gallbladder problem________ Serious head injury ___Frequent/severe indigestion_______
Diabetes ______ Appendicitis ___ Rheumatic Fever____ Varicose Veins _______ Ulcer of stomach/duodenum ______
Skin disease __ Fainting _______ Tumor, any kind ______Thyroid disease____ Sexually transmitted disease________
Freq. Headaches_________ Hearing difficulty _____ Hypertension_______ Other ________________________________

Past surgical history: Have you ever had an operation on the following (CIRCLE ALL THAT APPLY AND APPROXIMATE YEAR):
Appendix _______ Gallbladder _______ D & C _______ Stones (Kidney)______ Tonsils ________
Cesarean section _____ Tumor of any kind_______ Ovary _______ Vaginal repair _________ Varicose veins _____
Hemorrhoids __________ Uterus (womb) __________ Hernia ______ Chest ________ Spine _________
Tubes _______ Breast ________ Other ________________________________
As of now, do you have any of the following symptoms (CIRCLE ALL THAT APPLY):

<table>
<thead>
<tr>
<th>Symptom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chills or fever</td>
</tr>
<tr>
<td>Swelling: neck, underarms, groin</td>
</tr>
<tr>
<td>Glasses</td>
</tr>
<tr>
<td>Marked disturbance of vision</td>
</tr>
<tr>
<td>Night sweats</td>
</tr>
<tr>
<td>Blood in stool</td>
</tr>
<tr>
<td>Recent weight change</td>
</tr>
<tr>
<td>Fainting Spells</td>
</tr>
<tr>
<td>Excessive weakness</td>
</tr>
<tr>
<td>Nosebleeds</td>
</tr>
<tr>
<td>Poor appetite</td>
</tr>
<tr>
<td>Abdominal pain</td>
</tr>
<tr>
<td>Deafness</td>
</tr>
<tr>
<td>Excessive sweating</td>
</tr>
<tr>
<td>Anxiety</td>
</tr>
<tr>
<td>Unusual hair growth</td>
</tr>
<tr>
<td>Frequent night urination</td>
</tr>
<tr>
<td>Painful urination</td>
</tr>
<tr>
<td>Loss of urine w/cough/sneeze</td>
</tr>
<tr>
<td>Mouth sores</td>
</tr>
<tr>
<td>Hoarseness</td>
</tr>
<tr>
<td>Sudden need to urinate</td>
</tr>
<tr>
<td>Dizziness</td>
</tr>
<tr>
<td>Diarrhea/constipation</td>
</tr>
<tr>
<td>Eye pain</td>
</tr>
<tr>
<td>Hearing Aid</td>
</tr>
<tr>
<td>Heartburn/indigestion</td>
</tr>
<tr>
<td>Sugar in urine</td>
</tr>
<tr>
<td>Leg cramps w/walking</td>
</tr>
<tr>
<td>Headaches</td>
</tr>
<tr>
<td>Marked Tiredness</td>
</tr>
<tr>
<td>Lumps/pain in breast</td>
</tr>
<tr>
<td>Palpitation of heart</td>
</tr>
<tr>
<td>Change in bowel habits</td>
</tr>
<tr>
<td>Nausea/vomiting</td>
</tr>
<tr>
<td>Ringing in ears</td>
</tr>
<tr>
<td>Shortness of breath</td>
</tr>
<tr>
<td>Black, tarry stool</td>
</tr>
<tr>
<td>Hot flashes</td>
</tr>
<tr>
<td>Social History: Occupation:__________________</td>
</tr>
<tr>
<td>Domestic violence (circle): yes no</td>
</tr>
<tr>
<td>Exercise (what and how often):________________</td>
</tr>
<tr>
<td>Have you ever lived in a foreign country?________________</td>
</tr>
<tr>
<td>Alcohol use (yes or no and how much):________________</td>
</tr>
<tr>
<td>Tobacco use (current/former/how much):________________</td>
</tr>
<tr>
<td>Recreational drug use (specify):________________</td>
</tr>
<tr>
<td>Do you use your seat belt regularly? yes no</td>
</tr>
</tbody>
</table>

Family History: Have YOU or any of YOUR grandparents, parents, uncles, aunts, sisters, brothers, children been diagnosed with:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>RELATIONSHIP</th>
<th>YES</th>
<th>NO</th>
<th>RELATIONSHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>___</td>
<td>___</td>
<td>Cancer</td>
<td>___</td>
<td>___</td>
<td>Diabetes</td>
</tr>
<tr>
<td>___</td>
<td>___</td>
<td>Tuberculosis</td>
<td>___</td>
<td>___</td>
<td>Heart Disease</td>
</tr>
<tr>
<td>___</td>
<td>___</td>
<td>Kidney problems</td>
<td>___</td>
<td>___</td>
<td>High blood Pressure</td>
</tr>
<tr>
<td>___</td>
<td>___</td>
<td>Hay fever/asthma</td>
<td>___</td>
<td>___</td>
<td>Epilepsy</td>
</tr>
<tr>
<td>___</td>
<td>___</td>
<td>Severe deafness</td>
<td>___</td>
<td>___</td>
<td>Blood disease</td>
</tr>
<tr>
<td>___</td>
<td>___</td>
<td>Muscular disorders</td>
<td>___</td>
<td>___</td>
<td>Emotional/Mental Illness</td>
</tr>
<tr>
<td>___</td>
<td>___</td>
<td>Hemophilia</td>
<td>___</td>
<td>___</td>
<td>Chromosomal disorder</td>
</tr>
<tr>
<td>___</td>
<td>___</td>
<td>Endometriosis</td>
<td>___</td>
<td>___</td>
<td>Thyroid disease</td>
</tr>
<tr>
<td>___</td>
<td>___</td>
<td>Spina bifida</td>
<td>___</td>
<td>___</td>
<td>Cystic Fibrosis</td>
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<tr>
<td>___</td>
<td>___</td>
<td>Sickle cell disorder</td>
<td>___</td>
<td>___</td>
<td>Blood disorders</td>
</tr>
<tr>
<td>___</td>
<td>___</td>
<td>Congenital heart disease</td>
<td>___</td>
<td>___</td>
<td>Recurrent miscarriages</td>
</tr>
<tr>
<td>___</td>
<td>___</td>
<td>Blood clotting disorders</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

At what age did your mother go through menopause? _________________________________

Any female relatives who went through menopause before age 40? _________________________________

What is your ethnic background?  ___________________________________________________________
Genetic counselling – will be discussed at your visit

**Vaccination history:** Have you been vaccinated against the following, and if so, what year?

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Yes</th>
<th>No</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pertussis</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Influenza</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polio</td>
<td></td>
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<td></td>
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<tr>
<td>Measles</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pertussis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chickenpox</td>
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<tr>
<td>HPV</td>
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<tr>
<td>Hepatitis A</td>
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<tr>
<td>Hepatitis B</td>
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**Gynecologic History:**

How old were you when you had your first period? ____________________________

What was the first day of your last period? __________________________________

How often do you get your period? __________________ Is it painful? Yes No

Do you ever skip periods? Yes No

Do you have pain with intercourse (if yes, describe)? __________________________

How many pads or tampons do you use daily? _________________________________

How many days does your period last? _______________________________________

Do you have bloating, mood swings or breast tenderness before your period starts? Yes No

Do you bleed/spot in between periods? Yes no

Do you bleed/spot with intercourse? Yes no

When was your last pap test? _________ Was your last pap test normal? Yes No

Have you had any abnormal pap tests or surgery on your cervix (if so, when)? ____________________________

Have you had any sexually transmitted diseases (circle and list approximate year):

- Gonorrhea
- Chlamydia
- Pelvic inflammatory disease
- Trichomonas
- Human Papilloma Virus
- Herpes Simplex Virus

Have you noted increased acne on your face, chest or back? Yes No

Have you noted increased hair growth on your face, chest or back? Yes No

Do you shave or wax or depilate your face, chest or back on a regular basis? Yes No

Have you noted any nipple discharge from your breasts? Yes No

Have you used birth control methods in the past? If so, please list _______________________________________

Who is your current OB/GYN provider? _______________________________________

**Obstetric History:** Please list any pregnancies and their characteristics:

<table>
<thead>
<tr>
<th>Year</th>
<th>Spontaneous conception?</th>
<th>Current partner?</th>
<th>Outcome?</th>
<th>Vaginal or Cesarean?</th>
<th>Complications?</th>
</tr>
</thead>
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</table>
**Fertility History:** Have you had any of the below evaluation or treatment in the past (if so, when, and list any results):

Blood work

Hysterosalpingogram (x-ray test of tubes)

Transvaginal ultrasound

Laparoscopy or hysteroscopy

Ovulation predictor kits

Clomid

Letrozole (Femara)

Gonadotropins

Intrauterine insemination

In vitro fertilization

Have you used ovulation predictor kits before?   Yes   No   Do they show positive ovulation? Yes   No
If yes, which one and what day do they turn positive?
How often do you and your partner have intercourse per week?
Do you use any lubricants? If so, which one?

Patient signature and date

Reviewed by Provider   RJH   KSD   MSK
Provider signature and date
**Partner questionnaire:**

<table>
<thead>
<tr>
<th>Name of partner:</th>
<th>date of birth</th>
<th>age</th>
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**Gender:**

- Male
- Female

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<tr>
<th>Weight</th>
<th>height</th>
<th>BMI</th>
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**Ethnicity:**

________________________________________________________________________

**Do you have any medical problems (if so, please list)?**
________________________________________________________________________

**Have you had any surgeries in the past (if so, please list)?**
________________________________________________________________________

**What medications do you take currently?**
________________________________________________________________________

**Do you have any allergies (if so, please list)?**
________________________________________________________________________

**What is your occupation?**
________________________________________________________________________

**Do you smoke? (if so, how much and how long?)**
________________________________________________________________________

**How much alcohol do you consume?**
________________________________________________________________________

**Do you use recreational drugs? (if so, what and how much?)**
________________________________________________________________________

**Any exposure to toxic substances at your work place?**
________________________________________________________________________

**Any history of sexually transmitted diseases? (if so, list)**
________________________________________________________________________

**For males:**

- Any injury to your groin or testicles? __________
- Any testicular pain? ____________________________
- Any difficulty with erections or ejaculation? ______
- Any fever within the last 3 months? ______________
- Have you fathered any children? (If so, what year?)
- Have you ever had a semen analysis? (if so, what was the result?)
- Have you ever used any steroid hormones for body building or testosterone? Yes No

**Partner signature and date**

________________________________________________________________________

I have examined this patient’s medical history and assess her/him to have ___or have no___ evidence of high risk behavior or clinical signs or symptoms of relevant communicable diseases.

**Reviewed by Provider**

RJH  KSD  MSK

**Provider signature and date**

________________________________________________________________________