NEW PATIENT CHECK LIST FOR YOUR APPOINTMENT

1. **PRE-REGISTRATION** - *If you haven't already taken care of this - Please contact KU Registration at 913-588-1000 prior to your appointment to register your personal information. This is a very important step in your new patient process. If you are not sure if you have taken care of this, please call our office and we would be glad to assist you. Your spouse/partner will also have to follow this important step prior to the appointment even if you have the same insurance plan.*
   If you have a medical insurance plan, you will need your insurance card when you make this call.
   NOTE: You still need to call this number even if you do not have an insurance plan.
   Please be aware this is a SECURED line for personal information.
   Failure to call KU Registration will cause delays in the check- in process and may shorten your consultation time with the physician (this is a separate step from checking benefit verification listed in #5)

2. **ARRIVAL TIME** – Your arrival time will be listed in your new patient letter or email. When you check in there will be additional new patient forms to complete.
   Plan to be here approximately 1.5 hours.

3. **HISTORY FORM** – Please complete the enclosed history form and bring it with you to your appointment. This is very important information needed for your consult with the physician.

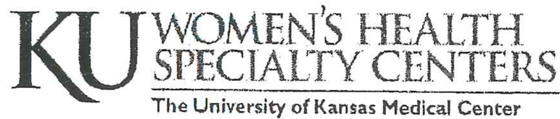
4. **PHOTO ID** – Please bring your ID such as a driver's license or state identification card to your appointment. This is to ensure your personal privacy.

5. **INSURANCE** – Please bring the most current insurance card(s) with you (primary and secondary) to your appointment. Most insurance plans do not cover infertility services *or* lab work associated with these services. If you are interested in knowing what your insurance plan covers for infertility service, complete the attached 2 page form from Fertility LifeLines at the end of this packet and fax to 866-882-2900. They will check your benefits and send you a letter outlining your infertility benefits (please list KU CENTER FOR ADVANCED REPRODUCTIVE MEDICINE as your physician). You can contact Fertility LifeLines at 866-538-7879 if you have any questions regarding this form. We also suggest that you contact your insurance company so you are aware of what your coverage/benefits are. Phone numbers will be listed on your insurance card.
   Please Note: This is a separate step from KU Registration listed in #1).

6. **REFERRALS** – If your insurance requires that you have a referral for your visit, *you* will be responsible for obtaining this. If you have Tricare – you must contact your PCM to start the referral process for the reproductive clinic. Referrals can be faxed to 913-588-6258. If the referral for the reproductive clinic has not been received, you will be expected to pay $350 when you check in.

7. **PRIVATE PAY** – If you do not have insurance coverage through an insurance company you will be expected to pay for charges incurred at the time service is rendered. New patient appointments are $350. We accept cash, personal check and all major credit cards. A financial representative will be able to meet with you to review costs for our services.

8. **MEDICAL RECORDS** – Due to HIPAA (personal privacy act), *you* are responsible for obtaining medical records pertaining to your gynecological related care prior to your visit. Your physician's office will have you complete their form to release your records to us. Records can be faxed to 913-588-6258. It is helpful if your records are faxed at least 1 week prior to your appointment.



CENTER FOR ADVANCED REPRODUCTIVE MEDICINE

10777 Nall Ave, Ste 200
Overland Park, Ks. 66211
(913) 588- 3216

PAYMENT POLICY

We are committed to providing you the best care. We understand that the financial aspect of your care can be somewhat confusing. Your clear understanding of our financial policy is important to our professional relationship. Please feel free to ask any questions regarding our fees, payment plans, financial policy, or your responsibility.

Regarding Insurance Responsibilities

It is important that you provide us with up to date insurance and maintain registration of your current insurance with our registration department (913-588-1000). We can only file claims to insurance we have on file **prior** to your appointment as we must verify coverage in advance and sometimes pre-certify your visits with your insurance carrier. Failure to register insurance prior to a visit could result in your being charged as a self-pay patient.

Please check with your insurance carrier to be sure that your plan is one that participates with us and to check your infertility benefits. Your insurance contract is between you and your insurance company. We have no responsibility with disputes between you and your insurance company regarding deductibles, co-payments, covered vs. non-covered services, etc.

We cannot quote costs for services ordered by your physician that are not provided by our clinic.

Payment Required at Time of Service

Services for which you have no insurance coverage **must be paid in full at/prior to the time of service.**

- In Vitro Fertilization and all related procedures-payment is due before you start your injectable medications for the cycle
- Artificial Insemination-payment is due the morning of the procedure (for weekend procedures we will call you on the Friday before to collect payment)
- Cryopreservation and storage of sperm
- Tubal Reversal
- Any service for which you do not have insurance coverage

***Please refer to new patient packet for additional information

AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE
Infertility History Form

FOR OFFICE USE ONLY

IMPORTANT:
Please complete this form and bring it with you to your scheduled visit.

This form was developed by the American Society for Reproductive Medicine to assist physicians and patients in obtaining a complete infertility history. It consists of three parts:

Part I: Contact information
Part II: Your medical history
Part III: Your spouse/male partner's medical history (if applicable)

PART I: CONTACT INFORMATION

First Name ______ **Middle Initial** __ **Last Name** ______ **Age**____

Date of Birth (MM/DD/YY) ____/____/______ Occupation ______

Home Street Address ______

City ______ State ____ Zip/Postal Code ______ Country ______

Indicate which number to call or leave messages.
☐ Home Telephone (   )______ ☐ Work Telephone (   )______ ☐ Cell Phone (   )______

Are you married? ☐ Yes ☐ No ☐ Divorced ☐ Other ______

Spouse/Partner's First Name ______ **Middle Initial** __ **Last Name** ______ **Age**____
☐ Not Applicable

Date of Birth (MM/DD/YY) ____/____/______ Occupation ______

Home Street Address ______

City ______ State ____ Zip/Postal Code ______ Country ______

Indicate which number to call or leave messages.
☐ Home Telephone (   )______ ☐ Work Telephone (   )______ ☐ Cell Phone (   )______

Who referred you?
☐ Physician
Name ______ Phone ( ) ______
Address ______

☐ Former Patient/Friend ______
☐ Web Site ______
☐ Insurance (Name of Insurance)______

Who is your Ob/Gyn?
Name ______ Phone ( ) ______
Address ______

Who is your Primary Care Physician?
Name ______ Phone ( ) ______
Address ______

Physician Notes (for office use only)

PART II: FEMALE MEDICAL HISTORY AND INFORMATION

Reason for Visit: ☐ Infertility Evaluation ☐ Insemination ☐ Other ______________________

What are your expectations for this visit?______________________

What questions do want answered at this visit?______________________

____

Do you have any personal, ethical, or religious objections to any of our tests or treatments such as insemination, in vitro fertilization, egg donation, sperm donation, masturbation to collect a semen sample, etc.? ☐ Yes______________________ ☐ No

How many months have you been having intercourse without using any form of birth control? _____

Pregnancy Summary

- Total Number of ALL Pregnancies: _____
- Number of Miscarriages (less than 20 weeks): _____
- Number of Ectopic/Tubal Pregnancies: _____
- Number of Elective Terminations (Abortions): _____
- Number of Full Term Deliveries: _____ Of these, how many were live births? ___ How many were stillborn? ___
- Number of Premature (less than 37 weeks) Deliveries: _____ Of these, how many were live births? ___ How many were stillborn? ___
- Any Pregnancies with Birth Defects? ☐ Yes - explain ______________________ ☐ No

Date Pregnancy Ended or Delivered	Months to Conception	Treatments to Conceive	Delivery Type/D&C/ Complications	Current Partner?
1. ________	________	________	________	☐Y ☐N
2. ________	________	________	________	☐Y ☐N
3. ________	________	________	________	☐Y ☐N
4. ________	________	________	________	☐Y ☐N
5. ________	________	________	________	☐Y ☐N
6. ________	________	________	________	☐Y ☐N

Menstrual History

- Menstrual cycle pattern (check all that apply): ☐ Regular periods ☐ Irregular periods ☐ Spotting before periods ☐ No periods ☐ Heavy periods ☐ Light periods ☐ Bleeding between periods
- Number of days between the start of one period to the start of the next period: _____days
- How many days of bleeding do you have? _____days
- Dates of the 1st day of your last 2 menstrual periods: _____/_____/_____; _____/_____/_____
- Age when you had your first period: _____years old
- Age when you first noticed: Breast development: ____years old Pubic hair: ____years old Underarm hair: ____years old
- How many periods do you have per year? _____
- Do you need medication to bring on a period? ☐ Yes - what type?__________________ ☐ No
- If you do not have periods, at what age did you stop having them? _____ years old
- Do you have severe cramping or pelvic pain with your periods? ☐ Yes: __Always __Sometimes __Recently __In the past ☐ No
- Did your mother take DES when she was pregnant with you? ☐ Yes ☐ No ☐ Don't know

Contraceptive History

☐ None ☐ Condoms - dates of use__________ ☐ Diaphragm - dates of use __________ ☐ Foam or Jelly
☐ Birth control pills - dates of use__________ - complications?______________________ ☐ Never used birth control pills
☐ Injectable contraception (Depo-Provera®, Lunelle™, etc.) - dates of use__________ - complications?______________________
☐ Skin patch - dates of use__________ - complications?______________________ ☐ IUD - dates of use__________
☐ Tubal sterilization procedure (tubes tied) - date (month/year)_____/_____ ☐ Tubes untied - date (month/year)_____/_____

Sexual History

- Are you sexually active? ☐ Yes ☐ No Is your partner ☐ Male ☐ Female
- How many times do you have intercourse per week? _____times per week ☐ None ☐ Not applicable
- Have you used over-the-counter ovulation kits to time intercourse? ☐ Yes ☐ No
- Do you have pain with intercourse? ☐ Yes ☐ No
- Do you use lubricants (K-Y Jelly®, etc.) during intercourse? ☐ Yes - what types?__________________ ☐ No

Have you had any of the following sexually transmitted diseases or pelvic infections? ☐ Yes (check all that apply) ☐ No
☐ Chlamydia - date_____ ☐ Gonorrhea - date_____ ☐ Herpes - date_____ ☐ Genital warts/HPV - date_____
☐ Syphilis - date_____ ☐ HIV/AIDS - date_____ ☐ Hepatitis - date_____ ☐ Other - date__________

Pap Smear History

- When was your last pap smear (month and year)?_____/_____ ☐ Normal ☐ Abnormal
- When was your last abnormal pap smear? _____ ☐ Not applicable

Have you undergone any procedures as a result of an abnormal pap smear?
☐ Yes (check all that apply) ☐ No
☐ Colposcopy ☐ Cryosurgery (Freezing) ☐ Laser treatment ☐ Conization ☐ LEEP procedure

Breast Screening History

Have you ever had a mammogram? ☐ Yes - date_____ Result: ☐ normal ☐ abnormal - explain __________________ ☐ No
Do you perform breast self exams?

Medical History

- Are you allergic to any medications? ☐ Yes ☐ No
  If yes, please list and describe reactions:____
  ____

- Are you allergic to any foods (peanuts, eggs, etc.)? ☐ Yes ☐ No
  If yes, please list and describe reactions:____
  ____

- List any medications you are currently taking, including over-the-counter medicines. ______________________________
  ____

- Do you take any herbal medicines/vitamins or health food store supplements? ☐ Yes ☐ No
  If yes, please list :____
  ____

- Do you have any medical problem(s)? ☐ Yes (Please list type, dates, and treatments.) ☐ No
  (1)____
  (2)____
  (3)____
  (4)____
  (5)____

Surgical History

- Have you had any surgeries? ☐ Yes (List all surgeries in chronologic order.) ☐ No

Year	Reason and Type of Surgery
(1)_________	(1)_______________________________________
(2)_________	(2)_______________________________________
(3)_________	(3)_______________________________________
(4)_________	(4)_______________________________________
(5)_________	(5)_______________________________________
(6)_________	(6)_______________________________________
(7)_________	(7)_______________________________________

- Did you have any problems with anesthesia? ☐ Yes (describe ______________________________________) ☐ No

- Have you had either of these childhood illnesses? ☐ Chickenpox (Varicella) ☐ German Measles (Rubella) ☐ Don't know
  Other childhood diseases:____

Vaccinations

- Chickenpox (Varicella): ☐ Yes (dates_________) ☐ No ☐ Don't know
- MMR - Measles, Mumps, and Rubella (German Measles): ☐ Yes (dates_________) ☐ No ☐ Don't know
- BCG (Tuberculosis): ☐ Yes (dates_________) ☐ No ☐ Don't know
- Hepatitis B: ☐ Yes (dates_________) ☐ No ☐ Don't know
- Polio: ☐ Yes (dates_________) ☐ No ☐ Don't know
- Hepatitis A: ☐ Yes (dates_________) ☐ No ☐ Don't know
- Tetanus: ☐ Yes (dates_________) ☐ No ☐ Don't know
- Influenza: ☐ Yes (dates_________) ☐ No ☐ Don't know

Social History

- How many caffeinated beverages (coffee, tea, soda) do you drink per day?_____ ☐ None
- Do you smoke cigarettes? ☐ Yes How many/day?_____ How many years?_____ ☐ Quit - when?______________ ☐ No
- Do you drink alcohol? ☐ Yes ☐ No
  If yes, how many drinks per week?________________________________
- Have you casually used marijuana, cocaine, or any other similar drug? ☐ Yes (describe________________________) ☐ No
- Do you exercise? ☐ Yes (describe________________________) ☐ No
- Are you aware of any radiation exposures other than X-rays? ☐ Yes (describe________________________) ☐ No
- Do you feel safe in your own home? ☐ Yes (describe________________________) ☐ No

Review of Physical Symptoms

General:
☐ Recent weight gain or loss
☐ Anorexia/Bulimia
☐ Lack of energy
☐ Fever/Chills
☐ Other________________
☐ None

Head, Eyes, Ears, Nose, and Throat:
☐ Dizziness ☐ Loss of sense of smell
☐ Headaches ☐ Chronic nasal congestion
☐ Blurred vision ☐ Ringing ears
☐ Hearing loss/deafness
☐ Other________________
☐ None

Respiratory:
☐ Shortness of breath
☐ Asthma ☐ Bronchitis
☐ Pneumonia ☐ Tuberculosis
☐ Bloody cough
☐ Other________________
☐ None

Endocrine/Hormonal:
☐ Diabetes ☐ Hair loss
☐ Thyroid gland problems
☐ Rapid weight gain or loss
☐ Excessive hunger/thirst
☐ Temperature intolerance– hot flashes or feeling cold
☐ Other________________
☐ None

Breasts:
☐ Discharge (clear?___ bloody?___ milky?___)
☐ Lumps ☐ Pain ☐ Cancer
☐ Abnormal mammogram
☐ Reduction
☐ Augmentation/Breast implants (saline?___ silicone?___)
☐ Other________________
☐ None

Neurological Problems:
☐ Weakness/Loss of balance
☐ Seizures/Epilepsy
☐ Headaches
☐ Migraine headaches
☐ Numbness
☐ Memory loss
☐ Other________________
☐ None

Gastrointestinal:
☐ Nausea/Vomiting ☐ Ulcers
☐ Hepatitis ☐ Diarrhea
☐ Blood in your stools ☐ Constipation
☐ Irritable Bowel Syndrome
☐ Change in bowel habits
☐ Colitis (ulcerative or Crohn's)
☐ Other________________
☐ None

Genito-Urinary:
☐ Bladder infections
☐ Kidney infections
☐ Vaginal infections
☐ Frequent urination ☐ Leaking urine
☐ Blood in the urine
☐ Herpes
☐ Other________________
☐ None

Skin/Extremities:
☐ Unexplained rash/inflammation
☐ Acne
☐ Skin cancer
☐ Burn injury
☐ Moles changing in appearance
☐ Excess hair growth
☐ Other________________
☐ None

Musculoskeletal:
☐ Unusual muscle weakness
☐ Decreased energy/stamina
☐ Rheumatoid arthritis
☐ Lupus Erythematosus
☐ Myasthenia gravis
☐ Other________________
☐ None

Hematologic:
☐ Blood clotting disorder/Blood clot
☐ Sickle cell Anemia ☐ Thrombophlebitis
☐ Easy bruising
☐ Swollen glands/lymph nodes
☐ Blood transfusions (dates/reasons________________)
☐ Other________________
☐ None

Cardiovascular:
☐ Palpitations/Skipped beats
☐ Chest pain ☐ Heart attack
☐ Stroke ☐ Murmurs
☐ High blood pressure
☐ Rheumatic fever
☐ Mitral valve prolapse (Need antibiotics before dental procedures? Yes___ No___
☐ Other________________
☐ None

Mental Health Problems:
☐ Depression ☐ Anxiety disorder
☐ Schizophrenia
☐ Other________________
☐ None

Physician Notes (for office use only) ____

Family History

	Living		Cause of Death/Age at Death
• Mother	☐Yes - age___	☐No	________________
• Father	☐Yes - age___	☐No	________________
• Brother(s)	☐Yes - age___	☐No	________________
	☐Yes - age___	☐No	________________
• Sister(s)	☐Yes - age___	☐No	________________
	☐Yes - age___	☐No	________________
• Maternal Grandmother	☐Yes - age___	☐No	________________
• Maternal Grandfather	☐Yes - age___	☐No	________________
• Paternal Grandmother	☐Yes - age___	☐No	________________
• Paternal Grandfather	☐Yes - age___	☐No	________________

What is your Ancestry?

☐ American Indian or Alaskan Native

☐ Asian or Pacific Islander

☐ Black, not of Hispanic Origin

☐ Hispanic

☐ White, not of Hispanic Origin

☐ Other (specify___________)

Disorders in You/Your Family

		Self or Relationship to You		
• Birth defects	☐Yes	________________	☐No	☐Don't Know
• Blood clots	☐Yes	________________	☐No	☐Don't Know
• Bloom syndrome	☐Yes	________________	☐No	☐Don't Know
• Bone/Skeletal Defects	☐Yes	________________	☐No	☐Don't Know
• Canavan disease	☐Yes	________________	☐No	☐Don't Know
• Cancer				
• Breast cancer	☐Yes	________________	☐No	☐Don't Know
• Colon cancer	☐Yes	________________	☐No	☐Don't Know
• Ovarian cancer	☐Yes	________________	☐No	☐Don't Know
• Other cancer______	☐Yes	________________	☐No	☐Don't Know
• Color Blindness	☐Yes	________________	☐No	☐Don't Know
• Cystic Fibrosis	☐Yes	________________	☐No	☐Don't Know
• Deafness/Blindness	☐Yes	________________	☐No	☐Don't Know
• Developmental delay	☐Yes	________________	☐No	☐Don't Know
• Diabetes	☐Yes	________________	☐No	☐Don't Know
• Down syndrome	☐Yes	________________	☐No	☐Don't Know
• Other chromosome defects	☐Yes	________________	☐No	☐Don't Know
• Dwarfism	☐Yes	________________	☐No	☐Don't Know
• Endometriosis	☐Yes	________________	☐No	☐Don't Know
• Familial Dysautonia	☐Yes	________________	☐No	☐Don't Know
• Fanconi Anemia	☐Yes	________________	☐No	☐Don't Know
• Galactosemia	☐Yes	________________	☐No	☐Don't Know
• Gaucher disease	☐Yes	________________	☐No	☐Don't Know
• Heart defect from birth	☐Yes	________________	☐No	☐Don't Know
• Heart disease	☐Yes	________________	☐No	☐Don't Know
• Hemochromatosis	☐Yes	________________	☐No	☐Don't Know
• Hemophilia	☐Yes	________________	☐No	☐Don't Know
• Infertility	☐Yes	________________	☐No	☐Don't Know
• Learning problems	☐Yes	________________	☐No	☐Don't Know
• Marfan syndrome	☐Yes	________________	☐No	☐Don't Know
• Menopause before age 40	☐Yes	________________	☐No	☐Don't Know
• Muscular Dystrophy	☐Yes	________________	☐No	☐Don't Know
• Neural Tube Defects	☐Yes	________________	☐No	☐Don't Know
• Neurologic (brain/spine)	☐Yes	________________	☐No	☐Don't Know
• Niemann-Pick disease	☐Yes	________________	☐No	☐Don't Know
• Obesity	☐Yes	________________	☐No	☐Don't Know
• Polycystic kidney disease	☐Yes	________________	☐No	☐Don't Know
• Psychiatric problems	☐Yes	________________	☐No	☐Don't Know
• Sickle Cell Anemia	☐Yes	________________	☐No	☐Don't Know
• Tay-Sachs disease	☐Yes	________________	☐No	☐Don't Know
• Thalassemia	☐Yes	________________	☐No	☐Don't Know
• Thyroid problems	☐Yes	________________	☐No	☐Don't Know
• Tuberculosis	☐Yes	________________	☐No	☐Don't Know
• High blood pressure	☐Yes	________________	☐No	☐Don't Know
• Glaucoma	☐Yes	________________	☐No	☐Don't Know
• High cholesterol	☐Yes	________________	☐No	☐Don't Know
• Gallstones	☐Yes	________________	☐No	☐Don't Know
• Hepatitis	☐Yes	________________	☐No	☐Don't Know

☐ None of the above ☐ Other (Specify ________________________

PRIOR INFERTILITY TESTING AND TREATMENT

• Have you had prior infertility testing or treatment elsewhere? ☐ Yes ☐ No

Prior Tests (check all that apply): ☐ Basal body temperature chart (date____/results________________________)

☐ Thyroid test (date____/results ________________________) ☐ Ovulation test kit (date_____/results______________)

☐ Day 3 blood test for FSH level (date____/results______________) ☐ Hysterosalpingogram (HSG) (date____/results__________)

☐ Laparoscopy surgery (date____/results______________________) ☐ Hysteroscopy surgery (date_____/results____________)

☐ Progesterone blood test (date____/results____________________) ☐ Prolactin blood test (date_____/results ____________)

Prior Treatment (check all that apply):

	# of cycles	Dates (mo/year) (mo/year)	Outcome
☐ Intrauterine insemination:	_____	From__/__ to__/__	__Pregnant: __Delivered __Ectopic __Miscarriage; __Not Pregnant
☐ Clomiphene citrate with timed intercourse: maximum # tablets per day?_____	_____	From__/__ to__/__	__Pregnant: __Delivered __Ectopic __Miscarriage; __Not Pregnant
☐ Clomiphene citrate with insemination: maximum # tablets per day?_____	_____	From__/__ to__/__	__Pregnant: __Delivered __Ectopic __Miscarriage; __Not Pregnant
☐ Daily fertility drug injections with insemination: maximum # vials per day?_____	_____	From__/__ to__/__	__Pregnant: __Delivered __Ectopic __Miscarriage; __Not Pregnant
☐ Completed in vitro fertilization cycle(s): 1. # eggs___ #embryos transferred___ #frozen___ 2. # eggs___ #embryos transferred___ #frozen___ 3. # eggs___ #embryos transferred___ #frozen___ 4. # eggs___ #embryos transferred___ #frozen___	_____	_____/_____ _____/_____ _____/_____ _____/_____	__Pregnant: __Delivered __Ectopic __Miscarriage; __Not Pregnant __Pregnant: __Delivered __Ectopic __Miscarriage; __Not Pregnant __Pregnant: __Delivered __Ectopic __Miscarriage; __Not Pregnant __Pregnant: __Delivered __Ectopic __Miscarriage; __Not Pregnant
☐ Frozen embryo transfers: 1. # embryos transferred_____ 2. # embryos transferred_____ 3. # embryos transferred_____ 4. # embryos transferred_____	_____	_____/_____ _____/_____ _____/_____ _____/_____	__Pregnant: __Delivered __Ectopic __Miscarriage; __Not Pregnant __Pregnant: __Delivered __Ectopic __Miscarriage; __Not Pregnant __Pregnant: __Delivered __Ectopic __Miscarriage; __Not Pregnant __Pregnant: __Delivered __Ectopic __Miscarriage; __Not Pregnant
Canceled in vitro fertilization attempt(s):	_____		
☐ Any other prior treatment (describe): ______________________________			

• Additional Information/Complications: ______________________________

____

____

EMOTIONAL STATUS

• On a scale of 1-10 (10 being the worst), estimate the level of stress you feel due to infertility and other pressures. ______

• Do you see a counselor? ☐ Yes - For how long? ________________ How often? ______________________ ☐ No

• List any antidepressant/antianxiety medications you are currently taking. ______________________________

• Describe any emotional, marital, or sexual problems caused by your infertility. ______________________________

____

____

PATIENT'S SIGNATURE______________________________ **DATE**________________

I confirm that I have reviewed the information above.

PHYSICIAN'S SIGNATURE______________________________ **DATE**________________

PART III: MALE MEDICAL HISTORY AND INFORMATION

Complete with your male partner if applicable.

- Have you been evaluated by a urologist? ☐ Yes ☐ No
- Have you previously conceived with another woman? Yes___ ☐ Yes: How many times?_____ ☐ No: Birth control used? No___
- Have you had a semen analysis? ☐ Yes ☐ No

Date	Volume	Count	Motility	Morphology
1.				
2.				
3.				

- Do you have difficulty with erections? ☐ 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 diseases 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 been diagnosed with any of the following diseases?
  ☐ Diabetes Mellitus - Yes___No___ ☐ Cancer - Yes___No___
  ☐ Multiple Sclerosis - Yes___No___ ☐ Other neurologic problems - Yes___No___
  ☐ Prostatic infections - Yes___No___ ☐ Urinary infections - Yes___No___
  ☐ High Blood Pressure - Yes___No___ If yes, any medications?____________________

- Have you had fever (>101° F) in the last 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 any radiation or harmful chemicals in the workplace? ☐ Yes ☐ No
- Have you had chemotherapy or radiation for cancer? ☐ Yes ☐ No
- • Are you allergic to any medications? ☐ Yes ☐ No
  If yes, please list and describe reactions:____________________
  ____

List your current medications:____________________

List any current medical problem(s):____________________

- How many caffeinated beverages do you drink per day?_____ ☐ None
- Do you smoke cigarettes? ☐ Yes How many/day?_____ How many years?_____ ☐ Quit - when?_______________ ☐ No
- Do you drink alcohol? ☐ Yes ☐ No
  If yes, how many drinks per week?____________________
- Have you casually used marijuana, cocaine, or any other similar drug? ☐ Yes (describe____________________) ☐ No
- Do you use herbal medicines/vitamins or health food store supplements? ☐ Yes (describe____________________) ☐ No
- Are you aware of any solvents/toxic materials exposure? ☐ Yes ☐ No
- Do you use hot tubs regularly? ☐ Yes ☐ No
- Did your mother take DES during pregnancy to prevent miscarriage? ☐ Yes ☐ No ☐ Don't know
- Have any of your immediate family members had difficulty conceiving a child? ☐ Yes ☐ No
  If yes, please describe____________________

Family History

	Living		Cause of Death/Age at Death
• Mother	☐Yes - age___	☐No	____________
• Father	☐Yes - age___	☐No	____________
• Brother(s)	☐Yes - age___	☐No	____________
	☐Yes - age___	☐No	____________
• Sister(s)	☐Yes - age___	☐No	____________
	☐Yes - age___	☐No	____________
• Maternal Grandmother	☐Yes - age___	☐No	____________
• Maternal Grandfather	☐Yes - age___	☐No	____________
• Paternal Grandmother	☐Yes - age___	☐No	____________
• Paternal Grandfather	☐Yes - age___	☐No	____________

What is your Ancestry?

☐ American Indian or Alaskan Native

☐ Asian or Pacific Islander

☐ Black, not of Hispanic Origin

☐ Hispanic

☐ White, not of Hispanic Origin

☐ Other (specify___________)

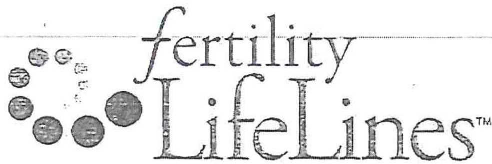
Disorders in Your Family

		Relationship to You		
• Bloom syndrome	☐Yes	____________	☐No	☐Don't Know
• Bone/Skeletal Defects	☐Yes	____________	☐No	☐Don't Know
• Canavan disease	☐Yes	____________	☐No	☐Don't Know
• Color Blindness	☐Yes	____________	☐No	☐Don't Know
• Cystic Fibrosis	☐Yes	____________	☐No	☐Don't Know
• Deafness/Blindness	☐Yes	____________	☐No	☐Don't Know
• Developmental delay	☐Yes	____________	☐No	☐Don't Know
• Down syndrome	☐Yes	____________	☐No	☐Don't Know
• Other chromosome defects	☐Yes	____________	☐No	☐Don't Know
• Dwarfism	☐Yes	____________	☐No	☐Don't Know
• Familial Dysautonia	☐Yes	____________	☐No	☐Don't Know
• Fanconi Anemia	☐Yes	____________	☐No	☐Don't Know
• Galactosemia	☐Yes	____________	☐No	☐Don't Know
• Gaucher disease	☐Yes	____________	☐No	☐Don't Know
• Heart defect from birth	☐Yes	____________	☐No	☐Don't Know
• Hemochromatosis	☐Yes	____________	☐No	☐Don't Know
• Hemophilia	☐Yes	____________	☐No	☐Don't Know
• Learning problems	☐Yes	____________	☐No	☐Don't Know
• Marfan syndrome	☐Yes	____________	☐No	☐Don't Know
• Muscular Dystrophy	☐Yes	____________	☐No	☐Don't Know
• Neural Tube Defects	☐Yes	____________	☐No	☐Don't Know
• Neurologic (brain/spine)	☐Yes	____________	☐No	☐Don't Know
• Niemann-Pick disease	☐Yes	____________	☐No	☐Don't Know
• Polycystic kidney disease	☐Yes	____________	☐No	☐Don't Know
• Sickle Cell Anemia	☐Yes	____________	☐No	☐Don't Know
• Tay-Sachs disease	☐Yes	____________	☐No	☐Don't Know
• Thalassemia	☐Yes	____________	☐No	☐Don't Know
• High blood pressure	☐Yes	____________	☐No	☐Don't Know
• Glaucoma	☐Yes	____________	☐No	☐Don't Know
• High cholesterol	☐Yes	____________	☐No	☐Don't Know
• Gallstones	☐Yes	____________	☐No	☐Don't Know
• Hepatitis	☐Yes	____________	☐No	☐Don't Know
☐ None of the above	☐ Other (Specify ____________			

SPOUSE/MALE PARTNER'S SIGNATURE______________________ **DATE**__________

I confirm that I have reviewed the information above.

PHYSICIAN'S SIGNATURE______________________ **DATE**__________



Insurance Benefits Verification Form

This form enables EMD Serono Fertility Lifelines™ to investigate your insurance coverage for fertility treatment. Please complete steps 1, 2, 3 and 4. Please fax the completed form toll-free to 1-866-882-2900. If you have any questions, please feel free to contact us toll-free at 1-866-LETS-TRY (1-866-538-7879).

STEP 1: Patient Information (To be completed by patient)

Patient Name	Social Security No.	Date of Birth	Sex ☐ Male ☐ Female
Home Address	City/State/Zip		
Home Phone	Work Phone	E-mail	
Preferred Phone: ☐ Home ☐ Work May we leave a message of you are not available? At home ☐ Yes ☐ No At work ☐ Yes ☐ No			
Physician Name	Physician Phone	Physician Fax	
Center Name ☐ Check here if you would like your results sent to your doctor.	Center Address		

STEP 2: Patient Insurance Information (To be completed by patient)

Please complete below and attach a copy of the front and back of your insurance card(s)

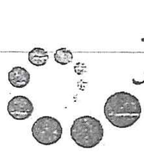
PRIMARY INSURANCE			SECONDARY INSURANCE		
Cardholder	ID No.		Cardholder	ID No.	
Group No.	Phone		Group No.	Phone	
Do you have a pharmacy benefit card? ☐ Yes ☐ No			Do you have a pharmacy benefit card? ☐ Yes ☐ No		
Name of Pharmacy Benefit Manager			Name of Pharmacy Benefit Manager		
ID No.	Group No.	Phone	ID No.	Group No.	Phone

STEP 3: Patient Consent (To be completed by patient)

I understand that EMD Serono Fertility Lifelines™ will use reasonable care in its investigation of my insurance coverage and will endeavor to accurately report to me information it receives from third parties regarding my insurance coverage. However, I understand that EMD Serono Fertility Lifelines™ can not guarantee the accuracy of information it receives from third parties and that the results of EMD Serono Fertility Lifelines™ investigation may differ from my insurance company's ultimate determination of coverage. I understand that the services provided by EMD Serono that are described in this authorization can be changed at any time, without prior notification.

Please review and complete patient authorization on reverse side.

PATIENT'S SIGNATURE	DATE
X	



1-866-LETS-TRY (1-866-538-7879)
Fax: 1-866-882-2900

STEP 4: Patient Authorization (To be completed by patient)

Authorization to Use and Disclose Health and Other Personal Information

I authorize my physician and their staff to disclose my health and other personal information, including, but not limited to, the information on my completed Insurance Benefits Verification Form to EMD Serono, Inc. and its agents and representatives (collectively "EMD Serono") so that EMD Serono may use and further disclose my information to healthcare providers, pharmacies, insurance companies, prescription drug plans and other third-party payers (collectively, "Third Parties") in order to assist me in evaluating my insurance coverage for infertility treatments, including medication coverage.

I further authorize the Third Parties to disclose health and other personal information about me in their possession to EMD Serono in order to assist EMD Serono in accomplishing the purposes described above.

I understand that once my information is disclosed pursuant to this authorization, it may no longer be protected by federal privacy laws (the Health Insurance Portability and Accountability Act). However, I understand that EMD Serono will not release my information to any party, except as provided in this authorization or as permitted by applicable law, without first obtaining my (or my authorized representative's) separate written consent.

I understand that I may refuse to sign this authorization and such refusal will not affect my ability to receive EMD Serono Fertility Products, but it will limit EMD Serono's ability to investigate my coverage for fertility treatment.

I understand that this authorization will remain in effect for ten years from the date of my signature, unless I revoke it earlier by contacting EMD Serono in writing at One Technology Place, Rockland, MA 02370.

If I revoke this authorization, EMD Serono will stop using and disclosing my information as soon as possible, but the revocation will not affect prior use or disclosure of my information in reliance on this authorization.

I also understand that I have the right to receive a copy of this authorization.

Patient Name (please print)

Patient Signature

Date