IVF Fertility Center − New Patient Form

Date: _____
Month Day Year

Name: _____
Last First Middle

Date of Birth: _____ Age: _____
Month Day Year

Driver's License (State & No.) _____ Social Security No. _____

Address: _____ Home Tel. No.: _____
_____ Work Tel. No: _____
Email: _____ Cell Tel. No.: _____

How did you hear about us?
□ Physician □ Friend □ Agency □ Internet □ TV □ Radio □ Magazine
□ Book □ Telephone yellow pages □ Newspaper □ Other

If referred by a physician:
Physician name: _____ Medical Specialty: _____
Address: _____ Office Tel. No.: _____
_____
_____

Reason for visit: _____
Marital Status: □ Single □ Married □ In a relationship □ Separated □ Divorced □ Widowed
Do you have a sexual partner? □ Yes □ No Gender of partner? □ Male □ Female

Menstrual History:
First day of last menstrual period: Date: _____
Month Day Year
Age at first period: _____ years old.
Menstrual cycles (1st day of bleeding to next 1st day of bleeding) range from: ____ (shortest cycle) days to ____ (longest cycle) days.
Duration of bleeding in days (circle all that apply): 1 2 3 4 5 6 7 8 9 10 more
Does bleeding or spotting occur between periods? □ No □ Yes
Are your periods painful? □ No □ Yes

Gynecology History:
Do you have pain during sex? □ No □ Yes
Date of last Pap smear? _____ Any prior abnormal Pap smear? □ No □ Yes
If Yes, treatment: □ Colposcopy □ Cryotherapy □ Laser □ Loop Excision (LEEP) □ Cone Biopsy
Date of last mammogram? _____ Any prior abnormal mammogram? □ No □ Yes
Any prior sexually transmitted disease or pelvic inflammatory disease? □ No □ Yes
If yes: □ Gonorrhea □ Chlamydia □ Herpes - genital □ Warts - genital □ Other (specify) _____

Pregnancy History: □ None

	Date	Delivery, Miscarriage, Ectopic or Abortion	Delivery type (Natural or C/S)	Weeks at delivery	Gender	Complications	Health Issues
1.							
2.							
3.							
4.							
5.							
6.							

Medical History: (Please check all that apply) □ None

□ Genetic/Chromosomal abnormalities
□ Birth defects
□ Fibroid Uterus
□ Endometriosis
□ Blood clots (thrombosis/embolism)
□ Bleeding disorder
□ Blood transfusion
□ Cancer
□ Diabetes
□ High blood pressure or Heart disease
□ Thyroid abnormality
□ High cholesterol
□ Asthma
□ Lung disease
□ Hepatitis
□ Liver disease
□ Kidney disease
□ Epilepsy or Seizures
□ Autoimmune or Connective tissue disease
□ HIV/AIDS
□ Sickle cell disease or trait
□ Thalassemia (alpha or beta)
□ Depression or Anxiety
□ Eating disorder
□ Other: _____

Surgical History: □ None

	Year	Reason and Type of Surgery
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____

Current Medications and Vitamins: (Please include amount and frequency) □ None

Please list: _____

_____

_____

_____

_____

Drug or Food Allergies: (Please include type of allergic reaction) □ None

Please list: _____

_____

_____

Social History:

Do you smoke? □ No □ Yes - Type: _____ Amount: _____ Duration: _____

Do you drink alcohol? □ No □ Yes - Type: _____ Amount: _____ Duration: _____

Do you use illicit drugs? □ No □ Yes - Type: _____ Amount: _____ Duration: _____

Do you exercise? □ No □ Yes - Type: _____ Duration: _____ Frequency: _____

What is your occupation? _____ What is your ethnicity? _____

What is your religion? _____

Family History: □ None

□ Genetic/Chromosomal abnormalities
□ Down Syndrome (Trisomy 21)
□ Mental retardation
□ Birth defects
□ Cystic Fibrosis
□ Sickle cell disease or trait
□ Thalassemia (alpha or beta)
□ Blood clots (thrombosis/embolism)
□ Bleeding disorder
□ Cancer
□ Diabetes
□ High blood pressure or Heart disease
□ Thyroid abnormality
□ High cholesterol

☐ Early menopause ☐ Other: _____
Please list affected relatives: _____
_____
_____

Other Symptoms: ☐ None
☐ Breast discharge ☐ Hot flashes ☐ Chronic pelvic pain
☐ Weight gain or loss ☐ Hair growth or loss ☐ Acne
☐ Change in energy ☐ Other: _____

Partner's History ☐ Not applicable (Skip this section)

Partner's Name: _____
Last First Middle

Date of Birth: _____ Age: _____
Month Day Year

Driver's License (State & No.) _____ Social Security No. _____

Address: _____ Home Tel. No.: _____
☐ Same _____ Work Tel. No: _____
Email: _____ Cell Tel. No.: _____

Conception History: ☐ None

Date	Delivery, Miscarriage, Ectopic or Abortion	Weeks at delivery	Gender	Complications	Health Issues
1.					
2.					
3.					
4.					
5.					
6.					

Medical History: (Please check all that apply) ☐ None
☐ Erectile dysfunction
☐ Ejaculatory dysfunction
☐ Testicular trauma or injury
☐ Undescended testicle(s)
☐ Mumps after puberty
☐ Genetic/Chromosomal abnormalities
☐ Birth defects
☐ Blood clots (thrombosis/embolism)
☐ Bleeding disorder
☐ Cancer
☐ Other: _____
☐ Diabetes
☐ High blood pressure or Heart disease
☐ Thyroid abnormality
☐ High cholesterol
☐ Hepatitis
☐ HIV/AIDS
☐ Sickle cell disease or trait
☐ Thalassemia (alpha or beta)
☐ Depression or Anxiety

Surgical History: ☐ None

Year	Reason and Type of Surgery
1.	
2.	
3.	
4.	
5.	
6.	

Current Medications and Vitamins: (Please include amount and frequency) ☐ None

Please list: _____

_____

_____

_____

_____

Drug or Food Allergies: (Please include type of allergic reaction) ☐ None

Please list: _____

_____

_____

Social History:

Do you smoke? ☐ No ☐ Yes - Type: _____ Amount: _____ Duration: _____

Do you drink alcohol? ☐ No ☐ Yes - Type: _____ Amount: _____ Duration: _____

Do you use illicit drugs? ☐ No ☐ Yes - Type: _____ Amount: _____ Duration: _____

Any prior sexually transmitted disease? ☐ No ☐ Yes

If yes: ☐ Gonorrhea ☐ Chlamydia ☐ Herpes - genital ☐ Warts - genital ☐ Other (specify) _____

What is your occupation? _____ What is your ethnicity? _____

What is your religion? _____

Family History: ☐ None

☐ Genetic/Chromosomal abnormalities
☐ Down Syndrome (Trisomy 21)
☐ Mental retardation
☐ Birth defects
☐ Cystic Fibrosis
☐ Sickle cell disease or trait
☐ Thalassemia (alpha or beta)
☐ Blood clots (thrombosis/embolism)
☐ Bleeding disorder
☐ Cancer
☐ Diabetes
☐ High blood pressure or Heart disease
☐ Thyroid abnormality
☐ High cholesterol
☐ Other: _____

Please list affected relatives: _____

_____

_____

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* I understand that I am financially responsible for all services rendered and IVF Fertility Center will collect full payment at the time of service.
* IVF Fertility Center can submit a claim to my insurance company on my behalf for direct reimbursement to me as a courtesy.
* If applicable, I authorize IVF Fertility Center to release all requested and necessary information to my insurance company to complete my claim.
* I confirm that I have read this entire form and the information provided above is true and correct. I understand and agree with the conditions stated above.

Please provide your driver's license and insurance card (if applicable) at the first visit.

Patient's Signature: _____ Date: _____

Partner's Signature: _____ Date: _____

I confirm that I have reviewed the information above.

Physician's Signature: _____ Date: _____

Physician's Name: _____ Time: _____