Coastal Fertility Medical Center | RSMC

Patient Forms

Contact Information

Patient

First Name: _____	Last Name: _____	Middle Initial: _____	Marital Status: _____
Best Ph # To Reach You: _____	OK to leave a message?: Yes ☐ No ☐	2nd Best Ph # To Reach You: _____	OK to leave a message?: Yes ☐ No ☐
Date Of Birth: _____	E-mail: _____	Age: _____	Address: _____
City: _____	State: _____	Zip Code: _____	DRIVER'S LIC: _____
State: _____	Occupation: _____	Work Hours: _____	Employer: _____
City: _____	State: _____	Zip Code: _____	

Do You have Partner ?: Yes ☐ No ☐

Partner

First Name: _____	Last Name: _____	Middle Initial: _____	Marital Status: _____
Best Ph # To Reach You: _____	OK to leave a message?: _____	2nd Best Ph # To Reach You: _____	OK to leave a message?: _____
Address: _____	City: _____	State: _____	Zip Code: _____
Date Of Birth: _____	Age: _____	DRIVER'S LIC: _____	ST: _____
E-mail: _____	Occupation: _____	Work Hours: _____	Employer: _____
Employer Address: _____	City: _____	State: _____	Zip Code: _____

Yes ☐ No ☐

Referral information

WHOM MAY WE THANK FOR THIS REFERRAL? Physician ☐ Friend ☐ Seminar ☐ Internet ☐ Support Group ☐
Physician (Name): _____________

Insurance information

Patient

PRIMARY INS: _______	Insured’s Name: _______	Insurance ID: _______

Type : HMO ☐ PPO ☐ POS ☐ EPO ☐ OTHER ☐		
CLAIMS ADDR: ________	**City:** ________	**State:** ________
Zip Code: ________	**Phone:** ________	
Do You have Partner?: Yes ☐ No ☐	**PRIMARY INS:** if Yes_____________	
Emergency contact person (not living with you): _____	**Relationship:** ______	**Insured's Name:** ______
Insured: HMO ☐ PPO ☐ POS ☐ EPO ☐ OTHER ☐		
CLAIMS ADDR: _________	**City:** ________	**State:** _______
Zip Code: _______	**Phone:** _______	
Do you have document to upload?: Yes ☐ No ☐		
Upload Front Insurance: ______________		
Upload Back Insurance: _______________		
Patient's signature: _________		**Date:** _________
Partner's signature: _________		**Date:** _________

Coastal Fertility Medical Center | RSMC Irvine

Infertility History

Has a Uterus

First Name: __________	**Middle Initial:** __________	**Last Name:** __________	**Age:** __________
Date of Birth: __________	**Occupation:** __________	**Home Street Address:** __________	**City:** __________
State: __________	**Zip/Postal Code:** __________	**Country:** __________	**E-mail:** __________

PATIENT MEDICAL HISTORY AND INFORMATION

Reason for Visit: Infertility Evaluation ☐ Sperm Insemination☐ Other☐
Reason for Visit (Other)______

What are your expectations for this visit?: ______

Any questions you wish to address: ______

Do you have any personal, ethical, or relations 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 History

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?: ________

Number of Premature (less than 37 weeks) Deliveries : ________

How many were stillborn?: ________

Any Pregnancies with Birth Defects?: Yes ☐ No ☐
If Yes, Please Specify______

Pregnancy History Details	Months to Conception	Treatments to Conceive	Delivery Type/D&C/Complications	Current Partner? (Yes/No)
_____	_____	_____	_____	_____

Menstrual Cycle 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: ___________

How many days of bleeding do you have?: ___________

Age when you had your first period: ___________

Age when you first noticed: Breast development (years): ___________

Age when you first noticed: Pubic hair (years): ___________

Age when you first noticed: Underarm hair (years): ___________

How many periods do you have per year?: ___________

If you do not have periods, at what age did you stop having them?: ___________

Do you have severe cramping or pelvic pain with your periods?: Yes ☐ No ☐
Always __ Sometimes __ Recently __In the past: ___________

Contraceptives Methods (History)

Do you use or have you used any contraceptives?: Yes ☐ No ☐

	Method	When they started?	Are you still using contraceptives	When they stopped?
☐	Condoms			
☐	Diaphragm	_____	Yes ☐ No ☐	___
☐	IUD	_____	Yes ☐ No ☐	___
☐	Birth control pills	_____ **Complications:** _____	Yes ☐ No ☐	___
☐	Inject able contraception	_____ **Complications:** _____	Yes ☐ No ☐	___

☐	Skin patch	________	Yes ☐ No ☐	___
☐	Foam or Jelly	________	Yes ☐ No ☐	___
☐	Tubal sterilization procedure (tubes tied)	______	Yes ☐ No ☐	___
☐	Tubes untied	______	Yes ☐ No ☐	___

Did your mother take DES when she was pregnant with you?: Yes ☐ No ☐ Don't know ☐

Sexual History

How many times do you have intercourse per week?: Yes ☐ No ☐

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 ☐ No ☐
If yes,what types?: __________

Pap Smear Medical History

When was your last pap smear (month and year)?: ______

When was your last abnormal pap smear?: _____

Have you undergone any procedures as a result of an abnormal pap smear?: Yes ☐ No ☐

Yes (check all that apply):

☐ Colposcopy
☐ Cryosurgery (Freezing)
☐ Laser treatmen
☐ Conization
☐ Leep procedure

Breast Screening History

Have you ever had a mammogram?: Yes ☐ No ☐

Date	Result
________	_________

Do you perform self breast exams?: Yes ☐ No ☐

Medical History

Are you allergic to any medications?: Yes ☐ No ☐

Are you allergic to any foods (peanuts, eggs, etc.)?: Yes ☐ No ☐
Please list and describe reactions: ___________

Do you take any medication?: Yes ☐ No ☐
If yes, please list: ___________

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 ☐ No ☐
Please list type, dates, and treatments: ___________

Did you have either of these childhood illnesses?:

☐ Chickenpox (Varicella)
☐ German Measles (Rubella)
☐ Don't know
☐ Other childhood diseases
If Other childhood diseases: ___________

Vaccinations

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

Social History

How many caffeinated beverages (coffee, tea, soda) do you drink per day?: ______

Do you smoke cigarettes?: Yes ☐ No ☐
How many/day?: ___________

Do you drink alcohol?: Yes ☐ No ☐

☐ Beer - # per week
☐ Wine - # per week
☐ Liquor - # per week

Do you use marijuana, cocaine, or any other similar drug?: Yes ☐ No ☐
If Yes please describe ___________

Do you exercise?: Yes ☐ No ☐
If Yes please describe __________

Are you aware of any radiation exposures other than X-rays?: Yes ☐ No ☐
If Yes please describe __________

Physician Notes (for office use only): ___________

Surgical History

Have you had any surgeries?: Yes ☐ No ☐
Number of surgeries: ____________

Year	Type of surgery in chronological
_________	_________

Did you have any anesthesia problems?: Yes No
please describe:

Physical Symptoms

- **General:**

☐ Diabetes
☐ Hair loss
☐ Anorexia/Bulimia
☐ Lack of energy
☐ Fever/chills
☐ Other
☐ None
Describe so it's consistent with the others – do for all similar responses : ____________

- **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
Describe so it's consistent with the others – do for all similar responses : ____________

- **Respiratory:**

☐ Shortness of breath

- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Bloody cough
- ☐ Other
- ☐ None

Describe so it’s consistent with the others – do for all similar responses : ______________

- **Endocrine/Hormona:**

- ☐ Recent weight gain or loss
- ☐ Thyroid gland problems
- ☐ Rapid weight gain or loss
- ☐ Excessive hunger/thirst
- ☐ Temperature intolerance-hot flashes or feeling cold
- ☐ Other
- ☐ None

Describe so it’s consistent with the others – do for all similar responses : ______________

- **Breasts:**

- ☐ Discharge
- ☐ Lumps
- ☐ Abnormal mammogram
- ☐ Reduction
- ☐ Augmentation/Breast Implants
- ☐ Other
- ☐ None

Describe so it’s consistent with the others – do for all similar responses : ______________

- **Neurological Problems:**

- ☐ Weakness/Loss of balance
- ☐ Seizures/Epilepsy
- ☐ Headaches
- ☐ Migraine headaches
- ☐ Numbness
- ☐ Memory Loss
- ☐ Other
- ☐ None

Describe so it’s consistent with the others – do for all similar responses : ______________

- **Gastrointestinal:**

- ☐ Nausea/Vomiting
- ☐ Ulcers
- ☐ Hepatitis

- [ ] Diarrhea
- [ ] Blood in your stools
- [ ] Irritable Bowel Syndrome
- [ ] Change in bowel habits
- [ ] Colitis (ulcerative or Cohn's)
- [ ] Other
- [ ] None

Describe so it's consistent with the others – do for all similar responses : ______________

- **Genito-Urinary:**

- [ ] Bladder infections
- [ ] Kidney infections
- [ ] Vaginal infections
- [ ] Frequent urination
- [ ] Blood in the urine
- [ ] Leaking Urine
- [ ] Herpes
- [ ] Other
- [ ] None

Describe so it's consistent with the others – do for all similar responses : ______________

- **Skin/Extremities:**

- [ ] Unexplained rash/inflammation
- [ ] Acne
- [ ] Skin caner
- [ ] Burn injury
- [ ] Moles changing in appearance
- [ ] Other
- [ ] None

Describe so it's consistent with the others – do for all similar responses : ______________

- **Musculoskeletal:**

- [ ] Unusual muscle weakness
- [ ] Decreased energy/stamina
- [ ] Rheumatoid arthritis
- [ ] Lupus Erythematosus
- [ ] Myasthenia gravis
- [ ] Other
- [ ] None

Describe so it's consistent with the others – do for all similar responses : ______________

- **Hematologic:**

- [ ] Blood clotting disorder/Blood clot
- [ ] Sickle Cell Anemia

- ☐ Thrombophlebitis
- ☐ Easy bruising
- ☐ Swollen glands/lymph nodes
- ☐ Blood transfusions
- ☐ Other

Describe so it's consistent with the others – do for all similar responses : ____________

- **Cardiovascular:**

- ☐ Palpitations/Skipped beats
- ☐ Chest pain
- ☐ Heart attack
- ☐ Stroke
- ☐ Murmurs
- ☐ High blood pressure
- ☐ Rheumatic fever
- ☐ Mitral valve prolapse
- ☐ Other
- ☐ None

Describe so it's consistent with the others – do for all similar responses : ____________

- **Mental Health Problems:**

- ☐ Depression
- ☐ Anxiety disorder
- ☐ Schizophrenia
- ☐ Other
- ☐ None

Describe so it's consistent with the others – do for all similar responses : ____________

Family History

Mother (Living): Yes ☐ No ☐

If Yes, Age___

If No, Cause of Death___

Father (Living): Yes ☐ No ☐

If Yes, Age___

If No, Cause of Death___

Brother (s) (Living): Yes ☐ No ☐

If Yes, Age___

If No, Cause of Death___

Sister (s) (Living): Yes ☐ No ☐

If Yes, Age___

If No, Cause of Death___

Maternal Grandmother (Living): Yes ☐ No ☐

If Yes, Age___

If No, Cause of Death___

Maternal Grandfather (Living): Yes ☐ No ☐

If Yes, Age___

If No, Cause of Death___

Paternal Grandmother (Living): Yes ☐ No ☐

If Yes, Age___

If No, Cause of Death___

Paternal Grandfather (Living): Yes ☐ No ☐

If Yes, Age___

If No, Cause of Death___

What is your Ancestry?:

☐ African - American
☐ Amer.Indian/NativeAmer
☐ Asian-American
☐ Cajun/French Canadian
☐ Caucasian
☐ Eastern European
☐ Hispanic - American
☐ Northern European
☐ Southern European
☐ Other

If other :

Disorders in Your Family

Medical Disorders	Yes/No/Don't Know	If yes, please list relationship to you
Breast cancer	________	_________
Ovarian cancer	________	________

Other cancer	_________	_________
Diabetes	_________	_________
Thyroid Problems	_________	_________
Heart Disease	_________	_________
Blood Clots	_________	_________
Obesity	_________	_________
Psychiatric problems	_________	_________
Tuberculosis	_________	_________
Infertility	_________	_________
Menopause before age 40	_________	_________
Birth Defects	_________	_________
Cystic Fibrosis	_________	_________
Tay-Sachs disease	_________	_________
Canavan disease	_________	_________
Bloom Syndrome	_________	_________
Gaucher disease		
Neimann-Pick disease	_________	_________
Fanconi Anemia	_________	_________
Familiar Dysautonia	_________	_________
Muscular Dystrophy	_________	_________
Neurologic brain/spine	_________	_________
Neural Tube Defects	_________	_________
Bone/Skeletal Defects	_________	_________
Dwarfism	_________	_________
Developmental Delay	_________	_________
Learning problems	_________	_________
Polycystic kidneydisease	_________	_________
Marfan syndrome	_________	_________

Hemophilia	________	________
Sickle Cell anemia	________	________
Thalassemia	________	________
Galactosemia	________	________
Deafness/Blindness	________	________
Color/Blindness	________	________
Hemochromatosis	________	________

PRIOR INFERTILITY TESTING AND TREATMENT

Have you had prior infertility testing or treatment elsewhere?:

Yes ☐ No ☐

Prior Tests (check all that apply):

	Prior Tests	Date	Results
☐	Basal body temperature chart	__________	__________
☐	Thyroid test	__________	__________
☐	Ovulation test	__________	__________
☐	Day 3 blood test for FSH level	__________	__________
☐	Hysterosalpingogram (HSG)	__________	__________
☐	Laparoscopy	__________	__________
☐	Hysteroscopy surgery	__________	__________
☐	Progesterone blood test	__________	__________
☐	Prolactin blood test kit	__________	__________
☐	Prolactin blood test kit	__________	__________
☐	None of these		

Prior Treatment (Check all that apply):

☐ **Intrauterine insemination**

No. of cycles: ______

List

Dates (MM/YY to MM/YY)	Outcome

☐ **Clomiphene citrate with timed intercourse**

No. of cycles: ______

List

Dates (MM/YY to MM/YY)	Outcome

☐ **Daily fertility drug injections with insemination**

No. of cycles: ______

List

Dates (MM/YY to MM/YY)	Outcome

☐ **Completed in vitro fertilization cycle(s)**

No. of cycles: ______

# of eggs	# of embryos transferred	# frozen

List

Dates (MM/YY to MM/YY)	Outcome

☐ **Frozen embryo transfers**

No. of cycles: ______

List

Dates (MM/YY to MM/YY)	Outcome

# of eggs	# of embryos transferred	# frozen

☐ **None of these**

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: fdgfdg

Do you see a counselor?: Yes ☐ No ☐

For how long?: _______

How often?: ______

List any anti-depressant/anti-anxiety medications you are currently taking?: ___________

Describe any emotional, marital, or sexual problems caused by your infertility: ___________

PATIENT'S SIGNATURE

____

Date (Patient): ___________

Indicate which number to call or leave messages

Phone (Home): ____________

Phone (Work): ___________

Do you have a spouse/partner? : Yes ☐ No ☐ other ☐
Please Specify:_______

Spouse/Partner

First Name: ____________

Last Name: ____________

Age: ____________

Date of Birth (MM/DD/YY): ____________

Occupation: ____________

Home Street Address: ____________

City: ____________

State: ____________

Zip/Postal Code: ____________

Country: ____________

Physician Notes (For office use only): ___________

Who is your Ob/Gyn?

Name: ____________

Phone: ____________

Who is your Primary Care Physician?

Name: ____________

Phone: ____________

PARTNER MEDICAL HISTORY AND INFORMATION

My Partner has a Uterus

Partner

Do you have any personal, ethical, or relations 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 ☐
If yes, please explain: _____________

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

Pregnancy History

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?: ________

Number of Premature (less than 37 weeks) Deliveries: ________

How many were stillborn?: ________

Any Pregnancies with Birth Defects?: Yes ☐ No ☐
If yes, please explain: _____________

Pregnancy History Details	Months to Conception	Treatments to Conceive	Delivery Type/D&C/Complications	Current Partner? (Yes/No)
_____	_____	_____	_____	_____

Menstrual Cycle 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: ___________

How many days of bleeding do you have?: ___________

Dates of the 1st day of your last 2 menstrual periods: ___________

Age when you had your first period: ___________

Age when you first noticed: Breast development (years): ___________

Age when you first noticed: Pubic hair (years): ___________

Age when you first noticed: Underarm hair (years): ___________

How many periods do you have per year?: ___________

If you do not have periods, at what age did you stop having them?: ___________

Do you need medication to bring on a period?: Yes ☐ No ☐
If yes: ___________

Do you have severe cramping or pelvic pain with your periods?: Yes ☐ No ☐
Always __ Sometimes __ Recently __In the past: ___________

Contraceptives Methods (History)

Do you use or have you used any contraceptives?: Yes ☐ No ☐

	Method	When they started?	Are you still using contraceptives	When they stopped?
☐	Condoms			
☐	Diaphragm	______	Yes ☐ No ☐	________
☐	IUD	______	Yes ☐ No ☐	__________
☐	Birth control pills	______ **Complications:** ____	Yes ☐ No ☐	________
☐	Inject able contraception	_______ **Complications:** ____	Yes ☐ No ☐	_________
☐	Skin patch	______	Yes ☐ No ☐	________
☐	Foam or Jelly	______	Yes ☐ No ☐	__________
☐	Tubal sterilization procedure (tubes tied)	______	Yes ☐ No ☐	______
☐	Tubes untied	______	Yes ☐ No ☐	_______

Did your mother take DES when she was pregnant with you?: _______

Sexual History

How many times do you have intercourse per week?: _______

Have you used over-the-counter ovulation kits to time intercourse: _______

Do you have pain with intercourse?: Yes ☐ No ☐

Do you use lubricants (K-Y Jelly*, etc.) during intercourse?: Yes ☐ No ☐

what types?: _________

Pap Smear Medical History

When was your last pap smear (month and year)?: _________

When was your last abnormal pap smear?: _________

Have you undergone any procedures as a result of an abnormal pap smear?: Yes ☐ No ☐

Yes (check all that apply):
☐ Colposcopy
☐ Cryosurgery (Freezing)
☐ Laser treatmen
☐ Conization
☐ Leep procedure

Breast Screening History

Have you ever had a mammogram?: Yes ☐ No ☐

Date	Result
________	_________

Do you perform self breast exams?: Yes ☐ No ☐

Medical History

Are you allergic to any medications?: Yes ☐ No ☐
Please list and describe reactions: _______

Are you allergic to any foods (peanuts, eggs, etc.)?: Yes ☐ No ☐
Please list and describe reactions: _______

Do you take any medication?: Yes ☐ No ☐
If yes, please list: _______

Do you take any herbal medicines/vitamins or health food store supplements?: Yes ☐ No ☐
Please list: _______

Do you have any medical problem(s)?: Yes ☐ No ☐
Please list type, dates, and treatments: _______

Did you have either of these childhood illnesses?:
☐ Chickenpox (Varicella)
☐ German Measles (Rubella)
☐ Don’t know
☐ Other childhood diseases
If Other childhood diseases: ___________

Vaccinations

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

Social History

How many caffeinated beverages (coffee, tea, soda) do you drink per day?: _______

Do you smoke cigarettes? : Yes ☐ No ☐
How many/day?: ___________ **Quit - when?:** ___________

Do you drink alcohol?: Yes ☐ No ☐
If you drink alcohol:

	Alcohol name	Enter quantity
☐	Beer - # per week	________
☐	Wine - # per week	_______
☐	Liquor - # per week	_______

Do you use marijuana, cocaine, or any other similar drug?: Yes ☐ No ☐
please describe: _________

Do you exercise?: Yes ☐ No ☐
please describe: _________

Are you aware of any radiation exposures other than X-rays?: Yes ☐ No ☐
please describe: _________

Physician Notes (for office use only): __________

Surgical History

Have you had any surgeries?: Yes ☐ No ☐
Number of surgeries: ___________

Year	Type of surgery in chronological
_________	_________

Did you have any anesthesia problems?: Yes ☐ No ☐
Describe: _________

Physical Symptoms

- **General:**

☐ Diabetes
☐ Hair loss
☐ Anorexia/Bulimia
☐ Lack of energy
☐ Fever/chills
☐ Other
☐ None
Describe so it’s consistent with the others – do for all similar responses : _____________

- **Head, Eyes, Ears, Nose, and Throat:**

☐ Dizziness
☐ Loss of sense of smell
☐ Headaches
☐ Chronic nasal congestion
☐ Blurred vision
☐ Ringing ears
☐ Hearing loss/deafness
☐ Other
Describe so it’s consistent with the others – do for all similar responses : _____________

- **Respiratory:**

☐ Shortness of breath
☐ Asthma
☐ Bronchitis
☐ Pneumonia
☐ Tuberculosis
☐ Bloody cough
☐ Other
Describe so it’s consistent with the others – do for all similar responses : _____________

- **Endocrine/Hormona:**

☐ Recent weight gain or loss
☐ Thyroid gland problems
☐ Rapid weight gain or loss
☐ Excessive hunger/thirst
☐ Temperature intolerance-hot flashes or feeling cold
☐ Other
☐ None
Describe so it’s consistent with the others – do for all similar responses : _____________

- **Breasts:**

  - ☐ Discharge
  - ☐ Lumps
  - ☐ Abnormal mammogram
  - ☐ Reduction
  - ☐ Augmentation/Breast Implants
  - ☐ Other

  Describe so it's consistent with the others – do for all similar responses : ______________

- **Neurological Problems:**

  - ☐ Weakness/Loss of balance
  - ☐ Seizures/Epilepsy
  - ☐ Headaches
  - ☐ Migraine headaches
  - ☐ Numbness
  - ☐ Memory Loss
  - ☐ Other

  Describe so it's consistent with the others – do for all similar responses : ______________

- **Gastrointestinal:**

  - ☐ Nausea/Vomiting
  - ☐ Ulcers
  - ☐ Hepatitis
  - ☐ Diarrhea
  - ☐ Blood in your stools
  - ☐ Irritable Bowel Syndrome
  - ☐ Change in bowel habits
  - ☐ Colitis (ulcerative or Cohn's)

  Describe so it's consistent with the others – do for all similar responses : ______________

- **Genito-Urinary :**

  - ☐ Bladder infections
  - ☐ Kidney infections
  - ☐ Vaginal infections
  - ☐ Frequent urination
  - ☐ Blood in the urine
  - ☐ Leaking Urine
  - ☐ Herpes

  Describe so it's consistent with the others – do for all similar responses : ______________

- **Skin/Extremities:**

  - ☐ Unexplained rash/inflammation
  - ☐ Acne

- [ ] Skin caner
- [ ] Burn injury
- [ ] Moles changing in appearance
- [ ] Excess hair growth
- [ ] Other

Describe so it’s consistent with the others – do for all similar responses : ____________

- **Musculoskeletal:**

- [ ] Unusual muscle weakness
- [ ] Decreased energy/stamina
- [ ] Rheumatoid arthritis
- [ ] Lupus Erythematosus
- [ ] Myasthenia gravis
- [ ] Other

Describe so it’s consistent with the others – do for all similar responses : ____________

- **Hematologic:**

- [ ] Blood clotting disorder/Blood clot
- [ ] Sickle Cell Anemia
- [ ] Thrombophlebitis
- [ ] Easy bruising
- [ ] Swollen glands/lymph nodes
- [ ] Blood transfusions

Describe so it’s consistent with the others – do for all similar responses : ____________

- **Cardiovascular:**

- [ ] Palpitations/Skipped beats
- [ ] Chest pain
- [ ] Heart attack
- [ ] Stroke
- [ ] Murmurs
- [ ] High blood pressure
- [ ] Rheumatic fever
- [ ] Mitral valve prolapse
- [ ] Other

Describe so it’s consistent with the others – do for all similar responses : ____________

- **Mental Health Problems:**

- [ ] Depression
- [ ] Anxiety disorder
- [ ] Schizophrenia
- [ ] Other

Describe so it’s consistent with the others – do for all similar responses : ____________

Family History

Mother (Living): Yes ☐ No ☐

If Yes, Age___

If No, Cause of Death___

Father (Living): Yes ☐ No ☐

If Yes, Age___

If No, Cause of Death___

Brother (s) (Living): Yes ☐ No ☐

If Yes, Age___

If No, Cause of Death___

Sister (s) (Living): Yes ☐ No ☐

If Yes, Age___

If No, Cause of Death___

Maternal Grandmother (Living): Yes ☐ No ☐

If Yes, Age___

If No, Cause of Death___

Maternal Grandfather (Living): Yes ☐ No ☐

If Yes, Age___

If No, Cause of Death___

Paternal Grandmother (Living): Yes ☐ No ☐

If Yes, Age___

If No, Cause of Death___

Paternal Grandfather (Living): Yes ☐ No ☐

If Yes, Age___

If No, Cause of Death___

What is your Ancestry?:

☐ African - American
☐ Amer.Indian/NativeAmer

- [ ] Ashkenazi Jewish
- [ ] Asian-American
- [ ] Cajun/French Canadian
- [ ] Caucasian
- [ ] Eastern European
- [ ] Hispanic - American
- [ ] Northern European
- [ ] Southern European
- [ ] Other

If other: _______

Disorders in Your Family

Medical Disorders	Yes/No/Don't Know	If yes, please list relationship to you
Breast cancer	__________	__________
Ovarian cancer	__________	__________
Other cancer	__________	__________
Diabetes	__________	__________
Thyroid Problems	__________	__________
Heart Disease	__________	__________
Blood Clots	__________	__________
Obesity	__________	__________
Psychiatric problems	__________	__________
Tuberculosis	__________	
Endometriosis	__________	__________
Infertility	__________	__________
Menopause before age 40	__________	__________
Birth Defects	__________	__________
Cystic Fibrosis	__________	__________
Tay-Sachs disease	__________	__________
Canavan disease	__________	__________
Bloom Syndrome	__________	__________

Gaucher disease	__________	__________
Neimann-Pick disease	__________	__________
Fanconi Anemia	__________	__________
Familiar Dysautonia	__________	__________
Muscular Dystrophy	__________	__________
Neurologic brain/spine	__________	__________
Neural Tube Defects	__________	__________
Bone/Skeletal Defects	__________	__________
Dwarfism	__________	__________
Developmental Delay	__________	__________
Learning problems	__________	__________
Polycystic kidneydisease	__________	__________
Marfan syndrome	__________	__________
Hemophilia	__________	__________
Sickle Cell anemia	__________	__________
Thalassemia	__________	__________
Galactosemia	__________	__________
Deafness/Blindness	__________	__________
Color/Blindness	__________	__________
Hemochromatosis	__________	__________

PRIOR INFERTILITY TESTING AND TREATMENT

Have you had prior infertility testing or treatment elsewhere? :

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 ☐ No ☐

For how long?: ______

How often?: ______

List any anti-depressant/anti-anxiety medications you are currently taking?: ______

Describe any emotional, marital, or sexual problems caused by your infertility: ______

PARTNER'S SIGNATURE ___________

Date (Partner): ___________

Physician Notes (for office use only): ___________

Coastal Fertility Medical Center | RSMC Irvine

Family History Questionnaire

Genetic Family History & Pregnancy Questionnaire

Date of Appointment: ________

Patient Information

Patient's Name: ________

Date Of Birth: ________

Occupation: ________

Address: ________

City: ________

State: ________

Zip: ________

Home Phone: ________

Work Phone: ________

Cell Phone: ________

Referring Physician's Name: ________

Referring Physician's Phone Number: ________

The following questions may help your doctor or genetic counselor complete a genetic risk assessment and determine if certain genetic tests are appropriate. If you are unsure about your family history, please speak with family members.

Patient	Partner	Both
☐ Chinese, Taiwanese, Asian Indian, Pakistani, Filipino or Southeast Asian ☐ Italian, Greek, Middle Eastern, Spanish, or Portuguese ☐ Jewish, French Canadian or Cajun ☐ African American, African descent, Black, Puerto Rican, Caribbean or Central American ☐ Hispanic or Mexican ☐ Caucasian ☐ Other (specify)	☐ Chinese, Taiwanese, Asian Indian, Pakistani, Filipino or Southeast Asian ☐ Italian, Greek, Middle Eastern, Spanish, or Portuguese ☐ Jewish, French Canadian or Cajun ☐ African American, African descent, Black, Puerto Rican, Caribbean or Central American ☐ Hispanic or Mexican ☐ Caucasian ☐ Other (specify)	☐ Chinese, Taiwanese, Asian Indian, Pakistani, Filipino or Southeast Asian ☐ Italian, Greek, Middle Eastern, Spanish, or Portuguese ☐ Jewish, French Canadian or Cajun ☐ African American, African descent, Black, Puerto Rican, Caribbean or Central American ☐ Hispanic or Mexican ☐ Caucasian ☐ Other (specify)

Have you, your partner or anyone in your families ever had the following conditions

Down Syndrome: Yes ☐ No ☐

Other Chromosome problems: Yes ☐ No ☐

Mental retardation, autism, or developmental delay: Yes ☐ No ☐

Spina bifida (open spine): Yes ☐ No ☐

Anencephaly (opening in head/brain): Yes ☐ No ☐

Blood disorder, such as hemophilia or sickle cell: Yes ☐ No ☐

Muscular dystrophy or neuromuscular disease: Yes ☐ No ☐

Cystic fibrosis: Yes ☐ No ☐

Neurofibromatosis: Yes ☐ No ☐

Skeletal disorder, like dwarfism: Yes ☐ No ☐

Polycystic kidney disease: Yes ☐ No ☐

Huntington disease or other adult neurological diseases (e.g. dementia, Alzheimer's: Yes ☐ No ☐

Heart defect: Yes ☐ No ☐

Cleft lip/cleft palate: Yes ☐ No ☐

Blindness/deafness: Yes ☐ No ☐

Baby who died at birth or within first year: Yes ☐ No ☐

Stillborn or 2 or more pregnancy losses: Yes ☐ No ☐

Any birth defect not in this list: Yes ☐ No ☐

Any other inherited (genetic) condition: Yes ☐ No ☐

Any other serious medical condition or surgery: Yes ☐ No ☐

Are you or your partner adopted?: Yes ☐ No ☐

Are you and your partner related to each other (other than by marriage)?: Yes ☐ No ☐

Is there a history of infertility in either you and /or your partner?: Yes ☐ No ☐
Please specify the cause of infertility, if known: ____________

Have you and / or your partner had:

Carrier testing for cystic fibrosis?: Yes ☐ No ☐

Carrier testing for any other genetic disorder?: Yes ☐ No ☐

Blood chromosome testing?: Yes ☐ No ☐

Are you taking the following:

Medications: Yes ☐ No ☐
If yes please list: ____________

Recreational Drugs: Yes ☐ No ☐

Alcoholic drinks: Yes ☐ No ☐

Cigarette smoking: Yes ☐ No ☐

Do you have diabetes, PKU (phenylketonuria) or lupus?: Yes ☐ No ☐

Are you considering or have you used:

Egg donor?: Yes ☐ No ☐

Donor sperm?: Yes ☐ No ☐

Preimplantation Genetic Diagnosis (PGD): Yes ☐ No ☐

Preimplantation Genetic Screening (PGS)?: Yes ☐ No ☐

Intracytoplasmic sperm injection (ICSI)?: Yes ☐ No ☐

☐ I have answered these questions to the best of my knowledge.

Patient Signature _____________

Date: __________

Coastal Fertility Medical Center | RSMC

Permission to Contact Insurance Carrier and Agreement of Financial Responsibility

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AUTHORIZATION FOR COASTAL FERTILITY MEDICAL CENTER / REPRODUCTIVE SPECIALTY LABS TO CONTACT MY INSURANCE CARRIER

☐ I authorize Coastal Fertility Medical Center/Reproductive Specialty Labs to inquire on my behalf, regarding information about my benefits and coverage. I also authorize the release of any medical or other information necessary to process my insurance claim(s).

Patient signature ______________

Date(Patient): ___________

Partner's signature ____________

Date(Partner): _________

AGREEMENT OF FINANCIAL RESPONSIBILITY and AUTHORIZATION TO BILL DESIGNATED INSURANCE CARRIER(S)

☐ I authorize Coastal Fertility Medical Center (CFMC) / Reproductive Specialty Labs (RSL) to bill my insurance carrier(s), and I also authorize benefits to be paid directly to CFMC and RSL. If my insurance carrier, for any reason, will not cover a particular treatment, medication, or procedure, either in full or part, I understand, and agree it is my responsibility to remit payment in full, unless prior written arrangements have been made with the CFMC/RSL billing department.

Patient's Signature:_________

Date(Patient): ________

SIGN BELOW ONLY IF YOU DO NOT WANT US TO CONTACT YOUR INSURANCE CARRIER

DO NOT CONTACT INSURANCE CARRIER

I wish to be a cash account. PLEASE DO NOT CONTACT MY INSURANCE CARRIER FOR ANY REASON, unless I request (in writing) for you to do so.

Patient's signature: ____________

Date(Patient): _________

Partner's Signature: _____________

Date (Partner): _________

Coastal Fertility Medical Center | RSMC Irvine

Insurance Verification

Dear Patient: To assist you in understanding your infertility benefits, we ask that you call your insurance company and ask the following questions. This will give you a better understanding of how your insurance may cover your treatment at Coastal Fertility Medical Center.

Does my health plan participate with Lawrence Werlin, M.D. or Coastal Fertility Medical Center?

1. Does my health plan participate with Lawrence Werlin, M.D. or Coastal Fertility Medical Center? (TAX I.D.# 33 0870026)
2. Do I have infertility benefits? If yes, then ask the following questions.
3. Do I have out of network benefits?
4. If you have a POS plan, ask the clerk which tier offers the best infertility coverage.
5. What services are covered for infertility?
    - Consultation
    - Second Opinion?
    - Diagnostic Testing?
    - Diagnostic or Corrective Surgery?
    - Medications:
        - Oral:
        - Self Injectable:
    - Treatment:
        - IUI (artificial insemination) IVF (in-vitro fertilization)
    - Do I have any limits on number of attempts?
    - Do I have any monetary limit?
    - What is my deductible?
    - Do I have an out of pocket maximum?
    - Do I need pre-certification?

Download Questions

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Email Consent

Patient Name: ___________

Patient E-mail Address: ___________

RISK OF USING EMAIL

Coastal Fertility Medical Center (CFMC) offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail, however, has a number of risks that patients should consider before using e-mail. These include, but are not limited to, the following risks:

- E-mail can be circulated, forwarded, and stored in numerous paper and electronic files.
- E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients.
- E-mail senders can easily misaddress an email.
- Email is easier to falsify than handwritten or signed documents.
- Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.
- Employers and online services have a right to archive and inspect e-mails transmitted through their systems,
- E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
- E-mail can be used to introduce viruses into computer systems.
- E-mail can be used as evidence in court

CONDITION FOR THE USE OF E-MAIL

CFMC will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, CFMC cannot guarantee the security and confidentiality of e-mail communication and will not e liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, patients must provude written consent, except as authorized or required by law.

Consent to the use of e-mail for patient information. Consent to the use of E-mail includes agreement with the following conditions:

- All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patient's medical record. Because they are a part of the medical record, other individuals, authorized to access the medical record, such As staff and billing personnel, will have access to those e-mails.
- Your Provider may forward e-mails internally to CFMC staff and agents as necessary for diagnosis, treatment, reimbursement, health care operations, and other handling .Your Provider will not, however forward e-mails to independent third parties without the patient' s prior written Consent, except as authorized or required by law.
- Although CFMC staff will endeavor to read and respond Promptly to an e-mail from the patient, we cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Thus the patient shall not use e-mail for medical emergencies or other time-sensitive matters.
- If the patients e-mail requires or invites a response from Provider and the patient has not received a response within a reasonable time period, it is the patient's responsibility to follow up to determine whether the intended recipient received the e-mail and when the recipient will respond.
- The patient should not use e-mail for communicationregarding sensitive medical information such as information regarding sexually transmitted diseases, AIDS/HIV, mental Health, developmental disability, substance abuse.
- The patient is responsible for informing your provider of any type of information the patient does not want to be sent by e-mail, in addition to those set out in 2(e) above
- The patient is responsible for protecting his/her pass word or other means of access to e-mail. CFMC is not liable for breaches of confidentiality caused by the patient or any third party.
- CFMC Providers shall not engage in e-mail communication that is unlawful, such as unlawful practicing medicine

across state lines.
- It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

INSTRUCTIONS

To communicate by e-mail, the patient shall:

- Limit or avoid use of his/her employer’s computer.
- Inform CFMC of changes in his/her e-mail address.
- Put the patient's name in the body if the e-mail.
- Include the category of the communication in the e.mail's subject line, for routing purposes (e.g., billing question).
- Review the e-mail to make sure it is clear and that all relevant information is provided before sending to your Provider.
- Inform your Provider that the patient received an email from your Provider.
- Take precautions to preserve the confidentiality of e-mails, such as using screen savers and safeguarding his/her computer password.
- Withdraw consent only by e-mail or written communication to your Provider.

PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between CFMC staff and me, and consent to the conditions outlined herein, as well as any other instructions that Provider may impose to communicate with patients by e-mail. Any questions I may have had were answered.

Patient signature: ______________

Date(Patient): ____________

Thank you for taking the time to make this all. When you come in for your consultation, you will meet with a financial advisor who will compare notes with your research and the verification that took place in our office. If three are any discrepancies, another call will be made by our staff to give us an accurate picture of what your insurance covers.

Coastal Fertility Medical Center | RSMC Irvine

Privacy Notice

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE AND ACKNOWLEDGMENT OF MEDICAL BOARD OF CALIFORNIA NOTICE TO CONSUMERS

I acknowledge that I have read the Privacy Notice
Patient or Personal Representative: ___________

Date: ___________

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient: ________

Patient's signature: ___________

Date(Patient): ___________

Partner's signature: ___________

Date(Partner): ___________

☐ I HAVE READ AND AGREE TO THE FINANCIAL POLICIES ENCLOSED