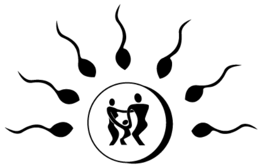

Jacksonville Center for Reproductive Medicine

Changing lives each and every day

Confidential Patient History Questionnaire

Name____**DOB**__________________**Today's Date**__________________

Past Medical History: (Please circle all conditions for which you have been treated by a doctor)

Stomach Ulcers, Heart Disease , Rheumatic Fever, High Blood Pressure, Breathing Problems, Kidney Disease, Cancer, Blood Disorders, Hepatitis/Cirrhosis, Diabetes, Thyroid, Skin Disease, Neurologic Disorders, Emotional Disorders

Surgeries	Year estimate	**Current Medications** (dose & frequency)	How long
___________________________	___________	____	___________
___________________________	___________	____	___________
___________________________	___________	____	___________
___________________________	___________	____	___________
___________________________	___________	____	___________
___________________________	___________	____	___________
___________________________	___________	____	___________
___________________	___________	____ _______	___________

Type of Work:_________________________Cigarette Smoking (packs/day)_______________Alcohol Use_____________

Family History:	**What Relation?**		**What Relation?**
Heart Disease	________________________	Diabetes	________________________
High Blood Pressure	________________________	Breast Cancer	________________________
Stroke	________________________	Uterine Cancer	________________________
Kidney Disease	________________________	Ovarian Cancer	________________________
Goiter	________________________	Genetically abnl children	________________________
Cancer: List Types	________________________	Endometriosis	________________________

Review of Symptoms: (Please circle or underline any of the following that applies to you)

Loss appetite, Changed weight (up, down), Fever, Night Sweats, Increased thirst, Heat / Cold intolerance, Painful swallowing, Change voice / hoarseness, Hand Tremor, Loss of scalp hair, Excessive hair growth on face or body, Acne, Thyroid disease, Diabetes, Breast secretions (milk), Loss of periods (disregard if menopause or hysterectomy).

Chronic headaches, Seizures, Problems with smell, Visual disturbance (seeing spots, tunnel vision), Dizziness, Excessive bleeding with tooth extraction, Blood transfusions in past; Heart disease, Rheumatic fever, Chest pain, Shortness of breath lying down, Heart murmur, Cough up blood, Asthma, Wheezing, Breast masses, Skin rashes.

Nausea, Vomiting, Diarrhea, Constipation, Abdominal pain, Gallbladder problems, Pancreatitis, Jaundice, Bright red blood in stools, Black stools, Hemorrhoids, Diverticulosis, Need for antacids, Ulcers, Spastic colon, Frequent bladder infections, Pain or burning on urination, Frequent urination, Extreme urge to urinate. Leakage of urine when coughing or sneezing, Difficulty starting urinary stream, kidney stones. Pain and swelling of any joints, Back pain

Last menstrual period started ________________, How far apart:_________days, Duration___________days, is flow heavy / scanty / normal, Menstrual period irregularity, Do you bleed between periods, In bed or miss work due to cramps. Pain with intercourse, History of sexually transmitted infection, Tubal infection, Pelvic pain, Endometriosis

Pregnancies: Number____ Miscarriages____ Tubal ____ Living Children ____ Complications __________________
Menopause: Date of menopause ______________. Bleeding YES NO, Hot flashes, Taking female hormones.

Medication Allergies: ____**Reaction**________________________

Patient Signature: _________________________________**Date:**_________________________**MD:**_____________ _____

LAST NAME ____________________ FIRST NAME ____________________ MI__________

D.O.B________________ AGE_______ SEX M F ETHNICITY________________________ SS#______________________________

ADDRESS____

CITY__________________________________ STATE________ ZIP______________ EMAIL _________________________________

HOME PHONE__________________________CELL PHONE_________________________WK PHONE__________________________

MARITAL STATUS (CIRCLE ONE) M S D W RELIGIOUS PREFERENCE________________________________

PATIENT EMPLOYER____

EMPLOYER ADDRESS____

SPOUSE'S NAME______________________________________ ETHNICITY ____________________DOB__________________

SPOUSE'S EMPLOYER____WK. PHONE_____________________

SPOUSE'S EMPLOYER ADDRESS____SSN#_________________________

PERSON TO CONTACT IN CASE OF EMERGENCY____

RELATIONSHIP____PHONE___________________________________

ADDRESS____

SEXUALLY INTIMATE PARTNER'S NAME____

DOB_______________________ ETHNICITY ______________________________ SSN#_________________________________

SEXUALLY INTIMATE PARTNER'S EMPLOYER______________________________________WK. PHONE________________________

SEXUALLY INTIMATE PARTNER'S EMPLOYER ADDRESS____

NAME OF PRIMARY CARE PHYSICIAN____

WHO CAN WE THANK FOR REFERRING YOU?____

DO YOU HAVE AN "ADVANCE DIRECTIVE" (LIVING WILL)? YES NO

CONSENT FOR TREATMENT: I/We voluntarily authorize the rendering of such care, including diagnostic procedures, medical and/or surgical treatment by: Jacksonville Center for Reproductive Medicine as may in their professional judgment be deemed necessary or beneficial. I/We acknowledge that no guarantees have been made as to the effect of such examination or treatment on my condition or the condition of the person for whom I am duly authorized to sign.

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION TO THIRD PARTIES: I/We herby give consent for disclosure of medical information to any third party which I allow to be present in the room during my visit/treatment.

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION: I/We hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to: Jacksonville Center for Reproductive Medicine. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. Should it become necessary to turn my account over to an outside agency, I will be responsible for all attorney fees, litigation fees, and court costs. I/We hereby authorize Jacksonville Center for Reproductive Medicine and its employees and agents, to release all information, reports, and records if necessary to secure payment of my account, including a discussion of my medical condition, to the insurance provider, hospitals, and doctors.

SIGNATURE____DATE__________________________________

RELATIONSHIP TO PATIENT____

Jacksonville Center for Reproductive Medicine

Changing lives each and every day

Fertility History Questionnaire

Wife Information

Last, First Name ___________________________
Age ___________________________
Chronic Medications ☐Yes ☐No
Pregnancy History
- # Previous Pregnancies __________
- # Delivered __________
- # Miscarriages __________
- # Ectopic (Tubal) __________
- Date Last Delivery __________

Intercourse Information
- How often/week (average) __________
- Do you douche? ☐Yes ☐No
- Do you use lubricants ☐Yes ☐No
- Pain with intercourse ☐Yes ☐No

Menstrual History
- Age menses began (years) __________
- Menses interval (days) __________
- Duration (days) __________
- Painful menses ☐Yes ☐No

Contraceptive History
- Birth Control Pills ☐Yes ☐No
- IUD ☐Yes ☐No
- Barrier Method(s) ☐Yes ☐No

Past Gynecological Problems
- Pelvic infections ☐Yes ☐No
- Sexually Transmitted Disease ☐Yes ☐No
- Abdominal/GYN surgery ☐Yes ☐No
- Endometriosis ☐Yes ☐No
- Abnormal pap tests ☐Yes ☐No
- Freezing of cervix ☐Yes ☐No
- DES exposure ☐Yes ☐No

Social Information
- Do you smoke (packs/day) __________
- Do you use alcohol __________

Previous Female Evaluation
- X-ray of the uterus (HSG) ☐Yes ☐No
- Post Coital Test (PCT) ☐Yes ☐No
- Hormonal Evaluation ☐Yes ☐No
- Sperm Antibodies ☐Yes ☐No
- Endometrial Biopsy ☐Yes ☐No
- Laparoscopy ☐Yes ☐No
- Hysteroscopy ☐Yes ☐No

Previous Female Treatment
- Insemination ☐Yes ☐No
- Ovulation Drugs ☐Yes ☐No
- Lupron ☐Yes ☐No
- Pelvic surgery ☐Yes ☐No
- IVF or GIFT ☐Yes ☐No

Husband Information

Last, First Name ___________________________
Age ___________________________
Chronic Medications ☐Yes ☐No
- List __________
  ____

Past Medical Conditions
- Previous pelvic or hernia surgery ☐Yes ☐No
- Mumps (involving testes) ☐Yes ☐No
- High blood pressure ☐Yes ☐No
- Testes tumor/injury/infection ☐Yes ☐No
- Exposure to chemicals/heat/ Radiation ☐Yes ☐No
- Undescended testes ☐Yes ☐No

Sexual History
- Fathered previous pregnancy ☐Yes ☐No
- Youngest age __________
- Difficulty with erections ☐Yes ☐No
- Difficulty with ejaculation ☐Yes ☐No

Social Information
- Do you smoke (packs/days) __________
- Do you use alcohol __________

Previous Male Evaluation
- Semen analysis ☐Yes ☐No
- Antibody testing ☐Yes ☐No
- Chromosome testing ☐Yes ☐No
- Hamster egg test ☐Yes ☐No
- Testicular biopsy ☐Yes ☐No
- Hormonal test(s) ☐Yes ☐No

Previous Male Treatment
- Insemination (donor, husb) ☐Yes ☐No
- Hormonal therapy ☐Yes ☐No
- Varicocele repair ☐Yes ☐No
- Vasectomy reversal ☐Yes ☐No
- IVF ☐Yes ☐No

Occupation ___________________________
Today's Date ___________________________

Family History (either side)
- Tay Sachs ☐Yes ☐No
- Cystic Fibrosis ☐Yes ☐No
- Sickle Cell ☐Yes ☐No
- Other __________________ ☐Yes ☐No

Jacksonville Center for Reproductive Medicine/
Advanced Reproductive Specialists
Changing lives daily

Patient Information

Name ____________________________________ Date of Birth ______________________
surname first name yy mm dd

Home Phone ( )______________ Cell Phone ( ) _____________ Email _________________

Insurance Name and ID # : ____

Partner's Name _______________________________ Date of Birth ______________________
surname first name yy mm dd

Address (Required) ____

Referring Doctor ____

Office Phone No: ( ) ______________________ Office Fax No: ( )___________________

How do you want the referral letter returned? Mail ☐ Fax ☐
Does this patient speak and understand English? Yes ☐ No ☐
Has the Patient consented to email communications? Yes ☐ No ☐

Patient Instructions :
Call (904) 493-2229 to schedule your appointment.
Please bring a picture ID to appointment.

Referral

- ☐ Michael D. Fox, M.D.
- ☐ Christopher W. Lipari, M.D.
- ☐ Melissa Yates, M.D. (Orlando)
- ☐ Laura Cedo, M.D. (Surgery)
- ☐ Sarah Paschall, M.D. (Surgery)

Location

- ☐ Southpoint Parkway
- ☐ Gainesville
- ☐ Panama City
- ☐ Orlando

Reason for Referral (check all that apply)

- ☐ In Vitro Fertilization (IVF) =/- ICSI/ Micromanipulation
- ☐ Pre -implantation Genetic Screening Diagnosis
- ☐ Laparoscopic Tubal Reversal/ Reproductive Surgery
- ☐ Donor Insemination
- ☐ Recurrent Pregnancy Loss
- ☐ Fertility Preservation/ Egg Freezing/ Sperm Freezing
- ☐ IUI
- ☐ Egg Donor
- ☐ Male Infertility Consult with Semen Analysis
- ☐ Fertility Consult Female
- ☐ Fertility Consult Male
- ☐ Endometriosis
- ☐ Fibroids
- ☐ PCOS
- ☐ Pelvic Pain
- ☐ Abdominal Cerclage Surgery
- ☐ Other ___________________________________

7051 Southpoint Parkway S, Ste 200 Jacksonville, FL 32216 Tel: (904)493-2229 Fax: 904-396-4546
www.jcrm.org
Please return via fax or email to info@jcrm.org