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_____

IF A PATIENT IS A MINOR, PLEASE GIVE US ALL THE INFORMATION ON BOTH PARENTS

MOTHER_____ FATHER _____

EMPLOYER_____EMPLOYER_____

BUS PHONE_____BUS PHONE_____

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/
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 _____

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www.jcrm.org
Please return via fax or email to info@jcrm.org