Duke Fertility Center

How did you hear about us?

(please check all that apply)

- ☐ Physician referral
- ☐ Newspaper or magazine ad
- ☐ Radio ad
- ☐ TV ad
- ☐ Web ad
- ☐ Web search
- ☐ In the news
  - ☐ Print
  - ☐ TV
  - ☐ Radio
  - ☐ Online
- ☐ Friend or family member

Other: _____

(for instance: Duke employee, Yellow Pages brochure, driving by, etc.)

Duke Fertility Center

Date: _____

Duke Fertility Center
Division of Reproductive Endocrinology and Infertility Intake Form

Referring Physician: _____

Patient Name: _____

Date of Birth: _____

Race: _____ Hispanic or Latino: ☐

Occupation: _____

Pronouns

☐ She/her/hers ☐ He/him/his ☐ They/them/their

Other: _____

Marital Status: _____

PREGNANCY HISTORY

How many pregnancies (including abortions) have you had? _____

Pregnancies	When? (year)	How long to conceive? (months)	Fertility therapy used? Y/N	Is current partner father? Y/N	Duration of pregnancy (months)	Outcome*	Complica-tions
1st pregnancy							
2nd pregnancy							
3rd pregnancy							
4th pregnancy							
5th pregnancy							

*Outcomes: Vaginal delivery = VD; Cesarean section = CS; Abortion = AB; Miscarriage = MS; Ectopic= EP

FERTILITY HISTORY

How long have you and your present partner been trying to conceive? _____

Have you ever been infertile with a past partner? _____ If so, how long? _____

Have you had any of the following tests performed on you? Please give details for all that apply and the results.

	Date	Results
☐ Basal Body Temperature		
☐ Urinary LH (Ovulation) Predictor Kit		
☐ Day 3 FSH and Estradiol		
☐ Antimullerian Hormone		
☐ Endometrial Biopsy		

	Date	Results
☐ Hysterosalpingogram (HSG)		
☐ Sonohysterogram		
☐ Ultrasound		
☐ Progesterone level		
☐ Laparoscopy		
☐ Hysteroscopy		
☐ Gonorrhea/Chlamydia Cultures		
☐ Rubella (German Measles)		
☐ Hepatitis B or C		
☐ HIV		
☐ RPR (Syphilis)		
☐ Blood Type and Rh		
☐ TSH		

What types of fertility theraphy have you received in the past?

Drug/Treatment	**Dose**	**How long or how many cycles?**	**When?**
Clomiphene citrate (Clomid, Seraphene)			
Gonadotropins (Pergonal, Repronex, Humegon, Metrodin, Fertinex, Gonal-F, Follistim)			
HCG (Profasi, Pregnyl)			
GnRH Agonists (Lupron, Zoladex, Synarel)			
Progesterone			
Prednisone or Dexamethasone			
Bromocriptine (Parlodel, Doxtinex)			
Artificial Insemination			
Donor Insemination			
In Vitro Fertilization = ICSI			

GYNECOLOGICAL HISTORY

How old were you when you started having periods? _____ Date your last period started: _____

Are your periods regular? ☐ Yes ☐ No _____

If yes, how many days between periods (start to start)? _____ If no, how many periods per year do you have? _____

How many days do your periods last? _____

Do you have cramps with your periods? ☐ Yes ☐ No If yes, are they: ☐ Mild ☐ Moderate ☐ Severe

Have you ever missed work or school due to menstrual pain? ☐ Yes ☐ No _____

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

Were you ever diagnosed with endometriosis? ☐ Yes ☐ No _____

What type of contraception have you used in the past?

☐ Birth Control ☐ IUD ☐ Depo Provera (birth control shots) ☐ Condoms
☐ Diaphragm ☐ Foams/Jellies ☐ Withdrawal ☐ Rhythm ☐ Tubal Ligation

Contraceptive complications: _____

_____

When did you last use contraception? _____

When was your last Pap smear? _____

Have you ever had an abnormal Pap smear? ☐ Yes ☐ No

If so, when? _____

What was done about it? _____

Have you ever had any of the following? Check all that apply.

☐ Gonorrhea ☐ Venereal Warts ☐ Syphilis
☐ Chlamydia ☐ Genital Herpes ☐ Pelvic Inflammatory Disease (PHD)

When was your last mammogram? _____

Have you ever had an abnormal mammogram? ☐ Yes ☐ No

If so, when? _____

What was done about it? _____

MEDICAL HISTORY

Do you have or have you ever had any of the following? Check all that apply.

☐ Anemia
☐ Appendicitis
☐ Arthritis
☐ Blood transfusions
☐ Breast Milky Discharge
☐ Breast pain
☐ Chicken Pox or vaccination
☐ Chronic bronchitis
☐ Chronic headaches
☐ Colitis
☐ Diabetes
☐ Gallbladder problems
☐ Heart disease
☐ Hepatitis
☐ Hirsutism (excess facial hair)
☐ High blood pressure
☐ Kidney infections
☐ Liver problems
☐ Migraine headaches
☐ Neurological problems
☐ Ovarian cysts
☐ Pneumonia
☐ Rheumatic Fever
☐ Rubella (German Measles)
☐ Scarlet Fever
☐ Seizures
☐ Thyroid problems
☐ Tuberculosis (TB)
☐ Ulcers
☐ Vision problems

Current medications: _____

_____

_____

Are you allergic to any medications? ☐ Yes ☐ No

What? _____

Have you ever had surgery before? ☐ Yes ☐ No

Date and type: _____

SOCIAL HISTORY

Current or recent employer/position: _____

Do you drink alcohol? ☐ Yes ☐ No

Number of drinks per week: _____

Do you smoke? ☐ Yes ☐ No

Number of cigarettes per day: _____ Number of years smoking: _____

Do you now, or have you ever, used illicit drugs (marijuana, cocaine, etc.)? ☐ Yes ☐ No

If yes, specify: _____

Do you have a special exercise program? ☐ Yes ☐ No

Type: _____ Number of hours per week: _____

Are you on a special diet? ☐ Yes ☐ No

Type: _____

REVIEW OF SYSTEMS

Have you had more than a 10-pound weight gain or loss in the past 12 months? ☐ Yes ☐ No

Do you have problems with your vision (besides usual glasses), hearing, swallowing, sinuses or throat?

☐ Yes ☐ No

If yes, specify: _____

Do you have heart problems, chest pain, irregular heartbeat or mitral valve prolapse? ☐ Yes ☐ No

If yes, specify: _____

Do you have asthma, wheezing, shortness of breath or trouble breathing? ☐ Yes ☐ No

If yes, specify: _____

Do you have breast pain, breast discharge or a lump in your breast? ☐ Yes ☐ No

If yes, specify: _____

Do you have chronic nausea or vomiting, stomach pain, diarrhea or constipation, blood in your stool or a history of ulcers? ☐ Yes ☐ No

If yes, specify: _____

Do you have urinary burning, incontinence, kidney stones or blood in your urine? ☐ Yes ☐ No

If yes, specify: _____

Do you have chronic joint pain or muscle pain or swelling? ☐ Yes ☐ No

If yes, specify: _____

Do you have any chronic skin rashes or moles that have changed in size or appearance? ☐ Yes ☐ No

If yes, specify: _____

Do you have changes in cold or hot tolerance, changes in skin tone or color or changes in your nails or body hair growth? ☐ Yes ☐ No

If yes, specify: _____

Do you have any history of seizures, recurrent headaches or numbness in your extremities? ☐ Yes ☐ No

If yes, specify: _____

Do you have any symptoms of depression, such as sadness, frequent crying or anger or emotional lability?

☐ Yes ☐ No

If yes, specify: _____

FAMILY HISTORY

Did your mother take diethylstilbestrol (DES; a tablet given to women with a history of miscarriage or bleeding during pregnancy) when she was pregnant with you? ☐ Yes ☐ No _____

Do any family members have significant health problems or inherited diseases? Check all that apply.

☐ Birth defects	☐ Down Syndrome	☐ Muscular Dystrophy
☐ Brain/spinal defects	☐ Fragile X Syndrome	☐ Sickle Cell Disease
☐ Cancer	☐ Heart Disease	☐ Tay-Sachs Disease
☐ Cystic Fibrosis	☐ Hemophilia	☐ Thalassemia
☐ Diabetes	☐ High blood pressure	☐ Thyroid Disease

Who? _____

_____

_____

Are you from any of these ethnic backgrounds? Check all that apply.

☐ Italian	☐ Jewish	☐ Caucasian	☐ African American
☐ Greek	☐ French Canadian/Cajun	☐ African	☐ Middle Eastern
☐ Hispanic	☐ Spanish	☐ Southern Chinese	☐ Asian Indian
☐ Taiwanese	☐ Filipino	☐ Southeast Asian	

Other: _____

If yes, have you had any specific genetic testing to see if you are a carrier of a genetic disease? ☐ Yes ☐ No

Specify: _____

ADDITIONAL HEALTH INFORMATION

_____

_____

_____

_____

Continue to next page.

PARTNER PROFILE

Partner Name: _____ DOB: _____

Medical Record # (if known): _____ Race or Ethnicity: _____

Weight: _____ Height: _____ Sex (at birth): _____

Pronouns

☐ She/her/hers ☐ He/him/his ☐ They/them/their Other: _____

PARTNER MEDICAL/SURGICAL HISTORY

Current medications (include supplements): _____

_____

Medical problems/hospitalizations: _____

_____

Surgeries (please include as infant/child): _____

History of hernia? If so, type of hernia? _____

PARTNER REPRODUCTIVE HISTORY

If your partner has children or achieved a pregnancy, please list the pregnancies below:

Pregnancy	Year	With you? (Yes/No)	Resulted in birth, miscarriage or termination?	Child health concerns (if applicable)
1				
2				
3				
4				

PARTNER EXPOSURE HISTORY

Cancer history and/or exposure to chemotherapy in the past? _____

Exposure to radiation (either from work or previous therapy)? _____

Current or past smoker? If applicable, quit date: _____

Marijuana or other recreational drug use? _____

Number of alcoholic drinks per week: _____

PARTNER FAMILY HISTORY

Does your partner's family have a history of any of the following? Check all that apply.

☐ Birth defects ☐ Sickle cell disease ☐ Down Syndrome

☐ Cystic Fibrosis ☐ Other genetic disease: _____

Partner's ethnic background: _____

Is your partner of French Canadian, Cajun or Ashkenazi Jewish background? _____

IF APPLICABLE: Has your partner ever had a semen analysis? If so, please list date and results: _____

_____

_____

IF APPLICABLE: Does your partner have problems with erections or ejaculation? _____

_____

GUIDE FOR ALTERNATIVE MEANS OF COMMUNICATIONS

Patient Name: _____

Medical Record Number: _____

Date of Birth: _____

Specific Clinic Where Patient is Seen: _____

The Health Insurance Portability & Accountability Act (HIPAA) requires the Private Diagnostic Clinic, PLLC ("PDC") to have reasonable safeguards in place to protect our patients' health information. In addition, HIPAA requires the PDC to reasonably limit incidental uses by our patients to communicate with them by alternative means or at alternative locations.

While we strive to provide our patients with prompt results of clinical and lab tests, the PDC's providers are often asked to disclose the results to spouses, children, significant others and other medical offices. In addition, some of the PDC's patients prefer to receive messages left on home answering machines or work voicemails. Absent an agreement by a specific PDC clinic or clinical site to the contrary (which shall cover only that particular clinic or clinical site), the PDC reserves the right to use its professional judgment to determine what reasonable actions and safeguards it should take when communicating with its patients and individuals involve in our patients' care. However, to help guide the PDC's judgment, please complete the relevant portions below to help your PDC providers understand what alternative means of communication and disclosures to individuals involved in your care you would prefer so that the PDC providers may use this information to determine reasonable ways to inform you of your test result and other pertinent clinical information.

☐ SPOUSE NAME/NUMBER: _____

☐ SIGNIFICANT OTHER NAME/NUMBER: _____

☐ CHILD/CHILDREN NAME/NUMBER: _____

NAME/NUMBER: _____

☐ WORK VOICE MAIL NUMBER: _____

☐ ANSWERING MACHINE NUMBER: _____

☐ DR. OFFICE NAME/NUMBER: _____

_____

☐ OTHER: _____

This form shall be used as a guide by the PDC providers, and it is not an agreement by the PDC to accept any restrictions or protections of the patient's protected health information requested by the patient or the patient's personal representative. In addition, this form is not a conclusive determination by the PDC that your requests for communications by alternative means or at alternative locations are reasonable. Further, this form shall be used only by the particular clinic or clinical site listed herein.

Patient Signature: _____ Date: _____