TO MAKE THE MOST OF YOUR FIRST VISIT

It is important that we have all fertility related medical records for you and your partner on file at our office before your visit. This allows the doctor adequate time to review these records before meeting with you. It also helps us to avoid duplicating tests that you have already had done.

These records include any recent care provided by:

- Your gynecologist (including your most recent pap smear and mammogram results)
- Your urologist
- Another reproductive endocrinologist (fertility doctor)

Please contact all of the above offices to have the requested information sent to us. Our fax number is (248) 619-9031.

WHAT TO EXPECT AT YOUR INITIAL APPOINTMENT

Part 1: Please plan on your consultation lasting 1 – 1 ½ hours. Your evaluation starts with a consultation with either Dr. Brad Miller or Dr. Lynda Wolf (both of whom are board certified reproductive endocrinologists). The doctor you meet during your initial consultation will direct your care. However, since the nature of our practice requires that monitoring & treatment be provided 365 days a year, some of your monitoring ultrasounds and/or your procedures may be performed by the other physician.

During this initial consultation, a comprehensive history will be taken. A physical exam may be performed. The doctor will discuss possible causes of your infertility and make recommendations about testing that may be helpful in determining a treatment plan. Some of this testing (including blood work and ultrasounds) may be done during this visit; some testing must be delayed until an appropriate time in your menstrual cycle.

Please Note: Exams, blood work and ultrasounds are not part of the $280 consultation fee and incur an additional cost that may or may not be covered by insurance. If your blood work needs to be sent to a specific lab due to insurance coverage please notify the lab tech who draws your blood of this fact.

Part 2: You will be introduced to your primary nurse. This nurse has special training in infertility care. She follows you through your treatment cycle and is your primary point of contact for any questions or concerns. She will schedule all diagnostic testing and order medications for you.

Part 3: You will have the opportunity to meet with a financial coordinator to discuss insurance coverage, available financial resources, multi-cycle plans, refund programs and the typical costs associated with your recommended treatment plan.

PATIENT REGISTRATION

PLEASE PRINT. ALL INFORMATION WILL REMAIN CONFIDENTIAL. THANK YOU!

SCHEDULED APPOINTMENT DATE: _____ HAVE YOU OR YOUR PARTNER EVER BEEN HERE BEFORE? ☐ YES ☐ NO

LEGAL NAME _____
(LAST) (FIRST) (MIDDLE)

HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____

PRIMARY PHONE _____ ☐ HOME ☐ CELL ☐ WORK DOB _____/_____/_____

SECONDARY PHONE _____ ☐ HOME ☐ CELL ☐ WORK AGE _____

SSN # _____-_____-_____ MARITAL STATUS: ☐ SINGLE ☐ MARRIED
(THE LAST 6 DIGITS ARE REQUIRED)

MAY WE CONTACT YOU VIA EMAIL? □ YES □ NO IF YES, EMAIL ADDRESS: _____

EMERGENCY CONTACT NAME _____ RELATIONSHIP _____ PHONE _____

ARE YOU EMPLOYED? ❒ YES ❒ NO IF YES, YOUR EMPLOYER _____ OCCUPATION _____

EMPLOYER'S ADDRESS _____ CITY _____ STATE _____ ZIP _____

WORK PHONE _____ MAY WE CONTACT YOU THERE? □ YES □ NO

PARTNER NAME _____
(LAST) (FIRST) (MIDDLE)

SSN # _____-_____-_____ DOB _____/_____/_____ AGE _____ SEX: ☐ MALE ☐ FEMALE

EMPLOYED BY _____ OCCUPATION _____

WORK PHONE _____ CELL PHONE _____

DOES YOUR LEGAL NAME MATCH YOUR INSURANCE? **YES** ☐ **NO** ☐
IF NO, PLEASE WRITE YOUR NAME AS SHOWN ON YOUR INSURANCE: _____

PATIENT INSURANCE COVERAGE

NAME OF INSURANCE _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
TELEPHONE _____
POLICY # _____
GROUP # _____
POLICY HOLDER _____
PARTNER COVERED UNDER THIS POLICY? YES ☐ NO ☐

SPOUSE/PARTNER INSURANCE COVERAGE

NAME OF INSURANCE _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
TELEPHONE _____
POLICY # _____
GROUP # _____
POLICY HOLDER _____
PARTNER COVERED UNDER THIS POLICY? YES ☐ NO ☐

***** PLEASE BE PREPARED TO PRESENT YOUR INSURANCE CARD AND VALID GOVERNMENT ISSUED PHOTO ID TO THE RECEPTIONIST *****

REFERRED BY (MARK ALL THAT APPLY)

- ❒ DOCTOR (PLEASE LIST NAME) _____ ❒ MD ❒ DO
- ❒ FRIEND / WORD OF MOUTH (PLEASE LIST NAME) _____
  MAY WE CONTACT THIS PERSON FOR REFERRING YOU? ❒ YES ❒ NO, I PREFER TO BE DISCRETE
- ❒ INSURANCE CO. _____
- ❒ RMA OF MI EMPLOYEE _____
- ❒ RMA OF MI SEMINAR
- ❒ RADIO
- ❒ INTERNET

I authorize payment of Medical Benefits to this facility/doctor. I authorize release of any medical information needed to process the claim. I hereby agree to pay for all services rendered to the above mentioned patient as incurred. I understand there is no guarantee any or all services will be covered by my insurance company. In the event of account default, I promise to pay collection costs and reasonable attorney fees as required effecting collection on the debt. I understand that should my account become delinquent or should I fail to pay as promise; RMA of Michigan reserves the right to deny further care to me either temporarily or permanently.

SIGNATURE _____ DATE _____

SHARED PROTECTED HEALTH INFORMATION

Name	Results / Medical Info	Bills / Account
	❒ Yes ❒ No	❒ Yes ❒ No
	❒ Yes ❒ No	❒ Yes ❒ No
	❒ Yes ❒ No	❒ Yes ❒ No

_____ _____
Please Print Patient / Guardian Name If Guardian, Relationship to Patient

_____ _____
Signature of Patient / Guardian Date

The Source for New Beginnings
RMA Michigan
Reproductive Medicine Associates of Michigan

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE FOR WOMEN

Patient Name: _____ Today's Date: _____

Partner Name: _____

What are your expectations for this visit and what questions would you like answered?

_____

_____

_____

_____

GYNECOLOGICAL HISTORY

Current Gynecologist or Primary Care Physician: _____ Phone: _____

May we keep this doctor informed of your care: (Please check one) ❒ Yes ❒ No

Age at first period: _____ Date of first day of last period: _____

Are your periods: ❒ Regular ❒ Irregular Amount of flow: ❒ Light ❒ Moderate ❒ Heavy

What are the usual # days from cycle day 1 to your next day 1? Minimum _____ Maximum _____

What is the usual duration of your periods (full flow): Minimum _____ Maximum _____

Do you have PMS: ❒ Yes ❒ No

If yes: ❒ Mild ❒ Moderate ❒ Severe

Do you have painful periods? ❒ Yes ❒ No

If yes: ❒ Mild ❒ Moderate ❒ Severe

Do you take pain medication for cramps: ❒ Yes ❒ No

If yes, please specify medication: _____

Do you bleed or spot in between periods: ❒ Yes ❒ No

Have you ever taken oral contraceptives: ❒ Yes ❒ No

If yes, please list date(s): _____

Were your cycles regular after discontinuing the oral contraceptives: ❒ Yes ❒ No

Have you used other forms of contraception: ❒ Yes ❒ No

If yes, what: _____

When was your last PAP smear performed: _____ Was it Normal? ❒ Yes ❒ No

Have you ever had an abnormal PAP? ❒ Yes ❒ No

If yes, please indicate date(s): _____

Treatment: ❒ None or repeated ❒ Colposcopy/biopsy ❒ Laser

❒ Conization ❒ LEEP ❒ Unknown

Is intercourse painful: ❒ Yes ❒ No

If Yes: ❒ Mild ❒ Moderate ❒ Severe

Do you use lubricants: ❒ Yes ❒ No

If yes, which brand? _____

Do you douche before or after intercourse: ❒ Yes ❒ No

How many times per week do you and your partner have intercourse: _____

Have you ever used an intrauterine device (IUD): ❒ Yes ❒ No

If yes, when? / which brand? _____

Have you ever had pelvic inflammatory disease (PID): ❒ Yes ❒ No

If yes, when? _____

How many months have you had unprotected intercourse: _____months

How many months have you been actively trying to achieve pregnancy: _____ months

Have you used Basal Body Temperature Charts (BBT): ❒ Yes ❒ No

If yes, what cycle day did you ovulate: _____

Have you used an ovulation predictor kit (OPK): ❒ Yes ❒ No

If yes, what cycle day did you ovulate: _____

Have you been exposed to any toxins or radiation: ❒ Yes ❒ No

If yes, describe: _____

Do you perform self breast exams on a regular basis: ❒ Yes ❒ No

Have you had a mammogram performed: ❒ Yes ❒ No

If yes, date of last one: _____

If yes, was it normal? ❒ Yes ❒ No

If no, treatment: _____

OBSTETRICAL HISTORY

How many times have you been pregnant? _____

Number of abortions: _____ Number of miscarriages (<20 weeks): _____

Number of ectopic pregnancies: _____ Number of pre-term (<37 weeks) births: _____

Number of full term (>37 weeks) births: _____ How many children are alive and well: _____

Do any of your children have birth defects? ❒ Yes ❒ No ❒ NA

If yes, please explain: _____

Please list all pregnancies:

Pregnancy #	Year Delivered	How many weeks?	Pregnancy Outcome: Live Birth? Miscarriage? Abortion? Ectopic? Complications?	Infertility therapy required to conceive?	How long in months did it take to conceive?	Is current partner the father?
1st Pregnancy						
2nd Pregnancy						
3rd Pregnancy						
4th Pregnancy						
5th Pregnancy						

MEDICAL HISTORY

Age _____ Weight _____ Height _____ Blood Type (if known) _____

Do you have anything in your health history that your partner is not aware of that you wish to keep confidential? ❒ Yes ❒ No

If yes, please specify: _____

_____

Have you lost or gained greater than 20 lbs. of weight in the last year: ❒ Yes ❒ No

Do you follow a particular food diet or have any special dietary habits: ❒ Yes ❒ No

If yes, please specify: _____

Have you ever had an eating disorder (anorexia or bulimia): ❒ Yes ❒ No

If yes, please specify: _____

Do you have any allergies (check all that apply): ❒ Yes ❒ No

If yes, please specify: ❒ Medication _____

❒ Food _____

❒ Latex

Do you exercise: ❒ Yes ❒ No

If yes, please specify the form and frequency of regular vigorous exercise (swimming, cycling, etc.):

Exercise _____ Hours/Week _____

Within the last year, have you taken any prescription medications? If taking prenatal vitamins please include.

Medication	Diagnosis	Dosage / Frequency	Duration

Have you taken any of the following medications? ❒ Thyroid (e.g. Synthroid) ❒ Bromocriptine (Parlodel)

Are you taking any over the counter medications / supplements on a regular basis? Please note below.

Medication	Diagnosis	Dosage / Frequency	Duration

Please provide us with the phone number to your local pharmacy _____

Vaccinations:

Chickenpox (Varicella)	❒ No	❒ Yes	Date(s)_____	❒ Don't Know
MMR	❒ No	❒ Yes	Date(s)_____	❒ Don't Know
BCG (Tuberculosis)	❒ No	❒ Yes	Date(s)_____	❒ Don't Know
Polio	❒ No	❒ Yes	Date(s)_____	❒ Don't Know
Hepatitis A	❒ No	❒ Yes	Date(s)_____	❒ Don't Know
Hepatitis B	❒ No	❒ Yes	Date(s)_____	❒ Don't Know
Tetanus	❒ No	❒ Yes	Date(s)_____	❒ Don't Know
Influenza	❒ No	❒ Yes	Date(s)_____	❒ Don't Know

Do you or have you ever had (please check all that apply):

❒ Scarlet fever
❒ Rheumatic fever
❒ Tuberculosis
❒ Hepatitis
❒ Syphilis
❒ Gonorrhea
❒ Pelvic Infection
❒ Chlamydia

❒ Herpes (HSV)
❒ Chronic Bronchitis
❒ Measles: Regular
❒ Measles: German (Rubella)
❒ Chickenpox (Varicella)
❒ Nongonococcal Urethritis
❒ Pneumonia
❒ Neurological Problems
❒ Vaginitis: Trichomoniasis or yeast infection
❒ Other:_____

❒ Kidney Infection
❒ Heart Disease
❒ Hirsutism (Excess Hair Growth)
❒ High Blood Pressure
❒ Gallbladder Problems
❒ Liver Problems
❒ Ulcers
❒ Appendicitis

❒ Colitis
❒ Diabetes
❒ Anemia
❒ Arthritis
❒ Thyroid Problems
❒ Ovarian Cysts
❒ Cervical Dysplasia/Cancer
❒ HPV or genital warts

❒ Breast Tenderness
❒ Breast Soreness
❒ Breast Discharge
❒ Breast Cancer
❒ Seizures
❒ Epilepsy
❒ Visual Disturbances
❒ Poor Sense of Smell

❒ Dizziness
❒ Loss of Balance
❒ Chronic Headaches
❒ Blood Transfusions
❒ Parasitic Infection
❒ Endometriosis
❒ Ovarian cancer

Physical Symptoms:

General:
❒ Recent weight gain or loss
❒ Anorexia/Bulimia
❒ Lack of energy
❒ Fever/Chills
❒ Other_____
❒ None

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

Respiratory:
❒Shortness of breath
❒ Asthma ❒Bronchitis
❒ Pneumonia ❒Tuberculosis
❒ Bloody cough
❒ Other_____
❒ None

Endocrine/Hormonal:
❒ Diabetes ❒ Hair loss
❒ Thyroid gland problems
❒ Rapid weight gain or loss
❒ Excessive hunger/thirst
❒ Temperature intolerance- hot flashes or feeling cold
❒ Other_____
❒ None

Breasts:
❒ Discharge (clear?____ bloody? ____ milky? ____)
❒ Lumps ❒ Pain ❒ Cancer
❒ Abnormal mammogram
❒ Reduction
❒ Augmentation/Breast implants (saline?___ silicone?___)
❒ Other_____
❒ None

Neurological Problems:
❒ Weakness/Loss of balance
❒ Seizures/Epilepsy
❒ Headaches
❒ Migraine headaches
❒ Numbness
❒ Memory loss
❒ Other_____
❒ None

Gastrointestinal:
❒ Nausea/Vomiting ❒ Ulcers
❒ Hepatitis ❒ Diarrhea
❒ Blood in your stools ❒ Constipation
❒ Irritable Bowel Syndrome
❒ Change in bowel habits
❒ Colitis (ulcerative or Crohn's)
❒ Other_____
❒ None

Genito-Urinary:
❒ Bladder infections
❒ Kidney infections
❒ Vaginal infections
❒ Frequent urination ❒ Leaking urine
❒ Blood in urine
❒ Herpes
❒ Other_____
❒ None

Skin/Extremities:
❒ Unexplained rash
❒ Acne
❒ Skin cancer
❒ Burn injury
❒ Moles changing appearance
❒ Excess hair growth
❒ Other _____
❒ None

Musculoskeletal:
❒ Unusual muscle weakness
❒ Decreased energy/stamina
❒ Rheumatoid arthritis
❒ Lupus Erythematosus
❒ Myasthenia gravis
❒ Other_____
❒ None

Hematologic:
❒ Blood clotting disorder/Blood clot
❒ Sickle cell Anemia
❒ Easy bruising
❒ Swollen glands/lymph nodes
❒ Blood transfusions (dates/reasons)
❒ Thrombophlebitis
❒ Other _____
❒ None

Cardiovascular:
❒ Palpitations/Skipped beats
❒ Chest pain
❒ Stroke
❒ High blood pressure
❒ Rheumatic fever
❒ Mitral valve prolapse
(Abx before dental procedures? Yes / No)
❒ Heart attack
❒ Murmurs
❒ Other _____
❒ None

Mental Health Problems:
❒ Depression ❒ Anxiety disorder ❒ Schizophrenia
❒ Other_____
❒ Do you see a counselor?_____ How long?_____
❒ None

SURGICAL HISTORY

Have you ever been surgically sterilized: ❒ Yes ❒ No

If yes, date reversal performed: _____

Any complications from anesthesia: ❒ Yes ❒ No

If yes, explain: _____

Please list all surgeries:

Date	Hospital	Procedure	Findings	Surgeon

PREVIOUS FERTILITY TESTING

	Yes	No	Date	Results (If Known)
Hysterosalpingogram (HSG)	❒	❒	_____	_____
Saline Sonogram	❒	❒	_____	_____
Hysteroscopy	❒	❒	_____	_____
Laparoscopy	❒	❒	_____	_____
Endometrial Biopsy	❒	❒	_____	_____
Day 3 FSH, Estradiol	❒	❒	_____	_____
Postcoital Test	❒	❒	_____	_____
Mycoplasma / Chlamydia Cultures	❒	❒	_____	_____
Thyroid Tests	❒	❒	_____	_____

INFERTILITY TREATMENT

Have you been treated for infertility before: ❒ Yes ❒ No

If yes, Diagnosis: (1) _____ (2) _____ (3) _____

Clomid or Letrozole Cycles

Cycle #	Dates	Starting Dose	Number of Follicles	Insemination? Yes or No	Pregnancy Outcome
1					
2					
3					
4					
5					

Follistim, Gonal-F, Menopur, Bravelle, etc. Cycles

Cycle #	Dates	Starting Dose	Maximum Estradiol level	Number of Follicles	Insemination? Yes or No	Pregnancy Outcome
1						
2						
3						
4						
5						

IVF History

	Cycle # 1	**Cycle # 2**	**Cycle # 3**	**Cycle # 4**	**Cycle # 5**	**Cycle # 6**
Date						
IVF Center						
Frozen Cycle?	❒ Y ❒ N	❒ Y ❒ N	❒ Y ❒ N	❒ Y ❒ N	❒ Y ❒ N	❒ Y ❒ N
Max Start Dose						
Max Estradiol						
# Eggs Retrieved						
# Eggs Fertilized						
ICSI?	❒ Y ❒ N	❒ Y ❒ N	❒ Y ❒ N	❒ Y ❒ N	❒ Y ❒ N	❒ Y ❒ N
# Embryos Transferred						
Embryo Age at Transfer Date (day 2, 3, 5 or 6)						
Pregnancy?	❒ Y ❒ N	❒ Y ❒ N	❒ Y ❒ N	❒ Y ❒ N	❒ Y ❒ N	❒ Y ❒ N
Delivered?	❒ Y ❒ N	❒ Y ❒ N	❒ Y ❒ N	❒ Y ❒ N	❒ Y ❒ N	❒ Y ❒ N

SOCIAL HISTORY

Do you read and write English? ❒ Yes ❒ No
If no, what is your primary language?_____ Who will be your interpreter? _____

Do you or have you ever used:

Alcohol ❒ Yes ❒ No If yes, how many glasses per week? Wine _____ Beer _____ Cocktails _____

Caffeinated beverages ❒ Yes ❒ No If yes, how many do you consume per day? _____

Recreational drug use, past or current: ❒ Yes ❒ No If Yes, what _____and when _____

Do you currently smoke cigarettes? ❒ Yes ❒ No Have you ever smoked? ❒ Yes ❒ No
If yes, when did you quit? _____

FAMILY HISTORY

Did your mother have any difficulty with conception or pregnancy: ❒ Yes ❒ No

Did your mother take diethylstilbestrol (DES) when she was pregnant with you: ❒ Yes ❒ No

At what age did your mother begin menopause: _____

Is there a family history of infertility: ❒ Yes ❒ No

If yes, who / relationship: _____

Is there a history of hormonal disorders in your family: ❒ Yes ❒ No

If yes, who / relationship: _____

Is there a family history of birth defects: ❒ Yes ❒ No

If yes, who / relationship: _____

Is there a family history of habitual pregnancy loss: ❒ Yes ❒ No

If yes, who / relationship: _____

Please list information below:

	Living		Cause of Death/age at Death
Mother	❒ Yes-age _____	❒ No	_____
Father	❒ Yes-age _____	❒ No	_____
Brother(s)	❒ Yes-age _____	❒ No	_____
	❒ Yes-age _____	❒ No	_____
	❒ Yes-age _____	❒ No	_____
Sister(s)	❒ Yes-age _____	❒ No	_____
	❒ Yes-age _____	❒ No	_____
	❒ Yes-age _____	❒ No	_____
Maternal Grandmother	❒ Yes-age _____	❒ No	_____
Maternal Grandfather	❒ Yes-age _____	❒ No	_____
Paternal Grandmother	❒ Yes-age _____	❒ No	_____
Paternal Grandfather	❒ Yes-age _____	❒ No	_____

Disorders in Your Family:	**Relationship to You**		
Breast Cancer	❒ Yes _____	❒ No	❒ Don't Know
Ovarian Cancer	❒ Yes _____	❒ No	❒ Don't Know
Colon Cancer	❒ Yes _____	❒ No	❒ Don't Know
Other Cancer_____	❒ Yes _____	❒ No	❒ Don't Know
Diabetes	❒ Yes _____	❒ No	❒ Don't Know
Thyroid problems	❒ Yes _____	❒ No	❒ Don't Know
Heart disease	❒ Yes _____	❒ No	❒ Don't Know
Blood clots	❒ Yes _____	❒ No	❒ Don't Know
Obesity	❒ Yes _____	❒ No	❒ Don't Know
Psychiatric problems	❒ Yes _____	❒ No	❒ Don't Know
Tuberculosis	❒ Yes _____	❒ No	❒ Don't Know
Endometriosis	❒ Yes _____	❒ No	❒ Don't Know
Infertility	❒ Yes _____	❒ No	❒ Don't Know
Menopause before age 40	❒ Yes _____	❒ No	❒ Don't Know
Birth defects	❒ Yes _____	❒ No	❒ Don't Know
Cystic Fibrosis	❒ Yes _____	❒ No	❒ Don't Know

What is your Ancestry?

❒ African American
❒ American Indian or Alaskan Native
❒ Ashkenazi Jewish
❒ Asian
❒ Native Hawaiian or otherPacific Islander
❒ White
❒ Hispanic or Latino

Tay-Sachs disease	❒ Yes _____	❒ No	❒ Don't Know
Canavan disease	❒ Yes _____	❒ No	❒ Don't Know
Bloom syndrome	❒ Yes _____	❒ No	❒ Don't Know
Gaucher disease	❒ Yes _____	❒ No	❒ Don't Know
Niemann-Pick disease	❒ Yes _____	❒ No	❒ Don't Know
Fanconi Anemia	❒ Yes _____	❒ No	❒ Don't Know
Familial Dysautonia	❒ Yes _____	❒ No	❒ Don't Know
Muscular Dystrophy	❒ Yes _____	❒ No	❒ Don't Know
Neurologic (brain/spine)	❒ Yes _____	❒ No	❒ Don't Know
Neural Tube Defects	❒ Yes _____	❒ No	❒ Don't Know
Bone/skeletal Defects	❒ Yes _____	❒ No	❒ Don't Know
Dwarfism	❒ Yes _____	❒ No	❒ Don't Know
Developmental delay	❒ Yes _____	❒ No	❒ Don't Know
Learning problems	❒ Yes _____	❒ No	❒ Don't Know
Polycystic kidney disease	❒ Yes _____	❒ No	❒ Don't Know
Heart defect from birth	❒ Yes _____	❒ No	❒ Don't Know
Down syndrome	❒ Yes _____	❒ No	❒ Don't Know
Other chromosome defects	❒ Yes _____	❒ No	❒ Don't Know
Marfan Syndrome	❒ Yes _____	❒ No	❒ Don't Know
Hemophilia	❒ Yes _____	❒ No	❒ Don't Know
Sickle Cell Anemia	❒ Yes _____	❒ No	❒ Don't Know
Thalasemia	❒ Yes _____	❒ No	❒ Don't Know
Galactosemia	❒ Yes _____	❒ No	❒ Don't Know
Deafness/Blindness	❒ Yes _____	❒ No	❒ Don't Know
Color Blindness	❒ Yes _____	❒ No	❒ Don't Know
Hemochromatosis	❒ Yes _____	❒ No	❒ Don't Know
Other _____	❒ Yes _____	❒ No	❒ Don't Know

MALE PARTNER (IF APPLICABLE)

Name: _____ Height: _____ Weight: _____ Age: _____

Have you ever conceived a pregnancy with a different partner? ❒ Yes ❒ No

Please give approximate dates and outcomes of any pregnancies conceived with a different partner:

Date of Pregnancy	Delivered	Aborted	Miscarried
	❒ Y ❒ N	❒ Y ❒ N	❒ Y ❒ N
	❒ Y ❒ N	❒ Y ❒ N	❒ Y ❒ N
	❒ Y ❒ N	❒ Y ❒ N	❒ Y ❒ N

Have you ever seen an Urologist: ❒ Yes ❒ No If yes, why: _____

Have you ever had antisperm antibody testing? ❒ Yes ❒ No If yes, result: _____

Have you ever had a semen analysis (sperm count): ❒ Yes ❒ No If yes, please list below:

Date	Location	Count (Million/ml)	Motility	Grade	Morphology

Do you have any medical problems unrelated to your fertility? For example: Diabetes, Multiple Sclerosis, Hypertension, Prostate Disease, Uinary Tract or Kidney Infections.

Nature of Problem (Diagnosis)	Treatment	Physician

Have you had any surgeries?

Date	Type of Surgery	Physician

Do you take any medications? Indicate medication, dosage, frequency and duration:

Medication	Diagnosis	Dosage / Frequency	Duration

Do you or have you ever used:

Alcohol ❒ Yes ❒ No If yes, how many glasses per week? Wine _____ Beer _____ Cocktails _____

Caffeinated beverages ❒ Yes ❒ No If yes, how many do you consume per day? _____

Recreational drug use, past or current: ❒ Yes ❒ No If Yes, what _____and when _____

Do you currently smoke cigarettes? ❒ Yes ❒ No Have you ever smoked? ❒ Yes ❒ No

If yes, when did you quit? _____

Do you or have you ever had any difficulties with (check all that apply):

Erection: ❒ Yes ❒ No

If yes, please explain: _____

Ejaculation: ❒ Yes ❒ No

If yes, please explain: _____

Have you been exposed in last 3 months to excessive heat, hot tubs, saunas or fevers ? ❒ Yes ❒ No

Have you had any serious injuries to your genitals? ❒ Yes ❒ No

Do you use your laptop on your lap? ❒ Yes ❒ No

Have you had scrotal or testicular pain? ❒ Left ❒ Right ❒ Both ❒ Yes ❒ No

Have you had undescended testes? ❒ Left ❒ Right ❒ Both ❒ Yes ❒ No

Have you had a hernia repair, bladder or penis surgery as a child? ❒ Yes ❒ No

Have you had a varicocele? ❒ Left ❒ Right ❒ Both Date of Repair_____ ❒ Yes ❒ No

Have you had a vasectomy? Date_____ Reversed? Date_____ ❒ Yes ❒ No

Have you ever been exposed to radiation, chemotherapy or other toxins? ❒ Yes ❒ No

Have you had any infections of your penis, testicles or prostate gland? ❒ Yes ❒ No

Have you ever had any sexually transmitted diseases? Check all that apply below: ❒ Yes ❒ No

❒ HIV/AIDS ❒ Herpes ❒ Chlamydia ❒ Gonorrhea ❒HPV/warts ❒ Hepatitis A, B or C

❒ Syphilis ❒ Mumps

Is there any history of birth defects in your family? ❒ Yes ❒ No ❒ Don't Know

Is there any history of recurrent miscarriage or infertility in your family? ❒ Yes ❒ No ❒ Don't Know

Do you have any allergies? ❒ Yes ❒ No

If yes, check all that apply: ❒ Medication ❒ Food ❒ Latex

If yes, please specify: _____

Do you have/use heated car seats? ❒ Yes ❒ No

Do you use heated driver's seat at the highest setting? ❒ Yes ❒ No

Please list information below:

	Living		Cause of Death/age at Death
Mother	❒ Yes-age _____	❒ No	_____
Father	❒ Yes-age _____	❒ No	_____
Brother(s)	❒ Yes-age _____	❒ No	_____
	❒ Yes-age _____	❒ No	_____
	❒ Yes-age _____	❒ No	_____
Sister(s)	❒ Yes-age _____	❒ No	_____
	❒ Yes-age _____	❒ No	_____
	❒ Yes-age _____	❒ No	_____
Maternal Grandmother	❒ Yes-age _____	❒ No	_____
Maternal Grandfather	❒ Yes-age _____	❒ No	_____
Paternal Grandmother	❒ Yes-age _____	❒ No	_____
Paternal Grandfather	❒ Yes-age _____	❒ No	_____

Disorders in Your Family:	**Relationship to You**		
Breast Cancer	❒ Yes _____	❒ No	❒ Don't Know
Ovarian Cancer	❒ Yes _____	❒ No	❒ Don't Know
Colon Cancer	❒ Yes _____	❒ No	❒ Don't Know
Other Cancer_____	❒ Yes _____	❒ No	❒ Don't Know
Diabetes	❒ Yes _____	❒ No	❒ Don't Know
Thyroid problems	❒ Yes _____	❒ No	❒ Don't Know
Heart disease	❒ Yes _____	❒ No	❒ Don't Know
Blood clots	❒ Yes _____	❒ No	❒ Don't Know
Obesity	❒ Yes _____	❒ No	❒ Don't Know
Psychiatric problems	❒ Yes _____	❒ No	❒ Don't Know
Tuberculosis	❒ Yes _____	❒ No	❒ Don't Know
Endometriosis	❒ Yes _____	❒ No	❒ Don't Know

What is your Ancestry?

❒ African American

❒ American Indian or Alaskan Native

❒ Ashkenazi Jewish

❒ Asian

❒ Native Hawaiian or otherPacific Islander

❒ White

❒ Hispanic or Latino

Infertility	❒ Yes	_____	❒ No	❒ Don't Know
Menopause before age 40	❒ Yes	_____	❒ No	❒ Don't Know
Birth defects	❒ Yes	_____	❒ No	❒ Don't Know
Cystic Fibrosis	❒ Yes	_____	❒ No	❒ Don't Know
Tay-Sachs disease	❒ Yes	_____	❒ No	❒ Don't Know
Canavan disease	❒ Yes	_____	❒ No	❒ Don't Know
Bloom syndrome	❒ Yes	_____	❒ No	❒ Don't Know
Gaucher disease	❒ Yes	_____	❒ No	❒ Don't Know
Niemann-Pick disease	❒ Yes	_____	❒ No	❒ Don't Know
Fanconi Anemia	❒ Yes	_____	❒ No	❒ Don't Know
Familial Dysautonia	❒ Yes	_____	❒ No	❒ Don't Know
Muscular Dystrophy	❒ Yes	_____	❒ No	❒ Don't Know
Neurologic (brain/spine)	❒ Yes	_____	❒ No	❒ Don't Know
Neural Tube Defects	❒ Yes	_____	❒ No	❒ Don't Know
Bone/skeletal Defects	❒ Yes	_____	❒ No	❒ Don't Know
Dwarfism	❒ Yes	_____	❒ No	❒ Don't Know
Developmental delay	❒ Yes	_____	❒ No	❒ Don't Know
Learning problems	❒ Yes	_____	❒ No	❒ Don't Know
Polycystic kidney disease	❒ Yes	_____	❒ No	❒ Don't Know
Heart defect from birth	❒ Yes	_____	❒ No	❒ Don't Know
Down syndrome	❒ Yes	_____	❒ No	❒ Don't Know
Other chromosome defects	❒ Yes	_____	❒ No	❒ Don't Know
Marfan Syndrome	❒ Yes	_____	❒ No	❒ Don't Know
Hemophilia	❒ Yes	_____	❒ No	❒ Don't Know
Sickle Cell Anemia	❒ Yes	_____	❒ No	❒ Don't Know
Thalasemia	❒ Yes	_____	❒ No	❒ Don't Know
Galactosemia	❒ Yes	_____	❒ No	❒ Don't Know
Deafness/Blindness	❒ Yes	_____	❒ No	❒ Don't Know
Color Blindness	❒ Yes	_____	❒ No	❒ Don't Know
Hemochromatosis	❒ Yes	_____	❒ No	❒ Don't Know
Other _____	❒ Yes	_____	❒ No	❒ Don't Know

PATIENT COMMENTS

Do you or your partner (if applicable) have personal / religious objections to intrauterine insemination (IUI), invitro fertilization (IVF), Donor Sperm, Donor Egg, and Genetic Testing (PGD)? If yes, please list:

_____

_____

_____

Please use this space to add any additional comments or information you feel our physician should know.

_____

_____

_____

_____

The Source for New Beginnings
RMA Michigan
Reproductive Medicine Associates of Michigan

Brad T. Miller, M.D.
Lynda J. Wolf, M.D.

Patient Financial Agreement

General Financial Provisions:
The patient, or their legal guardian, is ultimately responsible for all services incurred at RMA of Michigan. Spouses cannot sign this Agreement on behalf of the patient. Your insurance policy is a contract between you and the insurance company. We are NOT a party to that contract. RMA will do its best to verify your insurance benefits. However, RMA is not responsible if your insurance company provides incorrect or false information which results in unexpected out-of-pocket expenses. We strongly suggest you attempt to verify your own insurance benefits and ensure all necessary pre-authorizations are in place prior to the date of service.

Financing Options:
RMA of Michigan has established relationships with several financing companies for those interested in obtaining a low-interest/no interest financing. **RMA does not carry balances or offer payment plans.** Our Financial Counselor is available to discuss these program details.

If We Participate With Your Insurance Company:
RMA of Michigan participates and submits claims to the following insurance carriers provided we have all required information and you have granted Assignment of Benefits so that payment is made to us:

- Aetna
- Blue Cross Blue Shield of Michigan (excluding Blue Choice)
- Beaumont Health Plan (UMR)
- Cofinity
- HAP (excluding Henry Ford network)
- United HealthCare

Patient must pay the difference between the charges and the anticipated insurance payment at the time the services are incurred. This includes all non-covered services, unpaid deductibles and co-pays/co-insurance. If your insurance company pays less than anticipated; we will bill you for the balance. You agree to clear that balance within 30 days. We are not able to offer payment plans. You agree to take full responsibility for any and all non-covered charges incurred due to out-of-network and/or RMA of Michigan's non-participation status with your insurance company. Patient acknowledges and understands that it is their responsibility to verify the participation status of RMA of Michigan with their insurance carrier prior to any services being rendered, this includes but is not limited to: Bradley Miller, M.D., Lynda Wolf, M.D., and Reproductive Medicine Associates of Michigan.

RMA will make every attempt to resolve insurance claim issues with your insurance company. However, if your insurance company does not pay us within 60 days; we will see payment from you.

Please inform us upon receipt of a new insurance card or any changes in coverage. This prevents delays in processing claims.

If We Do Not Participate With Your Insurance Company Or You Are Uninsured:
All services must be paid on the date services are rendered. We do not carry balances or offer payment plans. RMA of Michigan does not verify benefits or submit claims for insurance companies not listed above.

Payment Methods
The following payment methods are accepted: Cash for payments not to exceed $700.00, personal check, money order, cashier check, Visa, MasterCard, Discover, and American Express. IVF deposits may be paid by certified check or credit card and must be paid at least one week in advance of your cycle start.

NSF Check Policy
Returned checks will incur a $25.00 fee for each returned check. Once we receive a returned check, future payments must be made by credit card, money order, and cashier check. Cash can be used when payment does not exceed $700.00.

Cryopreservation and Storage Fees
If you have consented to freeze your embryos, oocyte, and/or sperm, an annual storage fee will occur. If storage fees are not paid within 30 days, the fee will be considered delinquent. Cryopreservation is not included in your cost estimate and is due within 5 days of the service being performed. Cryopreservation fees that become delinquent will enter the same collection process as unpaid storage fees. Additionally, RMA of Michigan reserves the right to consider unpaid cryopreserved items as unwanted or abandoned and has the right to discard after all internal attempts to obtain payment have been exhausted.

Cancellation of Cycle
If your cycle is cancelled for any reason, you will be charged for all services up to that point. Any cycle deposit money remaining after those services are paid can be refunded to you. Please notify the financial department when the cycle is cancelled so that your refund request can be processed timely. Refunds take approximately 2 weeks from the date of request.

If you are undergoing an IVF cycle and convert to an insemination cycle, you will only be charged for the actual procedures performed during both cycles. An excess amount paid in your cycle deposit will be refunded to the patient/guarantor once the patient has been released from care and all insurance dispositions received.

Medications
Your physician will provide you with the necessary prescriptions for your treatment cycle. You may have the prescriptions filled at your local pharmacy or we can recommend a specialty pharmacy that may offer a cost advantage if your fertility medications are not covered by insurance. Some insurance companies require prior authorization before they will cover the cost of the fertility medications. We will complete the paperwork necessary to obtain this authorization when necessary.

Anesthesia
Anesthesia fees are due prior to the service being rendered, our anesthesia providers do not participate with any insurance carrier, therefore this fee cannot be billed to your insurance.

Subsequent Cycles and Treatment
Your account must be reconciled prior to any new cycle start. This means that you must have a $0.00 balance on both your patient account and insurance account. If it is not, you will not be able to proceed with the start of further treatment until it is reconciled.

Requests for Medical Records
We will gladly provide you with copies of your medical records. For each request we must have a signed medical records release form which contains the name, address and fax number of the healthcare provider where you wish the records to be sent. This form is available on our website at www.rmami.com. Spouses cannot authorize record release for one another. Copying fees, based upon the Michigan Medical Records Access Act, Act 47 of 2004, are $23.00 per request for 2012 and can change on an annual basis. This fee may be waived when your medical records are for the purpose of sharing with your primary care doctor or your ob-gyn. We cannot copy your medical records that were provided to us from your other healthcare providers. You will need to contact those healthcare providers directly. Please allow five (5) days for us to respond to your copying request.

Refunds
Overpayments and credit balances will be refunded to the appropriate party after review of the account. Patient refunds will not be processed until all insurance dispositions are received, if applicable. Once a refund is requested, it may take up to 2 weeks to be processed.

Delinquent Accounts
All accounts that cannot be collected by RMA of Michigan will be referred to a collection agency or attorney for further collection action in accordance with established guidelines as deemed appropriate. Any fees assessed will be the responsibility of the debtor. Additionally, RMA will no longer be able to offer care to those whose accounts needed third-party assistance to collect on the debt.

Patient Acknowledgement and Guarantee
I have read, understand, and agree to the Patient Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payment and deductibles, are my responsibility and I guarantee that my account with RMA will be paid per the terms of the Agreement.

_____
Print Patient Name

_____ _____
Signature of Patient Date