Women's Care

Physicians and Surgeons **Female Profile** **Date:** ____________

Patient Information

Use Legal Name. Please Print Clearly

Last Name	First	MI	Marital Status ( ) M ( ) W ( ) S ( ) D
Mailing Address	City	State	Zip
Street Address (if different)	City	State	Zip
Home Phone	Work/Cell Phone	Date of Birth	Social Security #
Employer/School		Occupation/Retired/Student	
Primary Care Physician Name:		Referring Physician:	

Primary Insurance Information

Insurance Company Name	Identification Number	Group Number	Insurance Phone
Name of Insured Party	Relationship to Patient (Self, Spouse, Parent, Other)		Sex ( ) M ( ) F
Insured Party Date of Birth	Insured Party Employer		Effective Date

Secondary Insurance Information

Insurance Company Name	Identification Number	Group Number	Insurance Phone
Name of Insured Party	Relationship to Patient (Self, Spouse, Parent, Other)		Sex ( ) M ( ) F
Insured Party Date of Birth	Insured Party Employer		Effective Date

Guarantor ( ) Same as Patient ( ) Other ______________________________ Phone ________________

Address: (Street, City, St., Zip) ____ Date of Birth__________

Emergency Contact: Name______________________________________ Phone ________________

I authorize Women's Care to bill the above insurance on my behalf, and assign any insurance benefits payable directly to Women's Care. I understand that I am financially responsible for all non-covered services.

Signature: ________________________________ **Date:** ____________________________

ACKNOWLEDGMENT AND CONSENT

I understand that Women's Care, (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By:________________________________ Date:______________
(Patient)

-OR-

By:________________________________ Date:______________
(Patient representative)

Description of Representative's Authority: ________________________________

AUTHORIZATION
TO USE/DISCLOSE HEALTH INFORMATION

I authorize ______________________________ to disclose a copy of the specific health and medical information described below regarding:

____
(Name of patient)

consisting of: ____

____

(Describe information to be used/disclosed)

to: The Fertility Center of Oregon, 590 Country Club Parkway, Ste A, Eugene, OR 97401,

for the purpose of: ____
(Describe each purpose of disclosure or state "at the request of the individual" if this authorization is initiated by the individual and the individual does not, or elects not to, provide a statement of purpose.)

Your health care and payment for that health care cannot be conditioned upon receipt of this signed Authorization unless your health care or treatment is for the purpose of:

(1) Creating health information about you to be disclosed to a third party; or
(2) For the purpose of research.

You have the right to revoke this Authorization at any time, provided that you do so in writing. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission. To revoke this Authorization, please send a written statement to Jennifer Ocker at 590 Country Club Parkway, Eugene, OR 97401 that identifies the date you signed this Authorization, the recipient of the information identified in this Authorization, and state that you are revoking this Authorization.

This Authorization will expire on the earlier of ______________ (date), 180 days from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above-described purpose.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

By:________________________________ Date:______________
(Patient)

- OR -

By:________________________________ Date:______________
(Patient representative)

Description of Representative's Authority:_________________________________

THE FERTILITY CENTER OF OREGON
590 Country Club Parkway, Suite A Eugene, Or. 97401
Douglas Austin, M.D.

A deposit of $400 is required at your appointment and will be applied to the cost of your visit. If you have any questions please feel free to contact me prior to your appointment.

Thank You
Rebecca Bailey
Financial Coordinator
(541)683-1559

ANDROLOGY BILLING WAIVER

To our infertility patients:

Some of your treatment may include a variety of andrology (male infertility) tests and procedures. Among these are semen analysis, sperm antibody and survival tests, sperm penetration assay (hamster egg), sperm freezing, and sperm processing (sperm washing) for intrauterine insemination (IUI). Because of the complicated nature of andrology, we must separate the andrology laboratory from any contract we might have with your insurance company and we cannot bill for these services. We request that you pay for all andrology services at the time service is rendered, and we will give you a receipt for billing on your own if you request.

I have read the above information and understand that I am responsible for payment of andrology services provided by The Fertility Center of Oregon and acknowledge that my insurance company will not be billed by The Fertility Center of Oregon.

______________________	______________________	__________
Patient Name (please print)	Patient Signature	Date

CONSENT TO RELEASE MEDICAL RECORDS
TO INSURANCE COMPANY

To our infertility patients:

Infertility and gynecology are often considered private and sensitive areas in our patients' medical care. We will strive to preserve your confidentiality for any care rendered in our office to the fullest extent possible. However, we are frequently asked to provide copies of your medical records to your insurance company as part of their analysis or review process in the payment of claims. You have already signed a release to allow your insurance company to review your medical records when you become insured.

It is our policy to provide information about your infertility and gynecology medical care only with your specific acknowledgement and consent. We ask you to sign below that you consent to the release of your medical records under our care. If you do NOT wish for us to release this information to your insurance carrier, it is possible that they will deny payment for that portion of your services and you will then be responsible for a greater portion of the cost of your treatment.

Please indicate below your choice for release of medical information from your file.

I understand that it may be necessary to release my medical records to my insurance company if requested and I give my permission to do so.

____________________________________ ____________
Patient signature Date

I do <u>NOT</u> consent to the release of copies of my medical records to my insurance company and I agree to accept financial responsibility for payment of services which may be denied as a result of this action.

____________________________________ ____________
Patient signature Date

THE FERTILITY CENTER OF OREGON
Women's Care
590 Country Club Pkwy, Suite A
Eugene, Oregon 97401
(541) 683-1559

REPRODUCTIVE ENDOCRINOLOGY – INFERTILITY
FEMALE QUESTIONNAIRE

Name: ______________________ Preferred name: __________ Date of Birth: _______ Age: ___ Today's Date: ______

Primary Care Physician: _________________________ OB-GYN Physician: __________________________________

Who referred you to us for care: _____________________________

Main reason for visit (*in your own words*) ____

____

____

INFERTILITY

Have you been trying to get pregnant?

____ No *(go to the next section)*
____ Yes. Unprotected intercourse for ______ years / months *(please circle years or months)*

Have you done Basal body temperature charting? ___ Yes ___ No Biphasic temperature ___ Yes ___ No

Have you done LH monitoring? ___ Yes ___ No

Do you have positive (+) test? ___ Yes ___ No If yes, what day of cycle: _________

How have you timed intercourse? ____

Have you consulted another doctor about infertility?

____ No *(please go to the next section)*

____ Yes. Doctor's name, dates of treatment, and diagnosis:

____

____

Have you had any of these tests:

____ Hysterosalpingogram (X-ray of uterus and tubes)
Date _______ Result ____________________________
____ Laparoscopy (visual examination of pelvic organs through an instrument placed through the abdominal wall)
Date _______ Result ____
____ Endometrial biopsy (removal of samples of uterine lining)
Date _______ Result ____
____ Endocrine hormone laboratories
Date _______ Result ____

Have you had previous infertility treatments? *(check if yes)*

____ Infertility surgery
Date _______ Procedure ____
Date _______ Procedure ____
____ Artificial inseminations - Dates ____

____ Medical therapy

	Dose	# Months	Outcome
Metformin/Glucophage …………………………..			
Clomid ……………………………………………..			
Letrozole …………………………………………..			
Gonadotropin (Pergonal / Repronex / Follistim / Poravella / Menopur) …………………………			

____ IVF (In Vitro Fertilization)

Date ________ Outcome ___________________________

Date ________ Outcome ___________________________

Have you and your partner considered adoption? ____ No ____ Yes

Have you consulted an adoption agency? ____ No ____ Yes

Name of agency ____

How long have you been with your present partner? ________________

C. Have you attempted pregnancy with past partners?

____ No *(please go to next section)* ____ Yes

Any pregnancy? ____ No ____ Yes *(list in chart)*

Do you use contraception? ___ No ___Yes

If yes, years used ____ to ____ Type ______________________________

GYNECOLOGICAL HISTORY

First day of last normal menstrual period: _______________

How old were you when your menstrual period started: ________

Have you ever had irregular cycles? ____ No ____ Yes

What is the usual number of days from the start of one period to the start of the next: __________________

How many days do you flow: _____________

Flow is usually: ___ Light ___ Moderate ___ Heavy

Do you have any discomfort during your period (menstrual cramps)?

___ Never ___ Rarely ___ Usually *(If you checked "never", please skip to the next question)*

Onset: ____ years old

Severity: ____ severe *(have to stop usual activities)*
____ moderate
____ mild

Changes: ____ getting worse
____ about the same
____ getting better

Location: ____ midline lower abdomen
____ both sides lower abdomen
____ one side of abdomen

Timing: ____ starts before flow
____ starts on first day
____ starts on subsequent day

Have you ever had any of the following: *(Check if yes)*

Bleeding, staining, or spotting between periods _____
Bleeding or spotting after intercourse ____
Heavy bleeding, gushing, large clots (blood runs down leg, requires two pads at once) _____
Recent change in periods *(Please describe)* ____

Do you have PMS symptoms which generally interfere with normal activities: ____ No ____ Yes

What symptoms do you experience? ____

Have you ever had a Pap smear? ___ Yes ___ No

If yes, date: ____________ Doctor: ______________________________

Do you have a history of abnormal Pap smears? ____ Yes ____ No

If yes: Date _____________ Treatment ____________________________________

Have you ever had a mammogram? ____ Yes ____ No

If yes, date of last mammogram: ____________ Location: __________________________

Do have a history of abnormal mammogram? ____ Yes ____ No

Current method of birth control: ____

Have you ever had: *(check if yes and please tell us when)*

____ Chlamydia ______________________________
____ Gonorrhea (clap, GC) ______________________________
____ Infected tubes or ovaries ______________________________
____ Vaginal infections ______________________________
____ Blood in urine ______________________________
____ Infection of bladder or kidney ______________________________
____ Trouble starting to urinate ______________________________
____ Loss of urine with cough or sneeze ______________________________
____ Any other problems with female organs: ______________________________
____

Intercourse and contraception

Have you ever had sexual intercourse?

____ No (*please skip to the next section)*
____ Yes *(please continue this section)*

How often do you have sexual intercourse?

____ Times per day / week / month *(please circle one)*

Do you have orgasms (climax)? ____ No ____ Yes

If yes, how often?

____ Rarely or less than half the time
____ Usually or more than half the time
____ Almost always

Do you have any discomfort or pain with intercourse?

____ No ____ Yes *(please answer the following)*

Frequency: ____ Rarely or less than half the time
____ Usually or more than half the time
____ Almost always

Type: ____ Only with deep penetration
____ Both of the above
____ Persists after intercourse

Severity: ____ Mild ____ Moderate ____ Severe

Change: ____ Getting worse
____ Getting better
____ The same

Do you have a happy sex life? *(check one)* ____ great ____ good ____ fair ____ poor

Do use a lubricant? ____ No ____Yes

If yes, which one? ______________________________

Have you ever had any problems with any methods of contraception?
____ No ____ Yes *(please explain)* ____

Are you troubled by excessive hair growth? ___ No ___ Yes
If yes, please describe: ____

Do you have acne? ________

Have noticed hair loss from your scalp? ___ No ___ Yes
If yes, please describe: ____

PREGNANCY

A. Have you ever been pregnant? ___ No *(If no, please skip to the next section)*
___ Yes

Fill in the number of:

____ Term deliveries (baby weighed over 5½ pounds at birth and was born at least 37 weeks of pregnancy)
____ Premature deliveries (over 5 months pregnancy but baby weighed under 5½ pounds)
____ Miscarriages (before 5 months)
____ Abortions
____ Ectopic pregnancies
____ Children now living
____ Multiple gestations

B. If you have had any TERM or PREMATURE deliveries, please fill in this section *(Attach additional pages if needed)*

1. Delivery Date ____________ Weeks of pregnancy* _______________________

   Length of labor __________ Type of anesthesia _______________ Delivery Type _______________________
   Hospital ____
   Boy or girl (*circle)* Weight (pounds, ounces) _____________
   Any problems with delivery or pregnancy? ____

2. Delivery Date ____________ Weeks of pregnancy* _______________________
   Length of labor __________ Type of anesthesia _______________ Delivery Type _______________________
   Hospital ____
   Boy or girl (*circle)* Weight (pounds, ounces) _____________
   Any problems with delivery or pregnancy? ____

*Your due date was 40 weeks. If you delivered one week late, write 41. If you delivered three weeks early, write 37, etc.

C. If you have had any ABORTIONS or MISCARRIAGES, fill in this section

1. Month/Year ____________ Weeks of pregnancy* _______________________
   Doctor's name ____
   Hospitalized? ______________ D&C (scrape uterus) ____________

2. Month/Year ____________ Weeks of pregnancy* _______________________
   Doctor's name ____
   Hospitalized? ______________ D&C (scrape uterus) ____________

*Weeks between last normal menstrual period and termination of pregnancy.

MEDICAL HISTORY

Current medical problems: ____

Have you ever had any serious illnesses, injuries, or hospitalizations other than listed above: ________________________

Date __________ Problem ________________________ Treatment ____

Date __________ Problem ________________________ Treatment ____

SURGERIES

Date: ___________ **Procedure:** ____

___________ ____

___________ ____

___________ ____

MEDICATIONS

Med:_____________________________ **Dose:** __________________ **Prescriber:** _________________________

_____________________________ __________________ _________________________

_____________________________ __________________ _________________________

_____________________________ __________________ _________________________

ALLERGIES

Allergy to: _______________________ **Reaction:** ____

_______________________ ____

_______________________ ____

SOCIAL HISTORY

Occupation ___________________________________ Are you satisfied with your work? _________________________

Please check: ___ Single ___ Married ___ Same sex ___ Partnered ____ Widowed ___ Divorced

Partner's name: ______________________________ Years with current partner ____________

Do you smoke tobacco? ____ No ____ Yes *(if yes, please answer the following)*

If yes, how many packs per day _____ For how many years? ______

Previous tobacco use: Start date ___________ Quit date __________ Packs per day ______

Do you use any other tobacco products? ____ No ____ Yes

Do you drink alcohol? ____ No ____ Yes *(f yes, please answer the following)*

____ oz. liquor per *(circle one)* day / week / month

____ 12 oz. glasses beer per day / week / month

____ 6 oz. glasses wine per day / week / month

Have you ever used any non-prescription drugs such as: *(if yes, please indicate when last used)*

____ Marijuana ___________________________
____ LSD, STP, etc. _______________________
____ Heroin, etc. __________________________
____ Morphine, Demerol, etc. ________________
____ Barbiturates __________________________
____ Injected drug of any kind ________________

Have you ever been treated or diagnosed for anorexia or bulimia? ____ No ____ Yes

If yes, when ____

Have you ever been the victim of sexual, physical, or emotional abuse? ______________________________________

Hobbies / Activities? ____

FAMILY HISTORY

Please list any members of your family including parents, grandparents, brothers and sisters who have had significant medical problems (such as diabetes, high blood pressure, heart attack, cancer):

Relationship	Medical Problem
Maternal grandmother………………..	____________________________
Maternal grandfather ………………...	____________________________
Paternal grandmother ……………….	____________________________
Paternal grandfather …………………	____________________________
Mother …………………………………	____________________________
Father …………………………………	____________________________
Siblings: Brother / Sister *(please circle)*	____________________________
Brother / Sister	____________________________
Brother / Sister	____________________________
Children ……………………………….	____________________________

Has anyone in your immediate family or among grandparents, aunts, uncles and first cousins had any of the following diseases or problems? *(check if yes)*

____ Congenital abnormalities – i.e., any defects present at birth or any disorders which “run in the family”
____ Infertility – i.e., difficulty getting pregnant for any reason
____ Delayed puberty (didn’t shave; didn’t menstruate or develop breasts)
____ Breast, ovarian, or endometrial cancer
____ Frequent miscarriages

REVIEW OF SYSTEMS

Are you currently experiencing any of the following symptoms? *(Check if yes)*

_____ Weight change
_____ Fatigue
_____ Change in vision
_____ Difficulty swallowing
_____ Chest pain
_____ Racing or irregular heartbeat
_____ Fainting or blackout spells
_____ Shortness of breath
_____ Snoring
_____ Nausea
_____ Constipation
_____ Diarrhea
_____ Vomiting
_____ Urinary incontinence
_____ Vaginal discharge
_____ Vaginal odor
_____ Vaginal itching or irritation
_____ Pain with intercourse
_____ Irregular menstrual periods
_____ Heavy menstrual periods
_____ Neck or back pain
_____ Muscle aches or cramps
_____ Joint pain
_____ Acne
_____ Rash or skin lesion
_____ Headaches
_____ Numbness or tingling
_____ Dizziness
_____ Thoughts of Suicide
_____ Anxiety / Excessive worrying
_____ Depression
_____ Feeling excessive cold or warmth
_____ Unwanted hair growth
_____ Discharge from nipples
_____ Excessive bleeding or bruising
_____ Runny nose
_____ Sore throat
_____ Cough
_____ Pain. Location ______________________
_____ Other ______________________________