Women's Care

Physicians and Surgeons

Male 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 <u>each</u> 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
Women's Care
590 Country Club Pkwy, Suite A
Eugene, Oregon 97401
(541) 683-1559

••• MALE QUESTIONNAIRE.•••

INSTRUCTIONS: Please read the following carefully. Answer this questionnaire honestly and to the best of your ability. Your answers provide a database upon which your doctors will depend in providing your care. Seemingly unimportant facts may have great value.

We will review this questionnaire with you. If for any reason you have any problem in answering or any objection to answering any specific portion of this questionnaire, talk to us in private and explain the situation. Make a mark on the section to remind you to discuss it with us. This confidential questionnaire, as part of your case history, will be held in the strictest confidence according to the ethics of the medical profession.

Name: _____ Preferred name: _____ Date of Birth: _____ Age: ___ Today's Date: _____

Who is your primary care Physician? _____

Who referred you to our care? _____

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

_____

SEXUAL, FERTILITY HISTORY

How long have you been with your current partner? _____

How often do you have sexual intercourse? ____ Times per day / week / month *(please circle one)*

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

Have you ever had any problems with any methods of contraception?

____ No ____ Yes *(please explain)* _____

Have you attempted pregnancy with past partners? ____ No ____ Yes
Any pregnancy? ____ No ____ Yes *(list below)*
_____

Did you use contraception? ____ No ____ Yes Years used _____ to _____
Type of contraception: _____

Have you ever had a semen analysis? ____ No ____ Yes
If yes, date _____ Result _____

Have you ever had any treatment for infertility, low sperm count, or related problems?
____ No ____ Yes *(list dates, name of doctor/clinic and any treatments)*
_____
_____

Have you ever worked with or been exposed to solvents, chemicals, or radiation in your work or hobbies? (including military) ____ No ____ Yes *(explain)* _____

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

____ Trouble getting an erection _____
____ Trouble maintaining an erection for intercourse _____
____ Ejaculation (coming) before insertion _____
____ Unable to ejaculate during intercourse _____
____ "Wet dreams" more often than one per week _____
____ Blood in the seminal fluid (ejaculate) _____
____ Painful ejaculation _____
____ Any other related problem _____

Have you ever had any penile or testicular trauma or surgery? ____ No ____ Yes
If yes, date _____ Injury sustained or surgery done _____

CHILDHOOD: As a child, did you have any of the following problems? *(Check if yes, explain/give dates/age to right)*

____ Mumps _____
____ Epilepsy, fits or fainting spells _____
____ Any serious illness requiring doctor's care _____
_____
____Hernia (rupture) _____
____ Undescended testicle(s) at any age _____
____ Urinary tract infection _____
____ Bed wetting _____
____ Emotional problems requiring doctor's care _____

Compared to your friends and classmates, when did you note maturational changes in:

Pubic hair	___ Early	___ About the same age	___ Late
Axillary (armpit) hair	___ Early	___ About the same age	___ Late
Penis and testes enlargement	___ Early	___ About the same age	___ Late
Voice change	___ Early	___ About the same age	___ Late
Shaving	___ Early	___ About the same age	___ Late

GENITO-URINARY

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

____ Gonorrhea (clap, GC) _____
____ Blood in urine _____
____ Burning or stinging on urination _____
____ Discharge from penis (urethra) _____
____ Infection of bladder, kidney, or prostate _____
____ Trouble starting to urinate _____
____ Swelling of scrotum or testis from any cause _____
____ Catheterization of bladder (tube inserted to remove urine) _____
____ Sounding of urethra (instrument in urethra or penis) _____
____ Do you usually have to get up from sleep to urinate? How many times at night? _____

Have you ever taken any of these medications? *(check if yes)*

____ Viagra, Cialis, or Levitra
____ Chemotherapy
____ Blood pressure medication
____ Psychotherapeutic medication (antidepressant, antipsychotic)
____ Hormone therapy
  ____ testosterone
  ____ anabolic steroids
  ____ other hormones

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? ____ Yes ____ No

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

Partner's name: _____ Years with current partner _____

Are you satisfied with your 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 *(if 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? _____

Are you currently under stress? _____

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)*

____ Thyroid disease of any type
____ 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

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
____ Neck or back pain
____ Muscle aches or cramps
____ Joint pain
____ Rash or skin lesion
____ Headaches
____ Numbness or tingling
____ Dizziness
____ Thoughts of Suicide
____ Anxiety / Excessive worrying
____ Depression
____ Feeling excessive cold or warmth
____ Excessive bleeding or bruising
____ Runny nose
____ Sore throat
____ Cough
____ Pain. Location _____
____ Other _____