INVITRO FERTILIZATION
HYPOTHYROIDISM
HORMONAL IMBALANCE
OVARIANREJUVENATION

# HUGH D. MELNICK,M.D.

1625 THIRD AVENUE NEW YORK N.Y. 10128 TEL212-369-8700 FAX 212-722-5587
FOR APPOINTMENTS: AFSAPPOINTMENTS@GMAIL.COM FOR INFORMATION: AFSIVF1625@AOL.COM

## PATIENT INFORMATION SHEET ☐ INFERTILITY ☐ GYN ☐ THYROID ☐ HORMONAL _____

(Please print)

**PATIENT CODE:**_____ **DATE:**_____

## PATIENT INFORMATON (Please print)

NAME:_____ D.O.B_____ S.S.#_____
LAST FIRST MI

ADDRESS: _____APT#_____CITY:_____STATE:_____ZIP:_____

TELEPHONE: HOME:_____ WORK:_____ MARTIAL STATUS:

OCCUPATION:_____ EMPLOYER:

E-MAIL:_____

## PARTNER INFORMATION: IF APPLICABLE - (Please print)

NAME:_____ D.O.B_____ S.S.#____
LAST FIRST MI

TELEPHONE: HOME:_____ WORK:_____

OCCUPATION:_____ EMPLOYER:

## INSURANCE INFORMATION: THIS SECTION MUST BE COMPLETED - (Please print by the star * )

*PRIMARY CARRIER: _____ ADDRESS: _____

*ID/CERTIFICATE #: _____*GROUP/CONTRACT #:_____

*SUBSCRIBER:_____ DATE OF BIRTH: -SELF ☐ SPOUSE ☐ OTHER ☐

SECONDARY CARRIER: _____ ADDRESS: _____

*ID/CERTIFICATE #: _____*GROUP/CONTRACT #:_____

*SUBSCRIBER:_____ DATE OF BIRTH: —— ☐ SELF ☐ SPOUSE ☐ OTHER

## EMERGENCY CONTACT INFORMATION: *THIS SECTION MUST BE COMPLETED-* (Please print)

IN CASE OF EMERGENCY, PLEASE NOTIFY:_____

RELATIONSHIP:_____TELEPHONE #: _____

**REFERRED BY**

PRIMARY CARE PHYSICIAN/OB GYN:_____TELEPHONE # :
ADDRESS:_____

I authorize the release of any medical or other information necessary to process any claims. I hereby agree to be financially responsible for payment of all medical services rendered to me or my family members and for fees which are not paid for by my insurance company. Should I default in payment and an attorney is needed to collect my outstanding balance, I will be responsible for not only my past due balance, but also all costs of collection. These costs may include interest and legal fees.

X_____ _____

Patient Signature or Authorized Signature Date

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## PATIENT'S MEDICAL QUESTIONNAIRE

(PLEASE FILL ALL PAGES TO THE BEST OF YOUR ABILITY)

NAME:_____ DATE OF VISIT:_____
LAST FIRST

HEIGHT:_____ (FT) WEIGHT:_____ (LBS) D.O.B_____ AGE:_____

PAST/ CURRENT MEDICAL HISTORY

1. MEDICAL HISTORY: PLEASE INDICATE YES OR NO FOR THE FOLLOWING OPTIONS
   - DIABETES _____
   - HIGH BLOOD PRESSURE _____
   - CHOLESTEROL _____
   - HEART CONDITION _____
   - THYROID PROBLEMS _____
   - BREAST CANCER OR A LUMP _____
   - URINARY PROBLEMS (PAJN OR FREQUENCY) _____
   - IF NOT LISTED PLEASE INDICATE BELOW:

_____

_____

2. CURRENT MEDICATION(S):_____
3. A. PAST MEDICATION(S):_____

   B. ALLERGIES TO MEDICATION(S):_____
3. SURGICAL HISTORY: _____
4. GYNECOLOGICAL HISTORY: IF NOT APPLICABLE PLEASE NOTE *NIA.*

   A. PERVIOUS PREGNANCY/PREGNANCIES:

   LIVE BIRTH(S):_____ STILLBIRTH(S): MISCARRIAGE(S)_____ MISCARRIAGE (S)

   AFTER 10 WEEKS:_____ EARLY BIRTH(S):_____ ECTOPIC PREGNANCY:_____

   B. PREVIOUS FERTILITY TESTS/TREATMENTS: EG: BLOOD WORK, SONOGRAMS, IUI OR IVF _____

   C. LAST MENSTRUAL PERIOD (LMP) -
   _____

DATE/AGE OF YOUR FIRST PERIOD(MENARCHE):

_____

DURATION OF MENSTRUAL CYCLE (IN DAYS):

_____

B. BIRTH CONTROL METHOD(S) USED: _____

C. HOW LONG HAVE YOU BEEN SEXUALLY ACTIVE WITHOUT USING ANY FORM OF BIRTH CONTROL?

_____

D. DATE OF LAST PAP SMEAR: _____

ANY ABNORMALITIES? IF SO PLEASE INDICATE: _____

E. FERTILITY: (PLEASE ANSWER IF APPLICABLE).

NUMBER OF YEARS WITH CURRENT PARTNER: _____

NUMBER OF YEARS TRYING TO CONCEIVE: _____

F. CYCLE HISTORY: IF APPLICABLE, PLEASE ANSWER TO THE BEST OF YOUR ABILITY.

HOW OFTEN DO YOU GET YOUR PERIOD? EG-EVERY 28 OR 30 DAYS. _____

HOW MANY DAYS DO YOU BLEED? EG-4-6 DAYS. _____CLOTS?_____

DO YOU HAVE PAIN WITH YOUR PERIOD?_____

ANY MEDICATIONS TAKEN FOR MENSTRUAL CRAMPING?_____

DO YOU EXPERIENCE MOOD CHANGES BEFORE YOUR PERIOD?_____

NOTES/COMMENTS

_____

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# SYMPTOM QUESTIONNAIRE

**PLEASE ANSWER ALL QUESTIONS (circle yes or no)**

| | | | **COMMENTS** |
|---|---|---|---|
| ○ | FATIGUE | YES NO | _____ |
| ○ | DEPRESSION | YES NO | _____ |
| ○ | WEIGHT GAIN | YES NO | _____ |
| ○ | DIFFICULTY LOSING WEIGHT | YES NO | _____ |
| ○ | WATER RETENTION | YES NO | _____ |
| ○ | SENSITIVITY TO COLD | YES NO | _____ |
| ○ | COLD HANDS/FEET | YES NO | _____ |
| ○ | HAIR LOSS | YES NO | _____ |
| ○ | DRY HAIR | YES NO | _____ |
| ○ | DRY SKIN | YES NO | _____ |
| ○ | BRITTLE NAILS | YES NO | _____ |
| ○ | LOW SEX DRIVE | YES NO | _____ |
| ○ | MUSCLE/ JOINT PAIN | YES NO | _____ |
| ○ | POOR MEMORY | YES NO | _____ |
| ○ | DIFFICULTY CONCENTRATING OR AADD | YES NO | _____ |
| ○ | CONSTIPATION | YES NO | _____ |
| ○ | RINGING/TICKING IN EARS | YES NO | _____ |
| ○ | TREMOR OR SHAKING | YES NO | _____ |
| ○ | PALPITATIONS/IRREGULAR | YES NO | _____ |
| ○ | HEART BEAT | YES NO | _____ |
| ○ | SWEATY | YES NO | _____ |
| ○ | NERVOUSNESS/ ANXIETY | YES NO | _____ |
| ○ | SLEEP DISTURBANCE | YES NO | _____ |
| ○ | EXCESS BODY OR FACIAL HAIR | YES NO | _____ |
| ○ | ACNE | YES NO | _____ |

NOTES/COMMENTS

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## PATIENT ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

By singning below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices.

√_____
Print Patient or Personal Representative Full Name

√_____
Signature of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority