

**NEW PATIENT DEMOGRAPHIC FORM (MALE)**  
*COMPLETE ALL INFORMATION PLEASE*

NAME: \_\_\_\_\_ PATIENT Date of Birth: \_\_\_\_\_

First MI Last

ADDRESS: \_\_\_\_\_ ANY ADDITIONAL NAME: \_\_\_\_\_

Street Address Line One

Street Address Line Two

City/Town State Zip Code +4

HOME #: (\_\_\_\_)-\_\_\_\_ - \_\_\_\_\_ WORK #: (\_\_\_\_)-\_\_\_\_ - \_\_\_\_\_ ext: \_\_\_\_\_ CELL #:(\_\_\_\_)-\_\_\_\_ - \_\_\_\_\_

EMAIL: \_\_\_\_\_ @ \_\_\_\_\_ FAX: (\_\_\_\_)-\_\_\_\_ - \_\_\_\_\_

OK TO SEND MEDICAL RECORDS BY EMAIL? ( Y / N )

SS #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ RELIGION: \_\_\_\_\_

NEXT OF KIN / EMERGENCY CONTACT: \_\_\_\_\_

TELEPHONE: (\_\_\_\_)-\_\_\_\_ - \_\_\_\_\_ WORK: (\_\_\_\_)-\_\_\_\_ - \_\_\_\_\_ ext: \_\_\_\_\_

REFERRING PROVIDER NAME: \_\_\_\_\_

REFERRING PROVIDER ADDRESS: \_\_\_\_\_

Street Address Line One

Street Address Line Two

City/Town State Zip Code +4

TELEPHONE: (\_\_\_\_)-\_\_\_\_ - \_\_\_\_\_ FAX: (\_\_\_\_)-\_\_\_\_ - \_\_\_\_\_

EMAIL: \_\_\_\_\_ @ \_\_\_\_\_

PRIMARY PROVIDER NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

Street Address Line One

Street Address Line Two

City/Town State Zip Code +4

TELEPHONE: (\_\_\_\_)-\_\_\_\_ - \_\_\_\_\_ FAX: (\_\_\_\_)-\_\_\_\_ - \_\_\_\_\_

EMAIL: \_\_\_\_\_ @ \_\_\_\_\_

PREFERRED PHARMACY NAME: \_\_\_\_\_

PREFERRED PHARMACY ADDRESS: \_\_\_\_\_

Street Address Line One

Street Address Line Two

City/Town

State

Zip Code

+4

TELEPHONE: (\_\_\_\_)-\_\_\_\_ - \_\_\_\_\_ FAX: (\_\_\_\_)-\_\_\_\_ - \_\_\_\_\_

PRIMARY INSURANCE NAME: \_\_\_\_\_

PRIMARY INSURANCE ADDRESS: \_\_\_\_\_

Street Address Line One

Street Address Line Two

City/Town

State

Zip Code

+4

TELEPHONE: (\_\_\_\_)-\_\_\_\_ - \_\_\_\_\_ FAX: (\_\_\_\_)-\_\_\_\_ - \_\_\_\_\_

EMAIL: \_\_\_\_\_ @ \_\_\_\_\_

NAME OF POLICY HOLDER: \_\_\_\_\_

SS #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_

POLICY #: \_\_\_\_\_ GROUP #: \_\_\_\_\_ COPAY \$ \_\_\_\_\_

EMPLOYER NAME: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_

Street Address Line One

Street Address Line Two

City/Town

State

Zip Code

+4

TELEPHONE: (\_\_\_\_)-\_\_\_\_ - \_\_\_\_\_ FAX: (\_\_\_\_)-\_\_\_\_ - \_\_\_\_\_

EMAIL: \_\_\_\_\_ @ \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Occupation: \_\_\_\_\_ Height: \_\_\_\_\_ ins. Weight: \_\_\_\_\_ lbs.

Partner's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Are you married? \_\_\_\_\_ Race: \_\_\_\_\_

Why are you coming to see us? (check all that apply):

Infertility  Recurrent miscarriage  Assisted Reproduction (IVF, GIFT, et cetera)

Other (please specify): \_\_\_\_\_

In your words, what is the main reason that you are seeking consultation in our practice?

\_\_\_\_\_

PLEASE NOTE: Insurance companies often require that consultative letters be provided to referring practitioners. In addition, we feel that it is ideal if all of your healthcare practitioners are aware of your total medical picture. It is our practice to routinely provide you, as well as your other healthcare providers with copies of your consultation letters.

Name, address, telephone and fax numbers of your other providers:

1. \_\_\_\_\_ Specialty: \_\_\_\_\_

Telephone: ( ) FAX: ( )

2. \_\_\_\_\_ Specialty: \_\_\_\_\_

Telephone: ( ) FAX: ( )

3. \_\_\_\_\_ Specialty: \_\_\_\_\_

Telephone: ( ) FAX: ( )

How did you hear about our practice (check all that apply)?

Referral from your provider, Name: \_\_\_\_\_

Referral from a friend/relative/acquaintance, Name: \_\_\_\_\_

Yellow Pages  Radio Ad  Newspaper Ad  Internet Search Engine

IntegraMed Website  Insurance Company

PLEASE COMPLETE: I hereby give Albany IVF permission to release copies of my consultative letters and laboratory results as appropriate to the practitioners listed above and/or on my registration sheets.

\_\_\_\_\_  
Patient Signature Date

**PERSONAL ENDOCRINE/FERTILITY HEALTH APPRAISAL INTAKE FORM--MALE:**

Have you achieved pregnancy with your your current partner?  YES  NO  
How long (total time) have you had unprotected intercourse? \_\_\_\_\_ YEARS \_\_\_\_\_ MONTHS

Do you have any allergies to medicines or other substances?  YES  NO  
(i.e., environmental, latex)

If yes, please list medication or substance, when taken last, and response (if unsure, state unsure):

\_\_\_\_\_

Are you currently taking any medications (including pain medications, Tylenol, aspirin, vitamins, herbal/naturopathic medicines)?  YES  NO If yes, please list:

Medication	Reason for Taking	Prescribing Practitioner

**A. LIFESTYLE**

Marital status: Married \_\_\_\_\_ yrs. Single \_\_\_\_\_ Divorced \_\_\_\_\_ Plan Marriage \_\_\_\_\_  
Separated \_\_\_\_\_ Widowed \_\_\_\_\_ Cohabiting \_\_\_\_\_

Do you smoke cigarettes?  YES  NO  
If yes, how many packs per day? \_\_\_\_\_

Do you have any dietary restrictions?  YES  NO  
If yes, please specify: \_\_\_\_\_

Do you eat a special diet?  NO  YES  
If yes, please specify... \_\_\_\_\_

Do you ever crave non-food items (i.e., starch, clay, dirt)?  NO  YES

Do you vomit more than once per month?  NO  YES

Have you ever suffered from bulimia?  NO  YES

Have you ever suffered from anorexia?  NO  YES

Have you had a recent change in weight?  NO  YES  
Gain or Loss of weight (circle): GAIN / LOSS

Was the weight change voluntary?  NO  YES

Do you know your average daily caloric intake?  NO  YES

Have you ever seen a nutritionist or similar provider?  NO  YES

Do you exercise regularly?  NO  YES  
How often? (i.e., 1x/day; 3x/wk) \_\_\_\_\_

Type of exercise? \_\_\_\_\_

Do you know how many calories you burn during each workout?  NO  YES

If yes, how many, approximately? \_\_\_\_\_

Do you drink alcohol?  NO  YES

If yes, how many drinks? \_\_\_/d \_\_\_ /wk \_\_\_ /month

Ever experience DWI/DWAI?  NO  YES

Ever experience blackouts?  NO  YES

How much caffeine do you consume, in an average day? 4 oz of coffee

Coffee, # ounces: \_\_\_\_\_

Tea, # ounces: \_\_\_\_\_

Caffeinated soda, # ounces: \_\_\_\_\_

Have you ever used recreational drugs?  NO  YES

(Circle: marijuana / cocaine / crack / speed / Ecstasy)

If yes, last time used...\_\_\_\_\_

Do you work with radiation or X-Rays?  NO  YES

Are you exposed to organic solvents regularly?  NO  YES

If yes, specify...\_\_\_\_\_

**B. REPRODUCTIVE HISTORY:** (Please list all pregnancies you have fathered including abortions & miscarriages)

Year	Infertility treatment needed to conceive? (if yes, type)	How Long To Conceive?	Did current Partner mother the pregnancy?	Full-term, premature? Miscarriage/ Abortion?	Mode of Delivery (C-sec/vag'l)
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

History of your mother receiving DES (a drug to stop miscarriages) when she was pregnant with you?  NO  YES

Have you had any of the following?  
 One or more stillborn infants?  NO  YES  
 One or more neonatal deaths? (baby died before 1 month old)?  NO  YES  
 One or more infants requiring a stay in an intensive care nursery?  NO  YES

**C. GENERAL UROLOGIC AND SEXUAL HISTORY**

Number of sex partners within the last 10 yrs \_\_\_\_\_ 2 yrs \_\_\_\_\_

Have you or any of your sexual partners had:

	Year	Treatment
Gonorrhea: <input type="checkbox"/> Self <input type="checkbox"/> Sexual Partner	Details: (Year / Treatment): _____	
Chlamydia: <input type="checkbox"/> Self <input type="checkbox"/> Sexual Partner	Details: (Year / Treatment): _____	
HPV (Warts): <input type="checkbox"/> Self <input type="checkbox"/> Sexual Partner	Details: (Year / Treatment): _____	
Herpes: <input type="checkbox"/> Self <input type="checkbox"/> Sexual Partner	Details: (Year / Treatment): _____	
Syphilis: <input type="checkbox"/> Self <input type="checkbox"/> Sexual Partner	Details: (Year / Treatment): _____	
Urethritis: <input type="checkbox"/> Self <input type="checkbox"/> Sexual Partner	Details: (Year / Treatment): _____	
Hepatitis: <input type="checkbox"/> Self <input type="checkbox"/> Sexual Partner	Details: (Year / Treatment): _____	

Have you ever been physically abused/assaulted?  NO  YES  
 If yes, did you receive supportive counseling?  NO  YES  
 If no, would you like us to assist you in finding counseling?  NO  YES

Are you satisfied with your level of sexual desire or libido? NO YES  
 If no, would you like us to assist you in improving this area of your life? NO YES  
 Are you satisfied with the quantity and quality of your sex life? NO YES

If no, what have you done to address this? \_\_\_\_\_

If no, would you be interested in getting information about sex therapy?  
NO YES

My sexual orientation is: heterosexual homosexual bisexual  
 Are you comfortable with your sexual orientation/practice? NO YES  
 Any problems with erections? If yes, give details: NO YES

Any problems with ejaculation (ex, premature ejaculation)? NO YES If yes, give details:

Any other problems with intercourse? NO YES If yes, give details:

Do you use a lubricant (circle): Never Sometimes Always  
 If yes, what type: \_\_\_\_\_

How often do you and your partner engage in sexual relations (# of times) \_\_\_\_\_/week \_\_\_\_\_/month

Do you experience intravaginal orgasm without difficulty? NO YES

Would you have any difficulty collecting a semen sample by masturbation? NO YES

**D. SURGICAL HISTORY**--Please list all surgeries in order (attach a separate sheet if needed)

Date	Surgery type	Physician	Hospital	Diagnosis
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**E. PERSONAL MEDICAL HISTORY**

Have you ever had a blood transfusion? NO YES  
 If yes, when? \_\_\_\_\_

Do you know your bloodtype and Rh Factor? NO YES  
 If yes, what is it? \_\_\_\_\_

Do you have: If yes, give details:

High Blood Pressure  NO  YES \_\_\_\_\_

Frequent Headaches  NO  YES \_\_\_\_\_

Heart Disease  NO  YES \_\_\_\_\_

Diabetes  NO  YES \_\_\_\_\_

Birth Defects  NO  YES \_\_\_\_\_

Mental Retardation  NO  YES \_\_\_\_\_

Mental Illness  NO  YES \_\_\_\_\_

Depression/Anxiety  NO  YES \_\_\_\_\_

Alcohol/Drug Abuse  NO  YES \_\_\_\_\_

Prostatic Cancer  NO  YES \_\_\_\_\_

Testicular Cancer  NO  YES \_\_\_\_\_

Bowel Cancer  NO  YES \_\_\_\_\_

Thyroid Disease  NO  YES \_\_\_\_\_

Other Autoimmune  NO  YES \_\_\_\_\_

Obesity  NO  YES \_\_\_\_\_

Other cancers (list): \_\_\_\_\_

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Have you ever been tested as a carrier of: If yes, give details:

Tay-Sachs Disease  NO  YES \_\_\_\_\_

Sickle-Cell Disease  NO  YES \_\_\_\_\_

Cystic Fibrosis  NO  YES \_\_\_\_\_

Thalassemia  NO  YES \_\_\_\_\_

Muscular Dystrophy  NO  YES \_\_\_\_\_

HIV (AIDS)  NO  YES \_\_\_\_\_

**F. FAMILY HISTORY:**

Are there any known genetic diseases or conditions that run in your family? NO YES

If yes, please list: \_\_\_\_\_

Does anyone in your family have: If yes, give details including, who:

High Blood Pressure  NO  YES \_\_\_\_\_

Frequent Headaches  NO  YES \_\_\_\_\_

Heart Disease  NO  YES \_\_\_\_\_

Diabetes  NO  YES \_\_\_\_\_

Birth Defects  NO  YES \_\_\_\_\_

Mental Retardation  NO  YES \_\_\_\_\_

Mental Illness  NO  YES \_\_\_\_\_

Depression/Anxiety  NO  YES \_\_\_\_\_

Alcohol/Drug Abuse  NO  YES \_\_\_\_\_

Prostatic Cancer  NO  YES \_\_\_\_\_

Testicular Cancer  NO  YES \_\_\_\_\_

Bowel Cancer  NO  YES \_\_\_\_\_

Thyroid Disease  NO  YES \_\_\_\_\_

Other Autoimmune  NO  YES \_\_\_\_\_

Obesity  NO  YES \_\_\_\_\_

Other cancers (list): \_\_\_\_\_



**H. PREVIOUS FERTILITY THERAPY** *(if applicable)*

Have you ever taken clomiphene citrate therapy? NO YES  
If yes, when taken last, and at what dosage?

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Have you ever taken injectable fertility drugs? NO YES  
If yes, when taken last, and at what dosage and what drugs?

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Have you ever undergone assisted reproduction, such as IVF, GIFT/ZIFT/TET, or undergone therapy using  
donated sperm or eggs? NO YES  
If yes, what, when, where, and what was the outcome?

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