



# Carolina Conceptions

2601 Lake Drive

Suite 301

Raleigh, NC 27607

www.carolinaconceptions.com

Dr. Grace Couchman, Reproductive Endocrinologist

Dr. William Meyer, Reproductive Endocrinologist

Dr. John Park, Reproductive Endocrinologist

Date \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yy)

\_\_\_\_ Dr. Couchman \_\_\_\_ Dr. Meyer \_\_\_\_ Dr. Park

Patient ID # \_\_\_\_\_

## PATIENT INFORMATION

Patient Name: PRINT (First/MI/ Last)

Name you prefer to be called:

Partner or Spouse Name: (First/MI/Last)

Married\_\_ Divorced\_\_ Other\_\_

Street Address (of person filling out this form):

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone:(h) \_\_\_\_\_ (w) \_\_\_\_\_ (mobile/cell) \_\_\_\_\_

May we leave messages for you on the numbers listed above? Yes\_ or NO\_ If NO, please check \_\_\_(h) \_\_\_(w) \_\_\_(m/c)

EMAIL:

Date of Birth: (mm/dd/yy) \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Occupation:

If you have children, Please list their ages:

Your local pharmacy: \_\_\_\_\_ Pharmacy phone # : \_\_\_\_\_

### How Did You Hear About Us? (Please put an "x" by one and provide additional information):

Internet \_\_\_\_\_ when I searched for \_\_\_\_\_.  
 Friend \_\_\_\_\_ Friends Name \_\_\_\_\_ Radio \_\_\_\_\_ Print Ad \_\_\_\_\_ Other \_\_\_\_\_.  
 By Referral \_\_\_\_\_ Name of Referring Physician/Practice: \_\_\_\_\_.  
 Physician Phone # : \_\_\_\_\_ Fax#: \_\_\_\_\_.

### Insurance Information:

Policy Holder's Name \_\_\_\_\_ Sex: \_\_\_\_ Male \_\_\_\_ Female

Is the contact information for the Policy Holder same as the Patient contact information above? \_\_Y \_\_N  
 (if the answer is "no", please fill out Policy Holder Contact Information below)

Relationship to Patient:

Date of Birth: (mm/dd/yy) \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

### Ethnic/Racial History:

Jewish \_\_\_\_\_ Black/African American \_\_\_\_ Asian \_\_\_\_\_ Caucasian \_\_\_\_\_ American Indian \_\_\_\_\_

French-Canadian \_\_\_\_\_ Mediterranean ( Greek, Italian, Other) \_\_\_\_\_

( PLACE SCAN LABEL HERE )

Patient Name: \_\_\_\_\_

ID# \_\_\_\_\_

**Family History of Birth or Genetic Defects:**

Club Foot	Yes	No	Cleft Palate	Yes	No
Deafness	Yes	No	Blindness	Yes	No
Heart Defect	Yes	No	Down Syndrome	Yes	No
Open spine (spina Bifida)	Yes	No	Mental Retardation	Yes	No
			Other _____		

**Background Information:**

Have you or your partner undergone testing to rule out carrier status of Cystic Fibrosis? \_\_\_Yes \_\_\_No

Have you ever seen another fertility specialist? \_\_\_ Yes \_\_\_ No

Reason for Today's Visit: Infertility\_\_\_ Miscarriage \_\_\_ Donor Sperm/Egg\_\_\_ Other\_\_\_\_\_

**Pregnancies (include miscarriages, ectopic pregnancy, abortions and still births)**

Date: \_\_\_\_\_ Type and duration: \_\_\_\_\_ Father: \_\_\_\_\_ Prior or Current Partner: \_\_\_\_\_

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Previous Gyn Surgery (Laparoscopy, Hysteroscopy, Myomectomy, Leep, Freezing of Cervix)**

Date: \_\_\_\_\_ Type: \_\_\_\_\_ Physician: \_\_\_\_\_ Findings: \_\_\_\_\_

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Your Medical History:**

*Allergic to:*

Medication(s) \_\_\_\_\_ Reaction(s) \_\_\_\_\_

Environmental \_\_\_\_\_ Reaction(s) \_\_\_\_\_

Current medications/ dosage: \_\_\_\_\_

Current medical conditions: \_\_\_\_\_

Smoke? Yes \_\_\_ No \_\_\_, if so how much \_\_\_\_\_ how long \_\_\_\_\_

Prior Smoker? Yes \_\_\_ No \_\_\_, if so how much \_\_\_\_\_ how long \_\_\_\_\_

*Fertility Medication:*

Current: \_\_\_\_\_ Dates: \_\_\_\_\_

Prior: \_\_\_\_\_

Age at first menstrual period \_\_\_\_\_ How many days in cycle \_\_\_\_\_ Days Flow \_\_\_\_\_

Painful periods? \_\_\_Yes \_\_\_No Please rate pain on a scale of 1-10; 1=No pain, 10=severe pain: \_\_\_\_\_

Dates of last three periods: \_\_\_\_\_

**If you've had any of the following test, please provide date and results if possible:**

	Date	Results:
Sperm count	_____	_____
HSG (Hysterosalpingogram)	_____	_____
TSH, Prolactin	_____	_____
Progesterone	_____	_____
Day 3 FSH, Estradiol, AMH	_____	_____

( PLACE SCAN LABEL HERE )

Patient Name: \_\_\_\_\_

ID# \_\_\_\_\_

**Your Medical History, continued:**

**Previous Treatments:**

	Number of Cycles:	Location	Dates
Clomid/Timed intercourse (Coitus)	_____	_____	_____
Clomid/insemination (IUI)	_____	_____	_____
Letrozole (Femara)/ Coitus	_____	_____	_____
Letrozole (Femara)/ IUI	_____	_____	_____
Injectable/IUI	_____	_____	_____
IVF/ICSI	_____	_____	_____

**Questions and Concerns:**

1. What is the question you are primarily hoping to answer today? \_\_\_\_\_

\_\_\_\_\_

2. Are you confused about any specific infertility treatments that you have read about or experienced yourself? \_\_\_\_\_

\_\_\_\_\_

3. Other? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

( PLACE SCAN LABEL HERE )