



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: (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 ever seen another fertility Urologist? ___ Yes ___ No

If "yes", Physician's name _____ Date seen _____

Reason for Today's Visit: Infertility ___ Miscarriage ___ Donor Sperm/Egg ___ Other _____

Previous Urogenital Surgery (e.g. Varicocele repair, hernia etc..)

Date: _____ Type: _____ Physician: _____ Findings: _____

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

Your Medical History:

Allergies:

Medication (s) _____ Reaction (s) _____

Environmental _____ Reaction (s) _____

List your medications: _____

Smoke? Yes ___ No ___, if so how much _____ how long _____

Prior Smoker? Yes ___ No ___, if so how much _____ how long _____

Prior Semen Analysis:

	DATE _____	DATE _____	DATE _____
Volume	_____	_____	_____
Concentration	_____	_____	_____
Motility (%)	_____	_____	_____
Morphology (%)	_____	_____	_____

(PLACE SCAN LABEL HERE)