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Fertility & Reproductive Medicine Center

New Patient Packet | Welcome & Forms

Please click on the blue fields to fill out electronically.
Once you complete, please print and sign where signatures are needed.

Please complete and send in this material as soon as possible.

Please see *our website* for additional forms

fertility.wustl.edu

Please FAX pages **all filled out pages** for all individuals involved to the attention of your physician at **314-286-2455** prior to your appointment.
A fax cover sheet is included at the end of this packet.

Thank you

**Clinical services in Illinois provided by Washington University Physicians in Illinois, inc.*

Fertility & Reproductive Medicine Center

314-286-2400
Exchange 314-627-9848

Dear Patient,

Welcome to the Fertility & Reproductive Medicine Center at Washington University.
Deciding it's time to have a baby is an exciting and life-changing decision. But when pregnancy doesn't happen according to your plan, it can quickly become a frustrating and emotionally challenging experience. Dealing with infertility can feel very lonely. But it's important to realize that you're not alone. The specialists at the Fertility & Reproductive Medicine Center understand the challenges of infertility and are here to help.

All of our doctors are board-certified in both Obstetrics/Gynecology and Reproductive Endocrinology and Infertility. Our expertise and the extensive resources of Washington University School of Medicine enable us to offer the most effective procedures and technologies in fertility treatment today. We offer more than 30 years of experience providing consistently high pregnancy success rates, honest and accurate information, and compassionate care.

Our team provides comprehensive infertility services and the full array of medical and surgical options to women and men seeking to be parents. We are invested in our patients and focus on what you want most – consistently high success rates, honest accurate information and care from people who understand what you are experiencing – all in an attractive and accessible office setting.

Please feel free to reach out with any questions you may have. We are here for you.

Sincerely,

Randall Odem, MD

Valerie Ratts, MD

Patricia Jimenez, MD

Sarah Keller, MD

Kenan Omurtag, MD

Joan Riley, PhD, HCLD

CONTACT NUMBERS

New Patient Line (8:00 a.m. – 4:00 p.m.): **314-286-2497**

Main Number (8:00 a.m. – 4:00 p.m.): **314-286-2400** Option #3

Exchange (Urgent Care After Hours and Weekends): **314-627-9848**

Fax/FMLA Paperwork: **314-286-2455**

Billing: **314-286-2412**

LOCATIONS

CENTRAL WEST END

4444 Forest Park Ave.
Suite 3100
St. Louis, MO 63108

MISSOURI BAPTIST MEDICAL CENTER

3023 North Ballas Rd.
Building D, Suite 450
St. Louis, MO 63131

MEMORIAL EAST SHILOH, IL*

1414 Cross Street
Suite 140 B
Shiloh, IL 62269

TELEMEDICINE

Springfield, MO

AFTER HOURS

EMERGENCY CARE: If the situation is severe or life-threatening, call 911 or go immediately to the nearest emergency room/OB triage area, even if you are out of town. Call your physician or nurse practitioner within 24 hours.

URGENT CARE: If you have an urgent problem that cannot wait until our office is open, call our exchange at the number listed above. Do not call this line for appointment requests. It is our policy not to refill controlled substances (narcotics or pain medications) after business hours. Your physician may prescribe only enough medicine to treat your problem until an office visit can be scheduled. If your after-hour needs are not urgent, please call our office the following business day to schedule an appointment.

APPOINTMENTS & CO-PAYS

Please arrive 15 minutes prior to your appointment time so we can update your information. It is very important that you notify us if your address, phone number or insurance has changed since your last visit. Please understand that the physicians in this office must often handle urgent issues throughout the day. We realize that your time is valuable and we make every effort to be on schedule and return calls by the next business day. Please notify our office as soon as possible if you are unable to keep your appointment.

- If you arrive late for your appointment, you may need to be seen later in the day.
- Please present your insurance card at each appointment.
- If you have a co-pay, please be prepared to pay at time of check-in. This is a contractual agreement between you and your insurance company, and we collect at the time of service.

OUR SPECIALISTS

For patients that are undergoing in vitro fertilization, we function as a shared practice. This means that other physicians in the group may participate in your care during an IVF cycle. It is essential that there is always someone completely devoted to patients actively going through IVF and the shared physician model makes this possible. We (the physicians, the embryologists, the nurses, and all those involved in your care) meet weekly to discuss and keep current on your treatment.

**Clinical services in Illinois provided by Washington University Physicians in Illinois, inc.*

Female Medical History Questionnaire

Date: _____

PATIENT INFORMATION			
PATIENT NAME *Last:*	*First:*	*M.I.*	
Date of birth (mm/dd/yyyy):		Age:	
Occupation:			
Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed			
Home address:			
City:	State:	Zip code:	
Indicate which number to call or leave messages: ☐ Home: ☐ Work: ☐ Cell:			
Who is your Primary OB/GYN?:		Phone:	
Who is your Primary Care Physician?:		Phone:	
Reason for visit?			
How long have you been trying to conceive?			

Who referred you to us?			
☐ Physician:	☐ Patient or Friend:	☐ Website/Facebook:	☐ Insurance:

SPOUSE/PARTNER INFORMATION *(Please fill out Spouse/Partner form if applicable)*		
SPOUSE/PARTNER'S NAME: *Last:*	*First:*	☐ n/a
Date of birth (mm/dd/yyyy):	Age:	
Occupation:		
Home address: (☐ Same as above)		
City:	State:	Zip code:
Indicate which number to call or leave messages: ☐ Home: ☐ Work: ☐ Cell:		

PHARMACY INFORMATION	
Pharmacy name:	Pharmacy phone:
Pharmacy address:	
Mail order pharmacy information:	

INSURANCE INFORMATION	
INSURANCE COMPANY NAME*:*	
Policy holder's name:	Policy holder's SSN:
ID number (if different from SSN):	Group #:
Type of insurance plan: ☐ HMO ☐ PPO ☐ Medicare ☐ Medicaid ☐ Other:	
Claim mailing address:	
SECONDARY INSURANCE COMPANY NAME*:* ☐ N/A	
Policy holder's name:	Policy holder's SSN:
ID number (if different from SSN):	Group #:
Type of plan: ☐ HMO ☐ PPO ☐ Medicare ☐ Medicaid ☐ Other:	
Claim mailing address:	

Save

Reproductive & Sexual History Questionnaire

Name: _____ Date: _____

Please answer all that apply. Skip those that don't apply.

MENSTRUAL HISTORY

Menstrual cycle pattern (check all that apply):	☐ Regular periods ☐ Irregular periods ☐ Spotting before periods ☐ No periods ☐ Heavy periods ☐ Light periods ☐ Bleeding between periods
Number of days between the start of one period to the start of the next period:	days
How many days of bleeding do you have?	days
Dates of the 1st day of your last 2 menstrual periods:	/ / ; / /
Age when you had your first period:	years old
Age when you first noticed: *Breast development*:	years old *Pubic hair:* years old *Underarm hair:* years old
How many periods do you have per year?	
Do you need medication to bring on a period?	☐ Yes, what type?: ☐ No
If you do not have periods, at what age did you stop having them?	years old
Do you have severe cramping or pelvic pain with your periods?	☐ Yes: ☐ Always ☐ Sometimes ☐ Recently ☐ In the past ☐ No

PREGNANCY SUMMARY

Total # of ALL pregnancies:		Number of Miscarriages (less than 20 weeks):			
Number of Ectopic/Tubal Pregnancies:		Number of Elective Terminations (Abortions):			
Number of Full Term Deliveries:		How many were live births?		How many were stillborn?	
Number of Premature Deliveries: (less than 37 weeks)		How many were live births?		How many were stillborn?	

Any pregnancies with birth defects? ☐ Yes, explain: ☐ No

Date pregnancy ended or delivered	Months to Conception	Treatments to Conceive	Delivery Type/D&C/ Complications	Wt.	Sex	Current Partner?
					☐ Boy ☐ Girl	☐ Yes ☐ No
					☐ Boy ☐ Girl	☐ Yes ☐ No
					☐ Boy ☐ Girl	☐ Yes ☐ No
					☐ Boy ☐ Girl	☐ Yes ☐ No
					☐ Boy ☐ Girl	☐ Yes ☐ No
					☐ Boy ☐ Girl	☐ Yes ☐ No

PAP SMEAR HISTORY

When was your last pap smear?: (month/year)	/ ☐ Normal ☐ Abnormal
When was your last abnormal pap smear? (month/year)	☐ Not applicable
Have you undergone any procedures as a result of an abnormal pap smear?	☐ Yes (check all that apply) ☐ No
☐ Colposcopy ☐ Cryosurgery (Freezing) ☐ Laser treatment ☐ Conization ☐ LEEP procedure	

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BREAST SCREENING HISTORY

Have you ever had a mammogram? ☐ Yes - date: ☐ No

Mammogram results: ☐ Normal ☐ Abnormal - please explain:

Do you perform breast self exams? ☐ Yes ☐ No

SEXUAL HISTORY

How many times do you have intercourse per week? times per week ☐ None ☐ Not applicable

Have you used over-the-counter ovulation kits to time intercourse? ☐ Yes ☐ No

Do you have pain with intercourse? ☐ Yes ☐ No ☐ Loss/change in libido

Do you use lubricants (K-Y Jelly®, etc.) during intercourse? ☐ Yes - what types? ☐ No

Have you had any of the following sexually transmitted diseases or pelvic infections? *Check all that apply* ☐ No

☐ Chlamydia - date: ☐ Gonorrhea - date: ☐ Herpes - date: ☐ Genital warts/HPV - date:

☐ Syphilis - date: ☐ HIV/AIDS - date: ☐ Hepatitis - date: ☐ Other - date:

Is there a history of physical/sexual abuse? ☐ Yes (check all that apply) ☐ Physical ☐ Sexual ☐ No

If you answered yes to abuse, do you wish to discuss this? ☐ Yes ☐ No

PRIOR FERTILITY TREATMENTS *(if applicable)*

Clomiphene citrate	☐ Yes ☐ No	Number of cycles:
Letrozole	☐ Yes ☐ No	Number of cycles:
FSH injectable meds	☐ Yes ☐ No	Number of cycles:
hCG injectable med.	☐ Yes ☐ No	Number of cycles:
Intrauterine insemination	☐ Yes ☐ No	Number of cycles:
IVF	☐ Yes ☐ No	Number of cycles:

Other:

PRIOR FERTILITY EVALUATION *(if applicable)*

Urine ovulation predicator kits	☐ Yes ☐ No	☐ Normal ☐ Abnormal	Other:
TSH	☐ Yes ☐ No	☐ Normal ☐ Abnormal	
FSH blood test	☐ Yes ☐ No	☐ Normal ☐ Abnormal	
AMH level	☐ Yes ☐ No	☐ Normal ☐ Abnormal	
Semen analysis	☐ Yes ☐ No	☐ Normal ☐ Abnormal	
Hysterosalpingogram	☐ Yes ☐ No	☐ Normal ☐ Abnormal	
Pelvic ultrasound	☐ Yes ☐ No	☐ Normal ☐ Abnormal	
Sonohysterography	☐ Yes ☐ No	☐ Normal ☐ Abnormal	
Hysteroscopy	☐ Yes ☐ No	☐ Normal ☐ Abnormal	

CONTRACEPTIVE HISTORY

☐ None ☐ Condoms - dates of use: ☐ Diaphragm - dates of use: ☐ IUD - dates of use:

☐ Birth control pills - dates of use: complications? ☐ Yes ☐ No ☐ Never used birth control pills

☐ Injectable contraception (Depo-Provera®, Lunelle™, etc.) - dates of use: complications? ☐ Yes ☐ No

☐ Skin patch - dates of use: complications? ☐ Yes ☐ No ☐ Foam or Jelly

☐ Tubal sterilization procedure (tubes tied) - date (month/year) / ☐ Tubes untied - date (month/year) /

Save

Medical History Form

Date: _____

Name: _____

Please answer all that apply. Skip those that don't apply.

ALLERGIES	
Allergies to medications/drug sensitivities:	☐ None
Medication:	Reaction:
Medication:	Reaction:
Allergies to non-medicines: (latex, adhesive tape, specific food allergies, etc.)	☐ None
Allergy:	Reaction:
Allergy:	Reaction:

PATIENT'S MEDICAL HISTORY			
Heart disease	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No
Thyroid problems	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Kidney disease	☐ Yes ☐ No	Rheumatoid arthritis	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Lupus Erythematosus	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Blood clots (deep vein thrombosis/pulmonary embolus)	☐ Yes ☐ No	High blood pressure	☐ Yes ☐ No
Exposure to blood products	☐ Yes ☐ No	☐ Other medical problems:	

MEDICATION REVIEW *Include prescribed, over-the-counter drugs, folic acid or vitamins, herbal remedies or supplements, inhalers, etc.:*

Name of medication	strength/dose	Frequency taken	Reason for taking

IMMUNIZATIONS & GENETIC HISTORY:			
Have you had a rubella titer checked?	☐ Yes ☐ No	Have you had a chicken pox vaccine?	☐ Yes ☐ No
Have you had chicken pox?	☐ Yes ☐ No		

Save

SURGICAL HISTORY

Have you had any surgeries? ☐ Yes (Please list in chronological order) ☐ No

Year	Type of surgery	Reason for surgery

Did you have any problems with anesthesia? ☐ Yes - describe ☐ No

FAMILY HISTORY

Indicate, if yes	Relationship to you		Indicate, if yes	Relationship to you	
☐ Diabetes		☐ Unsure	☐ Neurologic (brain/spine)		☐ Unsure
☐ Thyroid problems		☐ Unsure	☐ High blood pressure		☐ Unsure
☐ Heart disease		☐ Unsure	☐ Glaucoma		☐ Unsure
☐ Blood clots		☐ Unsure	☐ Gallstones		☐ Unsure
☐ Obesity		☐ Unsure	☐ Hepatitis		☐ Unsure
☐ Psychiatric conditions		☐ Unsure	☐ Tuberculosis		☐ Unsure
☐ Infertility		☐ Unsure	☐ Endometriosis		☐ Unsure
☐ Menopause before age 40		☐ Unsure	☐ Genetic Disease		☐ Unsure
☐ Cystic Fibrosis		☐ Unsure	☐ Irritable Bowel Syndrome		☐ Unsure
☐ Cancer		☐ Unsure	Other:		

SOCIAL HISTORY

How many caffeinated beverages (coffee, tea, soda) do you drink per day? ☐ None

Do you smoke cigarettes? ☐ Yes - How many/day? How many years? ☐ Quit, year: ☐ No

Are you exposed to second-hand smoke? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes - ☐ Beer (# per week): ☐ Wine (# per week): ☐ Liquor (# per week): ☐ No

Do you use marijuana, cocaine, or any other similar drug? ☐ Yes - describe ☐ No

Do you exercise regularly? ☐ Yes ☐ No

How many hours of exercise per week? ☐ moderate (i.e. walking, yoga): ☐ vigorous (i.e. running):

Do you feel safe in your own home? ☐ Yes ☐ No - explain

Save

REVIEW OF SYSTEMS

General ☐ None	**Head, Eyes, Ears, Nose, & Throat** ☐ None	**Respiratory** ☐ None
☐ Recent weight changes (☐ gain ☐ loss) ☐ Anorexia/Bulimia ☐ Lack of energy ☐ Fever/Chills ☐ Other:	☐ Dizziness ☐ Loss of sense of smell ☐ Headaches ☐ Ringing ears ☐ Chronic nasal congestion ☐ Blurred vision ☐ Hearing loss/deafness ☐ Other:	☐ Shortness of breath ☐ Bronchitis ☐ Bloody cough ☐ Other:
Endocrine/Hormonal ☐ None	**Breasts** ☐ None	**Neurological Problems** ☐ None
☐ Hair loss ☐ Thyroid gland problems ☐ Rapid weight change ☐ Excessive hunger/thirst ☐ Temperature intolerance (hot flashes or feeling cold) ☐ Other:	☐ Discharge (☐ clear ☐ bloody ☐milky) ☐ Lumps ☐ Pain ☐ Cancer ☐ Abnormal mammogram ☐ Reduction ☐ Augmentation/Breast implants (☐ saline ☐ silicone) ☐ Other:	☐ Weakness/Loss of balance ☐ Seizures/Epilepsy ☐ Headaches ☐ Migraine headaches ☐ Numbness ☐ Memory loss ☐ Other:
Gastrointestinal ☐ None	**Genito-Urinary** ☐ None	**Skin/Extremities** ☐ None
☐ Nausea/Vomiting ☐ Ulcers ☐ Blood in your stools ☐ Constipation ☐ Diarrhea ☐ Change in bowel habits ☐ Colitis (ulcerative or Crohn's) ☐ Other:	☐ Bladder infections ☐ Kidney infections ☐ Vaginal infections ☐ Frequent urination ☐ Leaking urine ☐ Blood in the urine ☐ Herpes ☐ Other:	☐ Unexplained rash/inflammation ☐ Acne ☐ Skin cancer ☐ Burn injury ☐ Moles changing in appearance ☐ Excess hair growth ☐ Other:
Musculoskeletal ☐ None	**Hematologic** ☐ None	**Cardiovascular** ☐ None
☐ Unusual muscle weakness ☐ Decreased energy/stamina ☐ Other:	☐ Blood clotting disorder/Blood clot ☐ Sickle Cell Anemia ☐ Easy bruising ☐ Thrombophlebitis ☐ Swollen glands/lymph nodes ☐ Blood transfusions (dates/reasons) ☐ Other:	☐ Palpitations/Skipped beats ☐ Chest pain ☐ Heart attack ☐ Murmurs ☐ Rheumatic fever
Mental Health Problems ☐ None	**Other**	
☐ Depression ☐ Anxiety ☐ Schizophrenia ☐ Other:		

☐ All other systems negative

Patient signature Date Physician signature Date

Save

Washington University Fertility & Reproductive Medicine Center
Spouse/Partner Medical History Questionnaire

Spouse/Partner name:_____ Date of Birth: _____

PREGNANCY SUMMARY		
Have you caused a previous pregnancy? ☐ No ☐ Yes - Total # of pregnancies:		List dates:
How many years have you been attempting pregnancy?	Height:	Weight:
Have you had a prior evaluation? ☐ Yes (if yes, please answer below) ☐ No		
Prior test results:		
Prior treatment & results:		

SEXUAL HISTORY	
Do you have (or have you had) erectile difficulty?	☐ Yes ☐ No
Do you have (or have you had) ejaculatory difficulty?	☐ Yes ☐ No
Do you have (or have you had) a loss/change of libido (sex drive)?	☐ Yes ☐ No
Do you use lubricants (K-Y Jelly®, etc.) during intercourse? ☐ Yes ☐ No	If yes, list types:
Do you or have you had any of the following? ☐ Yes (check all that apply) ☐ No ☐ STDs ☐ Mumps ☐ Varicocele ☐ Undescended testes ☐ Genital surgery	

MEDICAL HISTORY			
Do you have any of the following medical problems?:			
☐ Yes ☐ No	Heart disease	☐ Yes ☐ No	Multiple sclerosis
☐ Yes ☐ No	Heart murmur	☐ Yes ☐ No	Epilepsy
☐ Yes ☐ No	Hypertension	☐ Yes ☐ No	Neurologic disease
☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Asthma or other lung/pulmonary disorder
☐ Yes ☐ No	Hepatitis		
☐ Yes ☐ No	Cancer - If yes, please indicate type & treatment:		
☐ Other (Please explain):			

SURGICAL HISTORY			
Have you had any of the following types of surgery? *If yes, please list specific procedure and date*			
Type of surgery		Specific procedure	Date
☐ Yes ☐ No	Orchidopexy (surgical repair of undescended testicle)		
☐ Yes ☐ No	Orchiectomy (surgical removal of testicle) If yes - diagnosis:		
☐ Yes ☐ No	Bladder neck surgery		
☐ Yes ☐ No	Hernia repair		
☐ Yes ☐ No	Pelvic surgery		
☐ Yes ☐ No	Scrotal surgery		
☐ Yes ☐ No	Retroperitoneal surgery (involving abdominal organs)		
☐ Yes ☐ No	Transurethral surgery		
☐ Yes ☐ No	Other:		

Save

Spouse/Partner Medical History Questionnaire

INFECTION HISTORY

Have you had any of the following types of infections? *If yes, please list how it was treated and date of treatment*

Type of infection		Treatment	Date
☐ Yes ☐ No	Gonorrhea		
☐ Yes ☐ No	Chlamydia		
☐ Yes ☐ No	Syphilis		
☐ Yes ☐ No	Herpes		
☐ Yes ☐ No	Mumps		
☐ Yes ☐ No	Viral		
☐ Yes ☐ No	Prostatitis		
☐ Yes ☐ No	Urethritis		
☐ Yes ☐ No	Cystitis (bladder infection)		
☐ Yes ☐ No	Pyelonephritis (kidney infection)		
☐ Yes ☐ No	Epididymitis/orchitis (testicle infection)		
☐ Yes ☐ No	Other:		

DISORDERS IN YOUR FAMILY

Indicate, if yes	Relationship to you		Indicate, if yes	Relationship to you	
☐ Other infertility		☐ Unsure	☐ Diabetes		☐ Unsure
☐ Heart disease		☐ Unsure	☐ Cancer		☐ Unsure

CHILDHOOD & DEVELOPMENT

Have you had testicular torsion/trauma ☐ Yes ☐ No

MEDICATION/CHEMICAL/ENVIRONMENTAL EXPOSURE

☐ Yes ☐ No	Prescription medications	*If yes, name and dosage:*
☐ Yes ☐ No	Drug Allergies	*If yes, name of drug:*
☐ Yes ☐ No	Alcohol	*If yes, how much and how often:*
☐ Yes ☐ No	Marijuana	*If yes, how much and how often:*
☐ Yes ☐ No	Other drugs	*If yes, how much and how often:*
☐ Yes ☐ No	Tobacco	*If yes, how much and how often:*
☐ Yes ☐ No	Hot tubs	
☐ Yes ☐ No	Anabolic steroids	
☐ Yes ☐ No	Have you now or have you ever used testosterone (gel, injection, patch, pills)	
☐ Yes ☐ No	Are you currently using, or have you ever used, complementary therapies to enhance fertility potential? (i.e., acupuncture, Chinese medicine, herbal remedies)	*If yes, please list:*

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Spouse/Partner Medical History Questionnaire

REVIEW OF SYSTEMS

General ☐ None	Head, Eyes, Ears, Nose, & Throat ☐ None	Respiratory ☐ None
☐ Recent weight gain or loss ☐ Weakness ☐ Lack of energy ☐ Fever/Chills ☐ Other:	☐ Dizziness ☐ Loss of sense of smell ☐ Headaches ☐ Ringing ears ☐ Chronic nasal congestion ☐ Blurred vision ☐ Hearing loss/deafness ☐ Other:	☐ Shortness of breath ☐ Asthma ☐ Bronchitis ☐ Pneumonia ☐ Tuberculosis ☐ Bloody cough ☐ Other:
Endocrine/Hormonal ☐ None	**Breasts** ☐ None	**Neurological Problems** ☐ None
☐ Diabetes ☐ Hair loss ☐ Thyroid gland problems ☐ Rapid weight gain or loss ☐ Excessive hunger/thirst ☐ Temperature intolerance (hot flashes or feeling cold) ☐ Other:	☐ Discharge (☐ clear ☐ bloody ☐milky) ☐ Lumps ☐ Pain ☐ Cancer	☐ Weakness/Loss of balance ☐ Seizures/Epilepsy ☐ Headaches ☐ Migraine headaches ☐ Numbness ☐ Memory loss ☐ Other:
Gastrointestinal ☐ None	**Genito-Urinary** ☐ None	**Skin/Extremities** ☐ None
☐ Nausea/Vomiting ☐ Ulcers ☐ Hepatitis ☐ Blood in your stools ☐ Constipation ☐ Diarrhea ☐ Irritable Bowel Syndrome ☐ Change in bowel habits ☐ Colitis (ulcerative or Crohn's) ☐ Other:	☐ Bladder infections ☐ Kidney infections ☐ Frequent urination ☐ Leaking urine ☐ Blood in the urine ☐ Herpes ☐ Other:	☐ Unexplained rash/inflammation ☐ Acne ☐ Skin cancer ☐ Burn injury ☐ Moles changing in appearance ☐ Other:
Musculoskeletal ☐ None	**Hematologic** ☐ None	**Cardiovascular** ☐ None
☐ Unusual muscle weakness ☐ Decreased energy/stamina ☐ Rheumatoid arthritis ☐ Lupus Erythematosus ☐ Myasthenia gravis ☐ Other:	☐ Blood clotting disorder/Blood clot ☐ Sickle Cell Anemia ☐ Easy bruising ☐ Thrombophlebitis ☐ Swollen glands/lymph nodes ☐ Blood transfusions (dates/reasons) ☐ Other:	☐ Palpitations/Skipped beats ☐ Chest pain ☐ Heart attack ☐ Stroke ☐ Murmurs ☐ High blood pressure ☐ Rheumatic fever ☐ Mitral valve prolapse (Need antibiotics before dental procedures?) ☐ Yes ☐ No
Mental Health Problems ☐ None	**Other**	
☐ Depression or Anxiety disorder ☐ Schizophrenia ☐ Other:		

☐ All other systems negative

Spouse/Partner signature Date Physician signature Date

updated 2/2020

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Genetic Screening Questionnaire

Fertility and Reproductive Medicine Center
Washington University Physicians and Barnes-Jewish Hospital

Patient's Name _____ Date of Birth _____

Partner's Name _____ Partner's Date of Birth _____

This questionnaire is designed to identify risk factors in your personal or family history that may impact your reproductive risks. The questions will enable us to determine whether you may benefit from additional testing or genetic counseling. All answers will be kept confidential.

Please note that no questionnaire can be comprehensive so if you have specific concerns about your/your partner's personal medical history or family history, please make your physician aware.

1. Please indicate your ancestry/ethnic origin (e.g. German, African, etc.).

   Self: _____

   Partner: _____

2. Do you or your partner have any Eastern European (Ashkenazi) Jewish ancestry?

   ☐ Self ☐ Partner ☐ Neither

3. Do you or your partner have any French-Canadian or Cajun ancestry?

   ☐ Self ☐ Partner ☐ Neither

4. Do you or your partner have any African/African-American, Asian, Caribbean, Hispanic, Mediterranean, Mennonite, Middle Eastern, or Sephardic/Mizrahi Jewish ancestry?

   ☐ Self ☐ Partner ☐ Neither

5. Have you or your partner ever had genetic testing such as carrier screening or a karyotype (chromosomes)?

   ☐ Self ☐ Partner ☐ Neither

   If yes, explain and please provide a copy of the test report(s) to our office: _____

   _____

6. Do you or your partner have a genetic condition or chromosome abnormality such as a translocation?

   ☐ Self ☐ Partner ☐ Neither

7. Have your or your partner ever had a stillbirth or more than two miscarriages together or with a different partner?

   ☐ Self ☐ Partner ☐ Neither

Fertility and Reproductive Medicine Center
4444 Forest Park Ave. Ste 3100, St. Louis, MO 63108
Phone: (314) 286-2497 • Fax: (314) 286-2455

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Genetic Screening Questionnaire

Fertility and Reproductive Medicine Center
Washington University Physicians and Barnes-Jewish Hospital

8. Are you and your partner biologically related to one another?

☐ Yes, relationship: _____ ☐ No

9. Do you, your partner, or any family member (children, parents, brothers, sisters, nieces, nephews, aunts, uncles, or grandparents) have any of the following? *If yes, please provide details and, if available, genetic test results.*

Condition	**Yes**	**No**	**Details** (affected individual, age diagnosed, etc)
Intellectual disability/developmental delay	☐	☐	
Autism	☐	☐	
Heart defect present at birth	☐	☐	
Cleft lip or palate	☐	☐	
Neural tube defect (e.g. spina bifida, anencephaly)	☐	☐	
Limb anomaly (e.g. extra/missing fingers, abnormality of arms, legs, hands, feet)	☐	☐	
Other birth defect	☐	☐	
Hearing loss or deafness diagnosed less than age 60	☐	☐	
Serious eye conditions or blindness	☐	☐	
Hemophilia or other bleeding/clotting disorder	☐	☐	
Alpha or beta thalassemia	☐	☐	
Sickle cell anemia or sickle cell trait	☐	☐	
Cystic fibrosis (CF) or CF carrier	☐	☐	
Spinal muscular atrophy (SMA)	☐	☐	
Tay-Sachs disease	☐	☐	
Polycystic kidney disease	☐	☐	
Neurofibromatosis	☐	☐	
Seizures/epilepsy	☐	☐	
Muscular dystrophy (e.g. Duchenne, myotonic) or other neuromuscular disease	☐	☐	
Dwarfism or skeletal dysplasia	☐	☐	
Huntington's disease	☐	☐	
Hereditary cancer syndrome (e.g. BRCA)	☐	☐	
Cancer diagnosed less than age 50	☐	☐	
Chromosome translocation or other chromosome condition (e.g. Down syndrome)	☐	☐	
Known carrier of a genetic condition	☐	☐	

10. Do you or your partner have concerns about any other conditions in either of your families not listed above?

☐ Yes, explain: _____ ☐ No

Fertility and Reproductive Medicine Center
4444 Forest Park Ave. Ste 3100, St. Louis, MO 63108
Phone: (314) 286-2497 • Fax: (314) 286-2455

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Washington University in St. Louis

AUTHORIZATION TO UTILIZE UNENCRYPTED EMAIL TO COMMUNICATE PROTECTED HEALTH INFORMATION

Electronic mail, or email, is a form of communication that may be utilized between you and the providers. We want to make sure you know that email communications between us are not encrypted and therefore are not secure communications. If you elect to communicate from your workplace computer, you also should be aware that your employer and its agents may have access to email communications between us. Finally, email communications may become a part of your patient medical record and be accessible to my clinical support staff as needed for our operations.

Incoming email communications will be reviewed and answered as soon as possible. If you have not heard from your provider's office with a response and are concerned that your message was not received, please call the office during regular business hours. EMAIL COMMUNICATION SHOULD NEVER BE USED IN THE CASE OF AN EMERGENCY OR FOR URGENT REQUESTS FOR INFORMATION.

This authorization may be revoked at any time and must be done in writing. It is understood that the revocation will not apply to information that has already been released based on this authorization.

Authorization is valid while in treatment relationship with any of the Washington University providers or in the event of:_____.

If you agree to the foregoing terms, please indicate your acceptance by your signature that you accept the terms and conditions outlined herein.

ACCEPTED: Signature of Individual_____Date_____

Printed Patient Name _____ DOB ____/_____/_____

Authorized E-mail of Individual _____

Department of origination of authorization_____

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Consent To Release Information

Fertility and Reproductive Medicine Center
Washington University Physicians and Barnes-Jewish Hospital

Patient

I, _____ , hereby authorize the Fertility and Reproductive Medicine Center at Washington University School of Medicine and Barnes-Jewish Hospital staff to discuss my medical treatment (including test results) as follows (*check all that apply*):

- ❑ Leave message at home
- ❑ Leave message at work
- ❑ Leave message on cell phone # _____
- ❑ Discuss medical treatment with my spouse/significant other
- ❑ Discuss medical treatment with my parent
- ❑ Discuss medical treatment with: _____

Spouse/Significant Other

I, _____ , hereby authorize the Fertility and Reproductive Medicine Center at Washington University School of Medicine and Barnes-Jewish Hospital staff to discuss my medical treatment (including test results) as follows (*check all that apply*):

- ❑ Leave message at home
- ❑ Leave message at work
- ❑ Leave message on cell phone # _____
- ❑ Discuss medical treatment with my spouse/significant other
- ❑ Discuss medical treatment with my parent
- ❑ Discuss medical treatment with: _____

I understand that it is my responsibility to inform the office if any of the above directives change.

_____ _____
Patient Name Date

_____ _____
Spouse/Significant Other Name Date

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Suite 3100, 4444 Forest Park Ave., St. Louis, MO 63108
Phone: (314) 286-2465 • Fax: (314) 286-2455

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BARNES-JEWISH Hospital BJC HealthCare | Washington University in St. Louis Physicians

NATIONAL LEADERS IN MEDICINE

AUTHORIZATION FOR MEDICAL TREATMENT AND FINANCIAL RESPONSIBILITY

ADDRESSOGRAPH

1. CONSENT

I authorize my physician and other physicians who may attend me, their assistants, including those employed by the Washington University School of Medicine (herein after referred to as "WU"), and Barnes-Jewish Hospital (herein after referred to as "Hospital"), its house staff, employees, and students to provide the medical care, tests, procedures, drugs, blood and blood products, services and supplies considered advisable by my physician. These services may include pathology, radiology, emergency services and other special services ordered by my physician(s). In consenting to treatment, I have not relied on any statements as to results. I further authorize my physician or Hospital staff to examine, use, store, and/or dispose of in any manner (except for organ donation and/or transplantation) any bones, organs, tissue, fluids or parts removed from my body.

In the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substances that are capable of transmitting disease and I am unable to consult timely with my physician prior to testing, I consent to limited testing to determine the presence, if any, of antibodies to hepatitis A, 8, and C and HIV.

2. STORAGE AND RELEASE OF INFORMATION

I consent to the electronic storage and transmission of patient health information. l hereby authorize my treating physician, WU and Hospital and its affiliates, to release by electronic means or otherwise any medical and/or billing information concerning my care, including copies of my medical records, to the following:

1. Any governmental or other entity as required by law for purposes of reporting, or for purposes of determining eligibility in government sponsored benefit programs.
2. The supplier of any blood or blood products which may be administered to me for the purposes of quality control and recipient monitoring.
3. Any continuing care, residential, or long-term care facility, or home health agency for the purposes of providing services for my care.

3. MEDICARE/TRICARE INSURANCE BENEFITS

I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize the release of medical or other information to the Medicare Program or its Intermediaries or carriers concerning this or a related claim filed by the Hospital or WU. I request that payment of authorized benefits be made on my behalf. I understand that I am responsible for the Part B deductible for each year and/or visit, the remaining co-insurance and any other non-covered personal charges.

I (or my representative) certify(ies) that I (or he/she) have read (or if the patient/representative is unable to read has had the form read to him/her) and understand(s), accepts(s) the above and further certify that I am the patient, or am duly authorized on behalf of the patient to execute such an agreement.

Save

BARNES-JEWISH Hospital BJC HealthCare | Washington University in St. Louis Physicians

NATIONAL LEADERS IN MEDICINE

AUTHORIZATION FOR MEDICAL TREATMENT AND FINANCIAL RESPONSIBILITY

ADDRESSOGRAPH

4. GUARANTEE FOR PAYMENT

In accordance with the above terms and in consideration of the services provided to the above-named patient by WU and/or the Hospital, the undersigned agrees, whether he/she signs as patient or-guarantor, to pay WU, physicians and the Hospital for all services ordered by the attending physician, or requested by the patient and/or the patient's family. If the requirements for referral, second opinion or pre-certification of care, as outlined by my insurer, benefit plan or other payer, have not been followed, the patient and/or guarantor may in some instances be personally responsible for all charges incurred.

5. ASSIGNMENT OF INSURANCE BENEFITS

In consideration of any and all medical services, care, drugs, supplies, equipment and facilities furnished by WU, all attending physicians and Hospital, I authorize direct payment to WU and/or the Hospital of all insurance benefits applicable to these medical and other services, which are now or which shall become due and payable to me. In addition, I hereby authorize payment to the Hospital of applicable insurance benefits for medical and/or surgical services rendered by physicians for whom the Hospital is authorized to bill and collect.

HIPAA - Notice of Privacy Practices Acknowledgement

I acknowledge that I have received or I have been provided the opportunity to receive a copy of the "Notice of Privacy Practice" that explains when, where, and why my confidential health information may be used or shared. I acknowledge that WU, the physicians, the nurses and other University staff may use and share my confidential health information with others in order to treat me, in order to arrange for payment of my bill and for issues that concern WU operations and responsibilities.

Initials of patient or person authorized to sign HIPAA Notice for patient. _____

Signature of patient or person authorized to consent	Date	Patient's relationship to person	
Signature of Guarantor	Date	Patient's Relationship to Guarantor	
Signature of Witness	Date		

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Fertility & Reproductive Medicine Center
4444 Forest Park Avenue, Suite 3100, St. Louis, MO 63108
314-286-2455 | 314-286-2455 | fertility.wustl.edu

fax

TO:		FROM:	
FAX:	314-286-2455	PAGES:	
PHONE:	314-286-2400	DATE:	
RE:		CC:	

☐ New Patient Paperwork ☐ Other

Comments:

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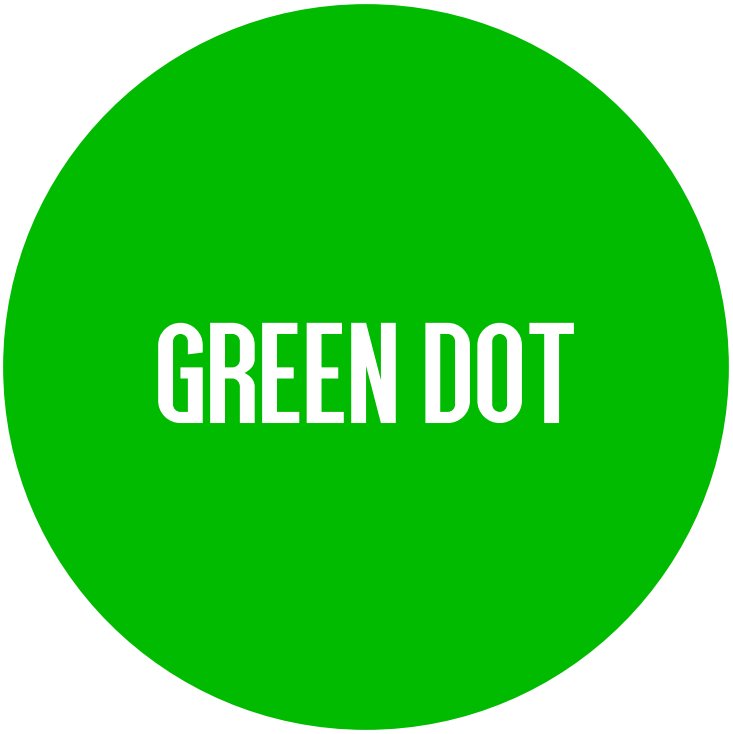
PLEASE PLACE ON DASHBOARD



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