



Package for New Patients

Thank you for choosing the New York University Fertility Center, a leader in the field of reproductive medicine. We are pleased to offer our patients a full range of treatments for both male and female infertility, as well as fertility preservation services and gynecologic care.

We ask that all patients please bring the following with you to your initial consultation:

- A copy of your medical records that relate to prior gynecologic treatment, infertility care or surgeries. The medical record information can be faxed to us from your referring physician prior to your appointment, or you can mail your medical records to us at the following address:

NYU Fertility Center
c/o <insert your physician's name>
660 First Avenue, 5th Floor
New York, NY 10016

If coming for fertility services and you have already had an hysterosalpingogram (HSG), please include the actual films and not just the report.

- Your insurance card and, if necessary, insurance referral and authorization.
- Photo ID
- Medical records that relate to fertility for your partner, if appropriate. The medical record information can be faxed to us prior to your appointment at (212) 263-7853.

Fertility and Oocyte Cryopreservation (Egg Freezing) Patients should complete:

- All documents in this package, which includes a *Notice of Privacy Practices Acknowledgement*. We ask that you please sign this only after reviewing the Notice of Privacy Practices, which will be provided to you in print when you sign in for your appointment and is also available online at:
<http://www.nyufertilitycenter.org/patients/forms>

General Gynecologic and Surgery Patients should complete:

- All documents in this package **except the Preconception Genetic Questionnaire**. We ask that you please sign the *Notice of Privacy Practices Acknowledgement* only after reviewing the Notice of Privacy Practices, which will be provided to you in print when you sign in for your appointment and is also available online at:
<http://www.nyufertilitycenter.org/patients/forms>

The NYU Fertility Center Team



Review of Systems

Patient Name: _____ **Date of Birth:** _____ **Today's Date:** _____

Please complete the following and return with your registration form. Answer yes to any current condition or condition that you have had in the past.

CONSTITUTIONAL	Yes	No	BREAST	Yes	No
Weight Change > 10lbs.	_____	_____	Masses	_____	_____
Fever	_____	_____	Breast Surgery	_____	_____
Sweats	_____	_____			
Fatigue	_____	_____			
			URINARY SYSTEM		
EYES			Urinary Tract/Bladder Infection	_____	_____
Glaucoma	_____	_____	Kidney stone(s)	_____	_____
Cataracts	_____	_____	Incontinence	_____	_____
Vision Surgery	_____	_____	Trouble urinating	_____	_____
			GENITAL		
EARS, NOSE, THROAT			Pelvic Infection	_____	_____
Loss of Hearing	_____	_____	Pelvic Surgery	_____	_____
Dizziness	_____	_____	Pelvic Pain	_____	_____
Nose Bleeding	_____	_____	Endometriosis	_____	_____
Gum Bleeding	_____	_____			
			SKIN		
RESPIRATORY			Cancer(s)	_____	_____
Chronic Cough	_____	_____	Rashes	_____	_____
Bronchitis	_____	_____			
Shortness of Breath	_____	_____	NEUROLOGIC		
Asthma	_____	_____	Stroke	_____	_____
Pneumonia	_____	_____	Seizures	_____	_____
			Head Injury	_____	_____
CARDIOVASCULAR			Nerve Damage	_____	_____
Heart Attack	_____	_____			
Chest Pain/Angina	_____	_____	PSYCHIATRIC		
Heart Murmur	_____	_____	Depression	_____	_____
Anemia	_____	_____	Anxiety	_____	_____
Transfusions	_____	_____	Substance Abuse	_____	_____
Phlebitis or Blood Clots	_____	_____			
Rheumatic Fever	_____	_____	MUSCULOSKELETAL		
Heart Surgery	_____	_____	Osteoarthritis	_____	_____
			Rheumatoid Arthritis	_____	_____
GASTROINTESTINAL			Gout	_____	_____
Reflux	_____	_____			
Hepatitis A	_____	_____			
Blood in Stools	_____	_____			
Diarrhea/Constipation	_____	_____			
Hernia/Repair	_____	_____			
Gall Bladder	_____	_____			
ENDOCRINE					
Diabetes	_____	_____			
Thyroid Problem	_____	_____			
Hormone Treatment	_____	_____			

COMMENTS:



Notice of Privacy Practices Acknowledgement

By signing below, I acknowledge that I have been provided with an online or print copy of the Notice of Privacy Practices.

Signature of Patient or Personal Representative

Print Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority



Preconception Genetic Questionnaire

Patient Name: _____ Date of Birth: _____

Partner Name: _____ Date of Birth: _____

1. Do you, your partner, or anyone in your families have any of these disorders? If yes, please indicate the relationship of the affected person to you or your partner.

Duchennes-Muscular Dystrophy	No	Yes	_____
Hemophilia	No	Yes	_____
Neural Tube Defect (Open Spine)	No	Yes	_____
Neurofibromatosis	No	Yes	_____
Marfan's Syndrome	No	Yes	_____
Polycystic Kidney Disease	No	Yes	_____
Myotonic Dystrophy	No	Yes	_____
Huntington's Disease	No	Yes	_____
Cystic Fibrosis	No	Yes	_____

2. Do you or your partner have a birth defect or familial disorder not listed above? If yes, please specify the disorder and indicate the relationship of the affected person to you or your partner: No Yes

3. Do you or your partner have a close relative with mental retardation, autism, a birth defect, Fragile X, familial disorder or a chromosome disorder such as Down Syndrome? If yes, please specify the disorder and indicate the relationship of the affected person to you or your partner: No Yes

4. In any previous marriage(s) or relationship(s), have you or your partner had a child born with a birth defect or had a pregnancy or child diagnosed with Down Syndrome? If yes, please specify the defect and indicate the relationship of the affected person to you or your partner: No Yes

5. Have you or your partner in this or any previous relationship had a stillborn child or more than two (2) first-trimester miscarriages? If yes, please provide further information: No Yes

6. Did you or your partner have carrier testing for cystic fibrosis? If yes, please indicate who was tested, the results and include a copy of report if possible: No Yes

7. Are you or your partner of Eastern European Ashkenazi Jewish, French-Canadian or Cajun ancestry? Self Partner

If Eastern European Ashkenazi Jewish, please indicate if you have been screened for:

	<i>You</i>		<i>Your Partner</i>	
Canavan Disease	No	Yes	No	Yes
Familial Dysautonomia	No	Yes	No	Yes
Metachromatic Leukodystrophy	No	Yes	No	Yes
Neimann Pick	No	Yes	No	Yes
Tay-Sachs Disease	No	Yes	No	Yes

8. Are you or your partner of African-American, Hispanic or Caribbean ancestry? Self Partner

Have you or your partner been screened for Sickle Cell trait? If yes, please indicate who was tested, the results and include a copy of the report if possible: No Yes

9. Please indicate your ancestry and the ancestry of your partner from the list below.

Mediterranean (<i>Italian, Greek, North African</i>)	Self	Partner
Asian (<i>Chinese, Indian or Pakistani</i>)	Self	Partner
Southeast Asian (<i>Taiwanese, Vietnamese, Indonesian, Philippine, Malaysian</i>)	Self	Partner
Middle Eastern (<i>Sephardic Jewish, Iranian, Turkish, Egyptian</i>)	Self	Partner
Have you or your partner been tested for Thalassemia? If yes, please indicate who was tested, the results and include a copy of the report if possible:	No	Yes

<i>I and my partner have answered the questions to the best of our knowledge. Based on our responses, my physician, Dr. _____, has recommended genetic counseling and the following testing:</i>		
	Accept	Decline
	Accept	Decline
	Accept	Decline
<i>The physician has also required a genetic consult and the following testing be performed before an In Vitro Fertilization (IVF) cycle can be initiated:</i>		
	Accept	Decline
	Accept	Decline
	Accept	Decline

Patient Signature

Date

Partner Signature

Date