



Laurel Fertility Care

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LAUREL FERTILITY CARE

Patient Bill of Rights

All patients seeking care at Laurel Fertility Care have the right to:

- 1. Accurate information as to their diagnosis and various treatment options. The guiding principle of treatment is informed consent which is interpreted to mean a full understanding, prior to treatment selection, of the efficacy, discomforts, inconveniences, risks and costs of each treatment choice.**
- 2. A second opinion regarding diagnosis and/or treatment from any other fertility center of their choice.**
- 3. Medical diagnosis and treatment that meets or exceeds the community and national standard of care.**
- 4. Courteous interactions with all Laurel Fertility Care medical, nursing and administrative staff members.**
- 5. Privacy during examinations and consultations.**
- 6. Confidentiality of all records pertaining to all aspects of their care at Laurel Fertility Care.**
- 7. A clean, safe and comfortable medical facility.**
- 8. Referral to competent specialists in other medical disciplines when necessary.**
- 9. A copy or accurate summary of their care while patients at Laurel Fertility Care, upon their written request.**
- 10. An understanding that in spite of all of the above, a successful pregnancy can not be promised or guaranteed, no matter what the clinical situation or treatment choice.**

Laurel Fertility Care Patient Information

Patient Information

Name:

Date of birth:

SSN:

e-mail:

Current address:

City:

State:

ZIP Code:

Phone(home):

(mobile):

(work):

Ok to leave message?

Ok to leave message?

Ok to leave message?

Occupation & Employer:

Marital Status(circle): Married

Single

Co-habiting

Partner Information

Name:

Date of birth:

SSN:

e-mail:

Phone(home):

(mobile):

(work):

Ok to leave message?

Ok to leave message?

Ok to leave message?

Occupation & Employer:

Emergency Contact

Name and relationship of a person not residing with you:

Address:

City:

State:

ZIP Code:

Phone:

Do you have an advance directive?:

Insurance Information

Insurance Company:

Phone:

Member(circle): Patient Other

Policy #:

Group #:

Claims Address:

City:

State:

ZIP Code:

Secondary Insurance Company:

Phone:

Member(circle): Patient Other

Policy #:

Group #:

Claims Address:

City:

State:

ZIP Code:

Preferred Pharmacy

Name:

Address(cross-street):

Phone:

Fax:

Referral to This Office(circle)

M.D. Friend Website

Other:

Specify:

I, THE UNDERSIGNED ASSIGN MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO COLLIN SMIKLE, MD. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE PAID BY INSURANCE. I FURTHER UNDERSTAND THAT ANY DELINQUENT PAYMENTS BY MYSELF, I.E., PAYMENTS NOT RECEIVED WITHIN 90 DAYS FROM THE DATE OF SERVICE, WILL ACCRUE INTEREST AT THE RATE OF 19%. I ALSO AUTHORIZE DR. COLLIN SMIKLE TO RELEASE ALL INFORMATION NECESSARY TO PROCESS MY CLAIM. BY SIGNING BELOW, I ACKNOWLEDGE MY AGREEMENT TO THESE TERMS.

Signature of Patient:

Date:



Laurel Fertility Care

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Laurel Fertility Care, a Professional Medical Corp.

Collin Smikle, MD

Lee C. Kao, MD

Marlane Angle, PhD

Phone: (415) 673-9199

Fax: (415) 673-8796

SF Address: 1700 California Street, Suite 570, San Francisco, CA 94109

Modesto Address: 1409 Briggsmore Avenue, Modesto, CA 95355

Directions to SF Office:

From the Golden Gate Bridge:

After crossing the GG Bridge, stay to the left towards Lombard Street. Exit at Lombard Street. Stay on Lombard until Van Ness Ave. Turn right onto Van Ness Ave. Make a right off of Van Ness onto California St. We are located in the building to your immediate right on the corner of Van Ness and California. The office is #1700 California St. in between Van Ness and Franklin St.

From South Bay/SFO:

Take 280/380N to 101N. Stay on the left hand lanes towards Civic Center and the Golden Gate Bridge. Exit Mission St., immediately making a right from the exit. Turn left at the signal onto Van Ness. Go a few blocks and make a left onto Hayes St. Make a right onto Franklin St. Go about 20 blocks and make a right onto California St. The office is #1700 California St. directly across from Whole Foods Market.

From the East Bay:

Cross the Bay Bridge and stay towards the right hand lane. Exit at 9th St. staying in the right hand lane. Follow the exit and turn right onto 9th street. Go about 7 blocks and stay in the left hand lane to go left at the fork in the road onto Hayes Street. Make a right onto Franklin St. Go about 20 blocks and make a right onto California St. The office is #1700 California St. directly across from Whole Foods Market.

Directions to the Modesto Office:

From 580 East:

Take I-580 East towards Stockton. Keep left to take I-205 East towards Tracy/Stockton. Merge onto I-5 North. Merge onto CA-120 East via EXIT 461 toward Manteca/Sonora. Merge onto CA-99 South toward Modesto/Fresno/Los Angeles. Take the Briggsmore Ave./Carpenter Road exit- EXIT 229. Turn LEFT onto W Briggsmore Ave./N Carpenter Rd. Continue to follow W Briggsmore Ave. to Coffee Road. Make a left turn onto Coffee Road. Turn right into the Memorial Hospital and park behind the hospital at the Gould Medical Group building

From 99 North:

From I-99 North, take the Mitchell Rd. exit. Turn slight right onto Mitchell Rd. Mitchell Rd. becomes El Vista Ave. El Vista Ave. becomes Oakdale Rd. Turn left onto East Briggsmore Ave. 1409 Briggsmore will be on your right in the Gould Medical Group building.

CONSENT FOR RELEASE OF MEDICAL INFORMATION

Date: _____

I hereby authorize Dr. _____ at

_____ (office address),

_____ (office phone and fax),

to release to *Laurel Fertility Care* my medical records including history and physical, laboratory reports, x-rays, and any other material regarding the medical consultations and treatment(s) which I have received.

Signature: _____

Name: (print): _____

Birth date: _____

Social Security Number: _____

Please send requested information to:

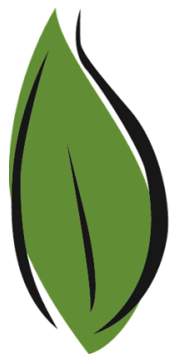
Laurel Fertility Care

1700 California Street, Suite 570, San Francisco, CA 94109

FAX: 415-673-8796

Note:

Give this completed form to your doctor to send your medical records to us.



Laurel Fertility Care
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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We are required by law to provide you with this notice that explains our privacy practices with regard to your medical information and how we may use and disclose your protected health information for treatment, payment, and for health care operations, as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information and we also describe those rights in this notice.

WAYS IN WHICH WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION:

The following paragraphs describe different ways that we use and disclose your protected health information. We have provided an example for each category, but these examples are not meant to be exhaustive. All of the ways we are permitted to use and disclose your health information fall within one of these categories.

TREATMENT. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. We will also disclose your health information to other physicians who may be treating you. Additionally we may from time to time disclose your health information to another physician whom we have requested to be involved in your care. For example – we would disclose your health information to a specialist to whom we have referred you for a diagnosis to help in your treatment.

PAYMENT. We will use and disclose your protected health information to obtain payment for the health care services we provide you. For example — we may include information with a bill to a third-party payer that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service.

HEALTH CARE OPERATIONS. We will use and disclose your protected health information to support the business activities of our practice. For example — we may use medical information about you to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. In addition, we may disclose your health information to third party business associates who perform billing, consulting, or transcription, or other services for our practice.

OTHER WAYS WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION:

APPOINTMENT REMINDERS. We will use and disclose your protected health information to contact you as a reminder about scheduled appointments or treatment.

TREATMENT ALTERNATIVES. We will use and disclose your protected health information to tell you about or recommend possible alternative treatments or options that may be of interest to you.

OTHERS INVOLVED IN YOUR CARE. We will use and disclose your protected health information to a family member, a relative, a close friend, or any other person you identify that is involved in your medical care or payment for care.

RESEARCH. We will use and disclose your protected health information to researchers, provided the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

AS REQUIRED BY LAW. We will use and disclose your protected health information when required to by federal, state, or local law.

TO AVERT A SERIOUS THREAT TO PUBLIC HEALTH OR SAFETY. We will use and disclose your protected health information to public health authorities permitted to collect or receive the information for the purpose of controlling disease, injury, or disability. If directed by that health authority, we will also disclose your health information to a foreign government agency that is collaborating with the public health authority.

WORKER'S COMPENSATION. We will use and disclose your protected health information for worker's compensation or similar programs that provide benefits for work-related injuries or illness.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of the practitioner or facility that compiled it, the information belongs to you. You have the right to:

A PAPER COPY OF THIS NOTICE. You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your next visit or by calling and asking us to mail you a copy.

INSPECT AND COPY. You have the right to inspect and copy the protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making decisions about you. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection or copying, by law. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request.

If you wish to inspect or copy your medical information, you must submit your request in writing to our Privacy Officer: Attention: Privacy Officer, Laurel Fertility Care, 1700 California Street, Suite 570, San Francisco, CA, 94109, Phone: (415) 673-9199. You may send your request by regular mail, electronic mail, or bring it to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay.

REQUEST AMENDMENT. You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to our practice manager, stating exactly what information is incomplete or inaccurate and the reasoning that supports your request.

We are permitted to deny your request if it is not in writing or does not include a reason to support the request. We may also deny your request if:

- The information was not created by us, or the person who created it is no longer available to make the amendment.
- The information is not part of the record which you are permitted to inspect and copy.
- The information is not part of the designated record set kept by this practice or if it is the opinion of the opinion of the health care provider that the information is accurate and complete.

REQUEST RESTRICTIONS. You have the right to request a restriction of how we use or disclose your medical information for treatment, payment, or health care operations. For example – you could request that we not disclose information about a prior treatment to a family member or friend who may be involved in your care or payment for care. Your request must be made in writing to our practice manager.

We are not required to agree to your request if we feel it is in your best interest to use or disclose that information. If we do agree, we will comply with your request except for emergency treatment.

AN ACCOUNTING OF DISCLOSURES. You have the right to request a list of the disclosures of your health information we have made outside of our practice that were not for treatment, payment, or health care operations. Your request must be in writing and must state the time period for the requested information. You may not request information for any dates prior to April 14, 2003, nor for a period of time greater than six years (our legal obligation to retain information).

Your first request for a list of disclosures within a 12-month period will be free. If you request an addition list within 12-months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.

REQUEST CONFIDENTIAL COMMUNICATIONS. You have the right to request how we communicate with you to preserve your privacy. For example – you may request that we call you only at your work number, or by mail at a special address or postal box. Your request must be made in writing and must specify how or where we are to contact you. We will accommodate all reasonable requests.

FILE A COMPLAINT. If you believe we have violated your medical information privacy rights, you have the right to file a complaint with our practice or directly to:

**Office for Civil Rights
Department of Health and Human Services
Attn: Patient Safety Act
200 Independence Ave., SW, Rm. 509F
Washington, DC 20201**

To file a complaint with our manager, you must make it in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation and send it to our Privacy Officer.

USES OR DISCLOSURES NOT COVERED

Uses or disclosures of your health information not covered by this notice or the laws that apply to us may only be made with your written authorization. You may revoke such authorization in writing at any time and we will no longer disclose health information about you for the reasons stated in your written authorization. Disclosures made in reliance on the authorization prior to the revocation are not affected by the revocation.

FOR MORE INFORMATION

If you have questions or would like additional information, you may contact our Privacy Officer.

Effective Date - April 14, 2003



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PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosure we have already made in reliance on your prior Consent. Laurel Fertility Care provides this form to comply with the Health Insurance Portability and Accountability Act of 1996.

The patient understands that:

- Protected health information may be disclosed or used for treatment, coordination of care with independent agencies, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon execution of this Consent.

This Consent was signed by: _____
Patient

This Consent was signed by: _____
Partner

Witness: _____ Date: _____

Printed name – Practice representative

Arbitration Agreement

ARTICLE 1

It is understood that any dispute as to medical malpractice, that is, as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, this arbitration agreement, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

ARTICLE 2

a. Parties To The Agreement. The term "Patient" as used in this Agreement includes the undersigned individual, his or her spouse, children (whether born or unborn), and heirs, assigns, or personal representatives. The individual signing this Agreement signs it on behalf of the foregoing persons, and intends to bind each of them to arbitration to the full extent permitted by law.

The term "Provider" as used in this Agreement includes the undersigned doctor, nurse practitioner, nurse midwife, or other health care provider and his or her professional corporation or partnership, and any employees, agents, successors-in-interest, heirs and assigns of the foregoing individuals or entities. The provider signing this Agreement signs it on behalf of all the foregoing individuals and entities, and intends to bind each of them to arbitration to the full extent permitted by law.

b. Treatment Covered. Patient understands and agrees that any dispute of the sort described in Article 1 between Provider and Patient will be subject to compulsory, binding arbitration.

c. Other Providers (If Applicable). Patient understands that he or she may at times receive treatment from one or more health care providers who take call for or otherwise practice jointly with the undersigned Provider. It is understood and agreed that any dispute of the sort described in Article 1 between Patient and such health care providers will be subject to compulsory, binding arbitration.

d. Coverage of Prenatal Claims (If Applicable). Patient understands and agrees that, if Provider treats her during pregnancy, any dispute of the sort described in Article 1 as to medical treatment rendered to or affecting the unborn child will be subject to compulsory, binding arbitration.

ARTICLE 3

a. Informal Resolution of Disputes. In the event Patient feels that a problem has arisen in connection with the medical care rendered by Provider to Patient, Patient will promptly notify Provider so that Provider may have the opportunity to resolve the matter. Notice may be given orally or in writing, and shall stop the running of the statute of limitations for 90 days.

b. Method of Initiating Arbitration. If the dispute is not resolved by mutual agreement, Patient may initiate arbitration by notifying Provider to that effect and by designating an arbitrator to act on Patient's behalf. Within 20 days of receipt of such notice, Provider will designate an arbitrator to act on Provider's behalf. In the event that more than two parties participate, parties aligned with Patient shall select one arbitrator, and parties aligned with Provider shall select a second arbitrator. The controversy shall then be submitted to the three arbitrators for a final and binding decision.

c. Applicable Law. The arbitration shall be conducted pursuant to the California Arbitration Act (C.C.P. 1280-1296). The arbitrators shall, in addition, have authority to order such other discovery as they deem appropriate for a full and fair hearing of the case. A determination on the merits shall be rendered in accordance with the law of the State of California which shall apply to the same extent as if the dispute were pending before a superior court of this State.

d. Interpretation of Agreement. If any part of this Agreement is held unenforceable, it shall be severed and shall not affect the enforceability of the remainder. This Agreement supersedes and replaces any previous arbitration agreement between Provider and Patient and applies to all care previously rendered by Provider to Patient.

ARTICLE 4

a. Rescission. Once signed, this Agreement governs all subsequent medical services rendered by Provider to Patient until or unless rescinded by written notice within 30 days of signature. Written notice may be given by a guardian or conservator of Patient if Patient is incapacitated or a minor.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient's Name (Please Print): _____

Dated: _____ Patient Signature: _____

Provider's Name (Please Print): _____

Dated: _____ Provider Signature: _____

FEMALE PATIENT HISTORY

I. IDENTIFYING INFORMATION

Date _____
 Name _____ Partner's Name _____
 Address _____
 Telephone: Day _____ Evening _____
 Date of Birth _____ Partner's Date of Birth _____ Duration of Relationship _____ Duration of Infertility _____
 Nature of present employment (Title, brief description) _____

II. MEDICAL HISTORY

YES NO

Weight _____ Height _____ Blood type (if known) _____

Have you lost greater than 20 pounds of weight in the last year?

Do you follow a particular food diet or have any special dietary habits?

If yes, specify: _____

List the form and frequency of regular vigorous exercise (swimming, cycling, running) and age you began:

Exercise _____ Hrs/Week _____ Age _____ Exercise: _____ Hrs/Week _____ Age _____

Have you ever had pelvic surgery?

If yes, specify: _____

Do you have or have you ever had (check all that apply):

- | | | |
|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Parasitic Infection |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Gallbladder Problems | <input type="checkbox"/> Pelvic Infection |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Poor Sense of Smell |
| <input type="checkbox"/> Breast Milky Discharge | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Breast Soreness | <input type="checkbox"/> Herpes | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Breast Tenderness | <input type="checkbox"/> Hirsutism (Excessive Hair Growth) | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cancer? Specify _____ | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Syphilis |
| _____ | <input type="checkbox"/> Immunization: German Measles | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chronic Headaches | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Vaginitis (Trichomoniasis, yeast) |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Measles: German | # of episodes _____ |
| <input type="checkbox"/> Color Blind | <input type="checkbox"/> Measles: Regular | <input type="checkbox"/> Visual Disturbances |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neurological Problems | <input type="checkbox"/> Any Allergies: List _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Nongonococcal Urethritis | _____ |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Ovarian Cysts | _____ |

Have you ever been treated for cancer?

If yes, specify: _____

Have you ever received X-rays to the pelvic area for therapy or diagnosis?

If yes, specify: _____

Within the last year, have you taken any prescription medications?

If yes, list all prescriptions and problems for which you were taking them: _____

Are you taking any over-the-counter medications on a regular basis?

If yes, list all medications and diagnoses: _____

Do you use or have you ever used (check all that apply)

Alcohol . How many glasses per week do you usually drink? Wine _____ Beer _____ Cocktails _____

Cigarettes . Number of packs per day _____ Number of years _____

Illicit or Recreational Drugs (Marijuana, Cocaine, etc.) If you would feel more comfortable not writing anything down, please discuss this directly with your physician. Specify: _____

III. MENSTRUAL AND PREGNANCY HISTORY

YES NO

Age at first period? _____ When was your last period begin? _____

Are your periods regular?..... YES NO

If yes, what is the usual number of days between periods?: _____

If no, how many times per year do you menstruate?: _____

What is the usual duration of your period? _____ Use: Tampons? Pads?

Are cramps present before, during, or after your period? _____

Are cramps: Mild Moderate Severe

Do you have to take pain medication for cramps? YES NO

If yes, specify medication: _____

Do you bleed or spot between periods? YES NO

How many pregnancies (including abortions) have you had? _____

	When? (Year)	End in Abortion?	End in Miscarriage?	Ectopic Pregnancy?	Infertility Therapy Required to Conceive?	How Long to Conceive?	Baby Born Alive?	Is Current Partner The Father?
1st Pregnancy								
2nd Pregnancy								
3rd Pregnancy								
4th Pregnancy								
5th Pregnancy								

Were there any complications during or after your pregnancies? YES NO

If yes, explain: _____

Did your mother have any difficulty with conception or pregnancy? YES NO

If yes, explain: _____

How long have you now been trying to get pregnant? _____

Did your mother take diethylstilbestrol (DES) when she was pregnant with you? YES NO

IV. CONTRACEPTIVE/SEXUAL HISTORY

YES NO

What form of contraception do you use now or have you used in the past? Check all that apply:

Pills Name: _____ IUD Name: _____ Diaphragm Withdrawal Foams/Jellies

Condom Rhythm None Other: _____

For each contraceptive method used, specify length of use and reason for discontinuation:

Method	Length of Use	Reason for Discontinuation
_____	_____	_____
_____	_____	_____
_____	_____	_____

If you've ever been on oral contraceptives (pills), were your periods regular after stopping the pills? YES NO

How many times per week do you and your partner have sexual intercourse? _____

How many times do you have intercourse around ovulation? _____

Is intercourse painful or difficult for you? YES NO

Do you use lubricants for intercourse? YES NO

If yes, which one? _____

Do you douche before or after intercourse? YES NO

V. FAMILY HISTORY

YES NO

Is there a family history of Infertility?

If yes, who (list all members and relationship to you): _____

Is there a history of hormonal disorders in your family??

If yes, who and what type: _____

VI. HISTORY OF FERTILITY THERAPY

YES NO

Have you been treated for infertility before?

If yes, who was your physician? _____

What cause of infertility was diagnosed? _____

What drugs have you taken for infertility? Check all that apply.

- Clomiphene citrate (Serophene, Clomid)
- hMG (Pergonal)
- Estrogens
- progesterone
- Prednisone (or cortisone-like drugs)
- antibiotics
- GnRH or LHRH (Factrel)
- hCG (Profasi, A.P.L.)
- Bromocriptine (Parlodel)
- Danazol (Danocrine)
- Urofollitropin or FSH (Metrodin)
- Other - Specify _____
- None

Which of the following tests have you had performed? Check all that apply and the results if known:

- BBT When? _____ Results: _____
- Postcoital Test When? _____ Results: _____
- Hormoneal Assays (FSH, LH, Prolactin, estrogen, DHEA-S, testosterone, progesterone) When? _____ Results: _____
- Endometrial Biopsy When? _____ Results: _____
- Hysterosalpingogram When? _____ Results: _____
- Ultrasound When? _____ Results: _____
- Antibodies When? _____ Results: _____
- Laparoscopy, Hysteroscopy When? _____ Results: _____
- Mycoplasma/Chlamydia Cultures When? _____ Results: _____
- Thyroid Tests When? _____ Results: _____
- Other - Specify When? _____ Results: _____

Have you ever had surgery for tubal reversal

If yes, specify dates: _____

Have you ever had surgery for lysis of adhesions?

Have you ever had cervical conization or cautery?

Have you ever had any other surgery (D&C, ovarian, appendectomy, thyroid)?

If yes, please specify dates: _____

Have you ever undergone artificial insemination or in vitro fertilization?

If yes, using partner or donor sperm? _____

Is your partner seeing a doctor for evaluation of infertility?

If yes, specify physician name and location _____

Does the doctor feel that your partner has an infertility problem?

If yes, what is the diagnosis and how is he being treated? _____

Has he ever fathered a child with another woman?

If yes, when? _____

MALE PATIENT HISTORY

I. IDENTIFYING INFORMATION

Date _____
 Name _____ Partner's Name _____
 Address _____
 Telephone: Day _____ Evening _____
 Date of Birth _____ Partner's Date of Birth _____ Duration of Relationship _____ Duration of Infertility _____
 Insurance Company _____ Insurance I.D. # _____

II. TRAVEL/WORK AND GENERAL BACKGROUND

All present employment—title(s), location, brief description, number of years employed:

Are you or have you ever been exposed to any of the following during employment or military seervice:

- Heat Toxic Fumes Other Specify: _____
 Chemicals Nuclear Radiation _____

III. MEDICAL HISTORY

YES NO

Weight _____ Height _____ Blood type (if known) _____

Have you lost greater than 20 pounds of weight in the last year? YES NO

Do you follow a particular food diet or have any special dietary habits? YES NO

If yes, specify: _____

List the form and frequency of regular vigorous exercise (swimming, cycling, running) and age you began:

Exercise _____ Hrs/Week _____ Age _____ Exercise: _____ Hrs/Week _____ Age _____

Do you frequently take saunas or steam baths? YES NO

Have you ever had surgery in the pelvic area? YES NO

If yes, specify date and type of surgery: _____

Have you ever received X-rays in the pelvic area for therapy or diagnosis? .. YES NO

If yes, explain: _____

Do you have or have you ever had (check all that apply):

- | | | |
|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Parasitic Infection |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Gallbladder Problems | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Prostatitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Breast Milky Discharge | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Breast Soreness | <input type="checkbox"/> Herpes | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Breast Tenderness | <input type="checkbox"/> Hirsutism (Excessive Hair Growth) | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Cancer? Specify _____ | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Testes Infections |
| _____ | <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> Testes injury |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Testes Tumor |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Chronic Headaches | <input type="checkbox"/> Measles: German | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Measles: Regular | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Color Blind | <input type="checkbox"/> Mumps | <input type="checkbox"/> Visual Disturbances |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neurological Problems | <input type="checkbox"/> Any Allergies: List _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Nongonococcal Urethritis | _____ |

		YES	NO
Have you ever been treated for cancer? If yes, explain therapy: _____	<input type="checkbox"/>		<input type="checkbox"/>
Within the last year, have you taken any prescription medications? If yes, list all prescriptions and problems for which you were taking them:: _____	<input type="checkbox"/>		<input type="checkbox"/>
Are you taking any over-the-counter medications on a regular basis? If yes, list all medications and diagnoses: _____	<input type="checkbox"/>		<input type="checkbox"/>
Do you use or have you ever used (check all that apply)			
<input type="checkbox"/> Alcohol . How many glasses per week do you usually drink? Wine _____ Beer _____ Cocktails _____			
<input type="checkbox"/> Cigarettes . Number of packs per day _____ Number of years _____			
<input type="checkbox"/> Illicit or Recreational Drugs (Marijuana, Cocaine, etc.) If you would feel more comfortable not writing anything down, please discuss this directly with your physician. Specify: _____			

IV. SEXUAL HISTORY

		YES	NO
Are you circumcised?	<input type="checkbox"/>		<input type="checkbox"/>
When you were a child, were both testes descended into the scrotum?	<input type="checkbox"/>		<input type="checkbox"/>
At what age did you begin shaving regularly or start to grow a beard? _____			
How many times have you been married? _____			
Have you ever produced a child with another partner? If yes, how long did it take to produce a child? _____ When was this (date)? _____	<input type="checkbox"/>		<input type="checkbox"/>
Have you ever tried to produce a child with another partner?	<input type="checkbox"/>		<input type="checkbox"/>
Do you have trouble getting an erection?	<input type="checkbox"/>		<input type="checkbox"/>
Maintaining an erection?	<input type="checkbox"/>		<input type="checkbox"/>
Do you have trouble with ejaculations? If yes, <input type="checkbox"/> Premature ejaculations <input type="checkbox"/> Retrograde ejaculations?	<input type="checkbox"/>		<input type="checkbox"/>
Do you feel that some of your ejaculate is deposited in the vagina?	<input type="checkbox"/>		<input type="checkbox"/>
Do you ever have orgasms without ejaculation during masturbation?	<input type="checkbox"/>		<input type="checkbox"/>
Do you have any discharge from the penis?	<input type="checkbox"/>		<input type="checkbox"/>
How many times per week do you and your partner have sexual intercourse? _____			
How many times do you have intercourse around ovulation? _____			
Have you noticed a change in your sexual drive recently?	<input type="checkbox"/>		<input type="checkbox"/>

V. FAMILY HISTORY

		YES	NO
Is there a family history of Infertility? If yes, who (list all members and relationship to you): _____	<input type="checkbox"/>		<input type="checkbox"/>
Is there a history of hormonal disorders in your family?? If yes, who and what type: _____	<input type="checkbox"/>		<input type="checkbox"/>

VI. HISTORY OF FERTILITY THERAPY

YES NO

Have you been treated for infertility before? YES NO

If yes, who was your physician? _____

What cause of infertility was diagnosed? _____

What drugs have you taken for infertility? Check all that apply.

- Clomiphene citrate (Serophene, Clomid)
- hMG (Pergonal)
- tamoxifen
- testolactone
- bromocriptin (Parlodel)
- testosterone or Male Hormone
- hCG (Profasi, A.P.L.)
- fluoxymesterone (Halotestin)
- GnRH or LHRH (Factrel)
- Urofollitropin or FSH (Metrodin)
- Other – Specify _____
- None

Have you ever had varicocele repair? YES NO

If yes, when: _____

Have you ever had vasectomy reversal or repair? YES NO

If yes, when: _____

Have you and your partner ever tried artificial insemination? YES NO

If yes, using your sperm? donor sperm

Have you and your partner ever undergone in vitro fertilization? YES NO

If yes, when and explain: _____

Which of the following tests have you had performed? Check all that apply and the results if known:

- Semen Analysis When? _____ Results: _____
- Chlamydia Test When? _____ Results: _____
- Mycoplasma Test When? _____ Results: _____
- Antibody Test When? _____ Results: _____
- Hamster egg Test When? _____ Results: _____
- Chromosome Test When? _____ Results: _____
- Testicular Biopsy When? _____ Results: _____
- Chromosome Test When? _____ Results: _____
- X-ray or Ultrasound of Testes When? _____ Results: _____
- Hormonal Tests (FSH, LH, Prolactin, testosterone) When? _____ Results: _____
- Thyroid Tests When? _____ Results: _____
- Other - Specify When? _____ Results: _____

Is your partner currently seeing a doctor for evaluation of infertility? YES NO

If yes, specify physician name and location _____

Does the doctor feel that your partner has an infertility problem? YES NO

If yes, what is the diagnosis and how is she being treated? _____

Has she ever had children with another man? YES NO

If yes, when? _____



Laurel Fertility Care

Growing dreams together

Mind Body Program

We at Laurel Fertility Care understand that moving toward having a family is a journey that can lead you down many different roads. We recognize the importance of a healthy balance during these travels. We are pleased to offer our holistic **Mind-Body Passport Program** designed to complement and enhance your existing care.

Our physicians and practitioners maintain close communication to create a comprehensive program for couples and individuals striving for conception. Our consortium of qualified and innovative mind-body practitioners emphasize the successful integration of eastern and western therapies. We offer customized individual support using evidence-based **acupuncture, guided imagery**, therapist-led **fertility groups** and **private therapy** sessions, **yoga, meditation** and **nutrition** and **lifestyle advice** to actively support you during your very personal journey.

Creating balance, joy and awareness in your day-to-day life-and applying relaxation techniques can help support and enhance your preparation for pregnancy and a healthy family.

Whether you are interested in obtaining the emotional tools to better manage the fertility treatment process, or would like to create more optimal conditions for conception, Laurel Fertility Care will be with you every step of the way to help you obtain your goal.

We look forward to collaborating with you on a program that's right for you.

In Health,
All of Us at Laurel Fertility Care



Laurel Fertility Care

Growing dreams together

COLLIN SMIKLE, M.D.

LEE C. KAO, M.D.

LAUREL FERTILITY CARE

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Phone: (415) 673-9199

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PLEASE READ AND INITIAL

___ I authorize my medical records to be mailed or faxed to other physicians.

___ I am financially responsible for today's services provided to me or my dependent by Laurel Fertility Care.

___ If at a later date I am able to show proof of contracted insurance coverage and/or written authorization for services rendered, Laurel Fertility Care will take necessary steps to provide my insurance carrier with information, but I am ultimately responsible for all charges.

___ Services provided at Laurel Fertility Care that are not authorized or covered by my primary insurance are my responsibility.

___ I authorize release of information to my insurance company.

___ I understand the diagnosis code WILL NOT be changed after a claim has been submitted to my insurance company.

___ I understand that I AM RESPONSIBLE FOR UNDERSTANDING WHAT MY INSURANCE COVERS.

___ I understand that my insurance may not pay for office visits, ultrasounds, labs, or medications that are considered "infertility".

___ I understand that I will be charged \$40.00 if I NO SHOW for an appointment.

Patient Name: _____ Signature: _____ Date: _____

Partner Name: _____ Signature: _____ Date: _____