

PATIENT INFORMATION FOR MEDICAL RECORDS

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PHONE: (925) 277-0600 FAX: (925) 277-0801

Referred By: _____

NAME: _____ MAIDEN NAME: _____
(Last) (First)

BIRTHDATE: ___/___/___ AGE: _____ EMAIL ADDRESS: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ PLACE OF BIRTH: _____

HOME PHONE: _____ CELL: _____ WORK: _____

SOCIAL SECURITY #: _____

EMPLOYED BY: _____ JOB TITLE: _____

WORK ADDRESS: _____

Married ___ Partnered ___ Single ___ Divorced ___ Separated ___

PARTNER INFORMATION:

NAME: _____ BIRTHDATE: ___/___/___ PHONE #: _____

EMPLOYED BY: _____ JOB TITLE: _____

In case of an EMERGENCY, please notify:

NAME: _____ PHONE #: _____

RELATIONSHIP TO PATIENT: _____

PREFERRED PHARMACY: _____ LOCATION: _____

MEDICAL INSURANCE INFORMATION:

NAME OF INSURANCE(S): _____

POLICY HOLDER NAME: _____ BIRTHDATE: ___/___/___

SOCIAL SECURITY #: _____ RELATIONSHIP TO PATIENT: _____

PRIMARY CARE PHYSICIAN: _____ PHONE #: _____

I understand that I have coverage with the above named insurance company and assign directly to Aimee Eyvazzadeh, MD, MPH, all surgical and/or medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits.

DATE: _____ SIGNATURE: _____

FEMALE PATIENT HISTORY

I. IDENTIFYING INFORMATION

Date _____
 Name _____ Partner's Name _____
 Address _____
 Telephone Number - Day: () _____ Evening: () _____
 Date of Birth _____ Partner's Date of Birth _____ Duration of Relationship _____ Duration of Infertility _____
 Insurance Company _____ Insurance I.D. # _____
 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? YES NO

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

If yes, specify: _____

List the forms 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? YES NO

If yes, specify date and type: _____

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 Transfusions | <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 (Excess 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? YES NO

If yes, explain therapy: _____

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

If yes, specify: _____

Within the last year, have you taken any prescription medications? YES NO

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? YES NO

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 _____
- 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? _____

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

YES NO

Do you use lubricants for intercourse?.....

If yes, which one?

Do you douche before or after intercourse?

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®)
 hCG (Profasi®, A.P.L.®)
 hMG (Pergonal®)
 bromocriptine (Parlodel®)
 estrogens
 danazol (Danocrine®)
 progesterone
 urofollitropin or FSH (Metrodin®)
 prednisone (or cortisone-like drugs)
 Other - Specify
 antibiotics
 None
 GnRH or LHRH (Factrel®)

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:
 Hormonal 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:

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 Number - 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 service:

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?

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

If yes, specify: _____

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

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

Do you frequently take saunas or steam baths?

Have you ever had surgery in the pelvic area?

If yes, specify date and type of surgery: _____

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

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"/> High Blood Pressure | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Cancer? Specify _____ | <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> Testes Infection |
| | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Testes Injury |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Testes Tumor |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Measles: German | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Chronic Headaches | <input type="checkbox"/> Measles: Regular | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Mumps with Testes Involved | <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?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, explain therapy: _____		
Within the last year, have you taken any prescription medications?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, list all medications and diagnoses: _____		

Have you had a high fever (over 102°F) during the past 3-4 months?	<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 _____		
<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?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how long did it take to produce a child? _____ When was this (dates)? _____		
Have you ever <i>tried</i> 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?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, <input type="checkbox"/> Premature ejaculations <input type="checkbox"/> Retrograde ejaculations?		
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 now have 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?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, who (list all members and relationship to you): _____		

Is there a history of hormonal disorders in your family?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, list who (relationship to you) 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:

- | | |
|---|--|
| <input type="checkbox"/> clomiphene citrate (Serophene®, Clomid®) | <input type="checkbox"/> hCG (Profasi®, A.P.L.®) |
| <input type="checkbox"/> hMG (Pergonal®) | <input type="checkbox"/> fluoxymesterone (Halotestin®) |
| <input type="checkbox"/> tamoxifen | <input type="checkbox"/> GnRH or LHRH (Factrel®) |
| <input type="checkbox"/> testolactone | <input type="checkbox"/> urofollitropin or FSH (Metrodin®) |
| <input type="checkbox"/> bromocriptine (Parlodel®) | <input type="checkbox"/> Other - Specify _____ |
| <input type="checkbox"/> testosterone or Male Hormone | <input type="checkbox"/> None |

Have you ever had varicocele repair?

If yes, when? _____

Have you ever had vasectomy reversal or repair?

If yes, when? _____

Have you and your partner ever tried artificial insemination?

If yes: using your sperm? donor sperm?

Have you and your partner ever tried in vitro fertilization?

If yes, when and explain: _____

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

- | | |
|--|----------------------------|
| <input type="checkbox"/> Semen Analysis | When? _____ Results: _____ |
| <input type="checkbox"/> Chlamydia Test | When? _____ Results: _____ |
| <input type="checkbox"/> Mycoplasma Test | When? _____ Results: _____ |
| <input type="checkbox"/> Antibody Test | When? _____ Results: _____ |
| <input type="checkbox"/> Hamster Egg Test | When? _____ Results: _____ |
| <input type="checkbox"/> Chromosome Test | When? _____ Results: _____ |
| <input type="checkbox"/> Testicular Biopsy | When? _____ Results: _____ |
| <input type="checkbox"/> X-ray or Ultrasound of Testes | When? _____ Results: _____ |
| <input type="checkbox"/> Hormonal Tests (FSH, LH, prolactin, testosterone) | When? _____ Results: _____ |
| <input type="checkbox"/> Thyroid Tests | When? _____ Results: _____ |
| <input type="checkbox"/> Other - Specify _____ | When? _____ Results: _____ |

Is your partner currently 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 she being treated? _____

Has she ever had children with another man?

If yes, when? _____

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. Dr. Aimee Eyvazzadeh 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

Date: _____

Witness: _____
Printed name – Practice representative



AIMEE EYVAZZADEH, M.D.

5401 Norris Canyon Road: suite 106

San Ramon, CA 94583

Phone: 925.277.0600

Fax: 925.277.0801

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 Dr. Aimee Eyvazzadeh

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

___ Services provided by Dr. Aimee Eyvazzadeh 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 \$50.00 if I NO SHOW for an appointment.

Patient Name: _____ Signature: _____ Date: _____

Partner Name: _____ Signature: _____ Date: _____

**PATIENT CONSENT FOR RELEASE OF MEDICAL
INFORMATION**

Date: _____

I hereby authorize _____ to release to
Dr. Aimee Eyvazzadeh our medical records including history and physical,
laboratory reports, x-rays, and any other material regarding the medical
consultations and treatment(s) which we have received.

Name: (print) _____

Signature: _____

Birthdate: _____

Name of Spouse: (print) _____

Signature of Spouse: _____

Birthdate of Spouse: _____

Please send requested information to:
Dr. Aimee Eyvazzadeh
5401 Norris Canyon Road; Suite 106
San Ramon, CA 94583
Phone: 925.277.0600
Fax: 925.277.0801



Aimee Eyvazzadeh, MD, MPH
5401 Norris Canyon Rd., Suite 106
San Ramon, CA 94583
P (925) 277-0600
F (925) 277-0801

From 680 South

From **680 South**, take the Crow Canyon Road exit (Exit 36). Turn left onto Crow Canyon Road. Turn Right onto Alcosta Boulevard. Turn left onto Norris Canyon Road. The 5401 Norris Canyon medical building will be on your right past the hospital.

From 680 North

From **680 North**, take the Crow Canyon Road exit (Exit 36). Turn right onto Crow Canyon Road. Turn Right onto Alcosta Boulevard. Turn left onto Norris Canyon Road. The 5401 Norris Canyon medical building will be on your right past the hospital.