Package for New Patients

Thank you for choosing the NYU Langone 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 related 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 one of the following addresses:

  NYU Langone Fertility Center — or fax to (212) 263-7853
  c/o <insert the name of your NYULFC physician>
  660 First Avenue, 5th Floor
  New York, NY 10016

  NYU Langone Fertility Center - West Side — or fax to (646) 754-2592
  c/o Dr. DeVore or Dr. Hodes-Wertz
  355 West 52nd Street, 3rd Floor
  New York, NY 10019

  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, prescription 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 or mailed to us prior to your appointment using the same information above.

Fertility and Oocyte Cropreservation (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://nyulangone.org/locations/fertility-center/patient-forms-orientation-videos

Thank you again and welcome!

The NYU Langone Fertility Center Team

NYU Langone Health

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**
Weight Change > 10lbs.	☐	☐
Fever	☐	☐
Sweats	☐	☐
Fatigue	☐	☐
EYES		
Glaucoma	☐	☐
Cataracts	☐	☐
Vision Surgery	☐	☐
EARS, NOSE, THROAT		
Loss of Hearing	☐	☐
Dizziness	☐	☐
Nose Bleeding	☐	☐
Gum Bleeding	☐	☐
RESPIRATORY		
Chronic Cough	☐	☐
Bronchitis	☐	☐
Shortness of Breath	☐	☐
Asthma	☐	☐
Pneumonia	☐	☐
CARDIOVASCULAR		
Heart Attack	☐	☐
Chest Pain/Angina	☐	☐
Heart Murmur	☐	☐
Anemia	☐	☐
Transfusions	☐	☐
Phlebitis or Blood Clots	☐	☐
Rheumatic Fever	☐	☐
Heart Surgery	☐	☐
GASTROINTESTINAL		
Reflux	☐	☐
Hepatitis A	☐	☐
Blood in Stools	☐	☐
Diarrhea/Constipation	☐	☐
Hernia/Repair	☐	☐
Gall Bladder	☐	☐
ENDOCRINE		
Diabetes	☐	☐
Thyroid Problem	☐	☐
Hormone Treatment	☐	☐

BREAST	**Yes**	**No**
Masses	☐	☐
Breast Surgery	☐	☐
URINARY SYSTEM		
Urinary Tract/Bladder Infection	☐	☐
Kidney stone(s)	☐	☐
Incontinence	☐	☐
Trouble urinating	☐	☐
GENITAL		
Pelvic Infection	☐	☐
Pelvic Surgery	☐	☐
Pelvic Pain	☐	☐
Endometriosis	☐	☐
SKIN		
Cancer(s)	☐	☐
Rashes	☐	☐
NEUROLOGIC		
Stroke	☐	☐
Seizures	☐	☐
Head Injury	☐	☐
Nerve Damage	☐	☐
PSYCHIATRIC		
Depression	☐	☐
Anxiety	☐	☐
Substance Abuse	☐	☐
MUSCULOSKELETAL		
Osteoarthritis	☐	☐
Rheumatoid Arthritis	☐	☐
Gout	☐	☐

COMMENTS:

NYU Langone Fertility Center
660 First Avenue, 5th Floor, New York, NY 10016 · tel 212.263.8990 · fax 212.263.7853 · www.nyufertilitycenter.org

NYU Langone Health

Preconception Genetic Questionnaire

Patient Name: _____ Date of Birth: _____

Partner Name: _____ Date of Birth: _____

1. Do you, your partner, your children, or anyone in your families have a genetic or chromosomal disorder? If yes, please indicate the relationship of the affected person to you or your partner. _____

   Examples of genetic disorders may include (but are not limited to):

   - *Muscular dystrophy (e.g. Duchenne, myotonic dystrophy)*
   - *Bleeding disorder (e.g. hemophilia)*
   - *Neurofibromatosis*
   - *Dwarfism/skeletal dysplasia*
   - *Marfan syndrome*
   - *Polycystic kidney disease*
   - *Huntington's disease*
   - *Cystic fibrosis*
   - *Spinal muscular atrophy*
   - *Intellectual/developmental disability or autism (e.g. Fragile X syndrome, Down syndrome)*
   - *Birth defect (e.g. spina bifida, cleft palate, heart defect)*
   - *Blindness or deafness*
   - *Hereditary cancer syndrome or cancer diagnosed < age 50*
   - *Balanced translocation*

2. In this or any previous relationship, have you or your partner had a pregnancy diagnosed with a chromosome disorder (e.g. Down syndrome) or a birth defect? If yes, please specify the diagnosis. ☐ No ☐ Yes _____

3. In this or any previous relationship, have you or your partner had a stillbirth or more than two (2) miscarriages? If yes, please provide further information. ☐ No ☐ Yes

   _____

4. Please indicate your ancestry/ethnicity (list all countries of origin):

   Self: _____

   Partner: _____

5. Do you or your partner have any Eastern European (Ashkenazi) Jewish ancestry?
   ☐ Self ☐ Partner

6. Do you or your partner have any French-Canadian or Cajun ancestry?
   ☐ Self ☐ Partner

7. Do you or your partner have any African (including African-American), Caribbean, Hispanic, Asian, Middle Eastern, Mediterranean, or Sephardic/Mizrahi Jewish ancestry?
   ☐ Self ☐ Partner

Preconception Genetic Questionnaire

8. Did you or your partner have carrier testing for any of the following diseases? If yes, please indicate the results and include a copy of your report if possible.

Cystic Fibrosis (CF)	☐ Self	☐ Partner	_____
Spinal Muscular Atrophy (SMA)	☐ Self	☐ Partner	_____
Fragile X	☐ Self	☐ Partner	_____
Sickle Cell Disease	☐ Self	☐ Partner	_____
Beta Thalassemia	☐ Self	☐ Partner	_____
Alpha Thalassemia	☐ Self	☐ Partner	_____
Bloom Syndrome	☐ Self	☐ Partner	_____
Canavan Disease	☐ Self	☐ Partner	_____
Dihydrolipoamide Dehydrogenase Deficiency	☐ Self	☐ Partner	_____
Familial Dysautonomia	☐ Self	☐ Partner	_____
Familial Hyperinsulinism	☐ Self	☐ Partner	_____
Fanconi Anemia Type C	☐ Self	☐ Partner	_____
Gaucher Disease	☐ Self	☐ Partner	_____
Glycogen Storage Disease Type 1A	☐ Self	☐ Partner	_____
Joubert Syndrome Type 2	☐ Self	☐ Partner	_____
Maple Syrup Urine Disease	☐ Self	☐ Partner	_____
Mucolipidosis Type IV	☐ Self	☐ Partner	_____
Nemaline Myopathy	☐ Self	☐ Partner	_____
Niemann-Pick Disease Type A	☐ Self	☐ Partner	_____
Tay-Sachs Disease	☐ Self	☐ Partner	_____
Usher Syndrome Type IF	☐ Self	☐ Partner	_____
Usher Syndrome Type III	☐ Self	☐ Partner	_____
Walker-Warburg Syndrome	☐ Self	☐ Partner	_____

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:

_____ ☐ Accept ☐ Decline

_____ ☐ Accept ☐ Decline

_____ ☐ Accept ☐ Decline

My physician listed above has also requested a genetic consult and the following testing be performed before an In Vitro Fertilization (IVF) cycle can be initiated:

_____ ☐ Accept ☐ Decline

_____ ☐ Accept ☐ Decline

_____ ☐ Accept ☐ Decline

NYU Langone Health

PHARMACY DATA SHEET

This information will help us streamline your care by providing electronic prescriptions when available.

Patient Name: _____ Date of Birth: _____

Do you have a pharmacy benefit?

☐ Yes – complete sections 1, 2 and 3
☐ No – complete sections 2 and 3

Section 1 – Pharmacy Benefit

Your Pharmacy Carrier is:

☐ Medco ☐ Caremark ☐ Cigna ☐ Aetna ☐ Other – please indicate: _____

Name of Primary Insured for Pharmacy Benefit: _____ ID#: _____

Section 2 – Preferred Pharmacy

If you have a preferred or local pharmacy for your general medications, please provide the following information. If you indicate a large brand store such as Duane Reade, CVS, Walgreens, ShopRite, etc. – you must indicate the store number (for example, CVS #2254) as well as the address.

Pharmacy : _____ Store #: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax: _____

Section 3 – Specialty Pharmacy

If you have fertility medication coverage, please indicate the specialty pharmacy required by your insurance carrier. In non-mandated situations, we prefer you use a pharmacy that has extensive experience in fertility medications. Specialty pharmacies can be found on our pharmacy list and include Apthorp, Kings, Metro Drugs, Kraupners and others. Specialty pharmacies also participate in savings programs for self-pay/cash patients.

Pharmacy : _____ Store #: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax: _____

NYULFC use only – Entered by: _____ Date: _____