MEDICAL AND REPRODUCTIVE HISTORY – INFERTILITY

PATIENT:
(Legal) Last Name:________________________________**(Legal)** First Name:_______________________Middle initial _________

Age:___________ Date of Birth: ___/_____/______ DOD #:________________________________

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner Length of Relationship: ________

PARTNER:
(Legal) Last Name:_________________________________**(Legal)** First Name:_______________________Middle initial ________

Age:__________Date of Birth:______/_____/______ DOD #:_____________________________

INSURANCE SUBSCRIBER:

Sponsor Name:_________________________________Sponsor DoD#: ____

MAILING ADDRESS:

Street:____

City: ______________________________ State: ___________________________ Zip Code: ____________________________

	OK to leave message?		Best # to reach you:
Home Phone Number: (___)_____-__________	☐ Yes	☐ No	☐
Patient Cell Phone Number: (_____)_____-__________	☐ Yes	☐ No	☐
Partner Cell Phone Number: (___)_____-__________	☐ Yes	☐ No	☐

Patient Email Address: ____

Partner Email Address: ____

FERTILITY HISTORY – PATIENT

List all pregnancies, specifying under outcome whether liveborn, stillborn, ectopic, miscarriage or elective termination (abortion):

Pregnancy #	Preg. Ended (mo./yr.)	Preg. Length (weeks, months)	Outcome	FATHER (check one)	
				Present partner	Previous partner

How long have you been sexually active without any form of birth control? : ____________________________

How long have you been trying to conceive? ____

How often do you have intercourse? _______ times per week _______ times per month _______none

Have you undergone fertility treatment or evaluation in the past? If so, please describe: ___________________

MENSTRUAL HISTORY- PATIENT

Age when you had your first menstrual period: ________

The first day of your most recent menstrual period: ____/____/______

How many days pass from the start of one period to the start of the next period? __________

How many days of bleeding do you typically have? _________

Menstrual cycle pattern without hormones or oral contraceptive pills -- (check all that apply):

____regular periods _____irregular or unpredictable periods ___no periods

____spotting before periods ______bleeding between periods ____heavy periods

Do you experience the following symptoms before or during your periods?

____ breast tenderness _____ bloating _____ moodiness or irritability

Do you experience pain or cramping with periods? (Yes or No) ____

If so: How often? (Always, sometimes, rarely): ____

Is your pain severe, moderate, or mild?____

Have you ever used Ovulation Predictor Kits (OPKs)?____

If so, what kind? _________________ Have the kits reliably demonstrated that you ovulate? __________________________

GYNECOLOGIC HISTORY- PATIENT

Do you experience pelvic pain at times other than your period? ____________________

If so: How often? (ex: always, sometimes, rarely) ____________________

Where is your pain located? ____________________

Is your pain severe, moderate, or mild? ____________________

Can you describe your pain? (ex: constant, throbbing, intermittent, etc) ____________________

Do you experience pelvic pain during intercourse?:____________________

If so: Is your pain upon entry or deep pelvic pain or both? ________How often? (Always, sometimes, rarely): ________________

Is your pain severe, moderate or mild?____________________

Do you feel like you have excess facial or body hair? ____________

If so, what treatments (if any) have you used?(ex: waxing, shaving, plucking, medications): ____________________

Have you ever or are you currently experiencing discharge from the nipples?:____________________

When was your last pap smear? _____/_____/_____

Have you ever had a: ______ Colposcopy ______LEEP ______ Cone biopsy _______ Cryotherapy

Have you ever had any of the following sexually transmitted infections?

_____Chlamydia _____Gonorrhea _____Syphilis _____Hepatitis _____Herpes _____HPV/genital warts _____ HIV

MEDICAL HISTORY – PATIENT

Do you have: (check all that apply)

_____ Heart Disease ______Hypertension ______ High Cholesterol _____ Disease of the Bowel
_____ Kidney Disease ______Liver Disease ______ Diabetes _____ Glucose Intolerance
_____ Asthma ______Seizure Disorder ______ Obstructive Sleep Apnea ____ Blood Clotting Disorder
_____ Depression ______ Anxiety ______ Other psychiatric condition

List any other present or past medical problems:____________________

What medications do you take? (list): ____________________

What over-the-counter medications/ vitamins do you take? (list): ____________________

Do you have any allergies to food or medications?: ____________________

SURGICAL HISTORY – PATIENT

Have you ever had surgery?____________

If so, list in order (year, type of surgery, reason):

____

____

____

____

Have you ever had a reaction to anesthesia?_____________ If so, reation: ___________________________

SOCIAL HISTORY – PATIENT

Current Occupation: ______________________________Pending Deployments?___________________________

Have you or do you use any of the following?:

	Never	Within the last 3 months?	Yes	How much & how often?
Tobacco				
Alcohol				
Social Drugs				
Exercise				

FAMILY AND GENETIC HEALTH HISTORY – PATIENT

What is your ethnicity:____

Have any of your blood relatives had:

_____ Downs Syndrome ______ Cystic Fibrosis ______Sickle Cell Anemia ______ Thalassemia

____ Spinal Cord Defects _____ Other Genetic Conditions Explain: ______________________________

Mother: Current age: _______ Age at menopause (if known): _________ How many children did she have? ___________

Did she have any GYN-related problems? (explain) ______________________________

Any female relatives with: ______ PCOS _______ endometriosis _______ infertility ________ repeat miscarriage

If so, who?: ______________________________

Any family members with: (list who)
Diabetes: _________ Hypertension:________ High Cholesterol:________ Thyroid Disease: _______________________

Blood clot in leg, lung or elsewhere (DVT)? _____________________ Rheumatological Conditions: __________________

Cancer:__________ Type: ______________________________

GENERAL MEDICAL HISTORY - PARTNER

List any present or past medical problems:

____

____

What medications do you take? *(list)*

____

____

What over-the-counter medications/ vitamins do you take? *(list)*

____

____

List all surgeries you have had:

____

SOCIAL HISTORY - PARTNER

What is your occupation?:____

Any pending deployments? Explain: ____

Have you or do you use any of the following?:

	Never	Within the last 3 months?	Yes	How much & how often?
Tobacco				
Alcohol				
Social Drugs				
Exercise				

FAMILY HISTORY – *MALE PARTNER ONLY*

What is your ethnicity?:____

Any blood relatives with:

_____ Downs Syndrome _____ Cystic fibrosis _____ Sickle cell anemia _____ Thalassemia

_____Spinal cord defects _____ Other genetic condition

_____ Cancer? (W*ho & Type):* ____

REPRODUCTIVE HISTORY - *MALE PARTNER ONLY*

Have you ever conceived with another partner? ____ No ___ Yes

If yes, how many children?________________________ Ages: ____

Have you ever had any of the following sexually transmitted infections? *(Check all that apply)*

____Chlamydia ____Gonorrhea ____Herpes ____HPV/genital warts

____Syphilis ____Hepatitis ____ HIV

Do you experience recurrent problems with?:

_____ Sexual desire _____ Obtaining or maintaining an erection _____ Orgasm or ejaculation

Madigan Reproductive Endocrinology & Infertility Clinic
Confidentiality Agreement

Privacy in health care matters is a prevalent concern. You have the right to expect that what is said here will remain private and confidential. However, the in MAMC REI Clinic, we see our patients and their spouses as couples since the ultimate goal of treatment is pregnancy.

By signing this statement you provide the MAMC REI Clinic with permission to share your fertility health care information between patient and spouse, whether this is in person, over the phone or via email.

Print Patient Name: ____

Patient Signature: ____

Date: ____

Print Spouse Name: ____

Spouse Signature: ____

Date: ____

**Should your decision to share your personal health information with your spouse change at anytime, you must present to the REI Clinic to inform the clinic staff and to revoke this consent.*

DEPARTMENT OF THE ARMY
MADIGAN HEALTHCARE SYSTEM
9040 JACKSON AVENUE
TACOMA, WA 98431-1100

Memorandum

Policy for Beneficiaries Receiving Infertility Treatment Outside of Madigan Army Medical Center

The Madigan Reproductive Endocrinology and Infertility team does not provide medications, laboratory testing, office procedures or cycle monitoring for patients who are receiving infertility care at centers outside of Madigan.

Limitations in government funding, and increased demands for infertility services within the Armed Forces, have resulted in the need to restrict these services to patients receiving care at Madigan. Our team does not have adequate staffing to safely and efficiently coordinate these services.

As infertility treatment is still considered "elective" within the military healthcare system, TriCare limits coverage in the civilian sector to the following services:

- Initial infertility evaluation
- Limited laboratory and radiologic screening related to the initial evaluation of infertility
- Oral ovulation induction medications, such as clomiphene citrate (Clomid®) and/or letrozole (Femara®), ONLY when used with timed intercourse

TriCare does <u>not</u> cover any infertility medications when used with intrauterine insemination (IUI) or those used for in vitro fertilization (IVF) cycles. You are responsible for confirming TriCare benefits and covered services <u>prior</u> to seeking civilian infertility services.

If you elect to receive care at a civilian center, or require services not provided at Madigan, you will be personally responsible for <u>all costs</u> associated with your treatment. These costs may include laboratory fees, medications, and ultrasound monitoring. Prescriptions for <u>all medications</u> (to include oral contraceptive pills, ovarian stimulation medications, antibiotics, and post-procedure pain medication) will be managed by the <u>treating</u> physician/facility. Medication prescriptions written by a civilian provider for infertility care may <u>not</u> be filled at the Madigan pharmacy. Laboratory tests and ultrasound monitoring appointments will be managed by the treating physician/facility.

Services not currently provided at Madigan include the following:

- Donor egg IVF
- Embryo donation/adoption
- Gestational carriers/Surrogacy
- Preimplantation genetic screening or diagnosis (PGS/PGD)

<u>Acknowledgement</u>

I/We have read this information sheet regarding infertility services obtained outside of Madigan. I/We understand that medications, laboratory testing, office procedures and/or cycle monitoring will <u>not</u> be provided for patients receiving care at civilian infertility centers.

____ ____________
Printed name (Patient) Signature Date

____ ____________
Printed name (Partner) Signature Date