Dear RSC Patient,

Welcome to our practice and thank you for choosing RSC. There are two very important policies we would like to make you aware of.

1. Should you need to reschedule your appointment please do so at least 48 hours prior to your scheduled appointment time. A $100 fee will apply if you were to “not show” for your appointment.

2. Please fill out your paperwork prior to your new patient appointment. If you do not fill out your paperwork and/or do not arrive 30 minutes early to do so your physician may ask you to reschedule your appointment or give you the option of being seen or have you schedule another follow up consultation to review your paperwork which would result in an additional fee.

We want you to have a very informative and productive 1 hour initial consultation. This can only be accomplished if we work together. You must do your part so that we can do ours. Our goal is to give you every conceivable opportunity for success.
You have received this packet because you have scheduled a new patient appointment with one of our seven physicians:

- Dr. Louis Weckstein
- Dr. Mary Hinckley
- Dr. Carmelo Sgarlata
- Dr. Sara Pittenger Reid
- Dr. Susan Willman
- Dr. Deborah Wachs
- Dr. Evan Rosenbluth

In one of our four locations:

- San Ramon
- Orinda
- San Jose
- Foster City

We know that you feel overwhelmed with information and that you have anxiety about what to expect before and after you enter our fertility center. We want to make this as easy as possible for you.

You should have received this new patient packet via fax, email, or US mail. In the packet are the following information. We suggest that you utilize the check boxes to the left as you review and complete each attachment.

- **Welcome Letter**
- **Map to our Centers**
- **Request for Release of Medical Records** **VERY IMPORTANT**
  - Healthcare privacy laws require your permission for your private medical information to be shared with any third party, including another physician. This form must be used to request medical records and test results from any of your previous medical providers. Records transmission can take up to three weeks. Please fax or bring the form to the providers’ office(s) at your earliest convenience.
- **Demographic form** Please complete*
- **Joint Notice of Privacy Practices**
- **Privacy and Message Requirements** Please complete and sign*
- **Conditions of Treatment / Assignment of benefits** Please complete and sign*
- **Patient History Forms** Please complete*
- **Genetic Screening consent form** Review only, will be signed in the office*

*These documents need to be signed and returned via fax (925-973-5064) or email (liz.gamez@integramed.com) prior to your initial consultation. If you are in possession of your medical records, please provide these as well.

Thank you for completing all the required documentation. This will make your initial consultation with the physician more informative.
The Initial Consultation:

- It is strongly recommended that another person attend the initial consultation with you (four ears are better than two)
- Please be prepared to be at RSC for 1 ½ -2 hours.
- PLEASE arrive 20 minutes prior to your appointment time and PLEASE fax your paperwork to 925-973-5064 at least 24 hours prior to your appointment. **If you have not turned in the required paperwork prior to your appointment and/or you are late, the initial consultation may be less than one hour.**
- Review of your prior medical records is an important aspect of your initial consultation. It is extremely helpful if your records are received in advance of your appointment. The most relevant results include:
  - HSG
  - Semen analysis
  - FSH
  - Estradiol
  - Anti-mullerian Hormone (AMH)
  - Thyroid Stimulating Hormone (TSH)
  - Prolactin (PRL)
  - Details of prior fertility treatment
- You will also have a **vaginal ultrasound** by your physician that will look at your ovaries and uterine lining. This can be done no matter where you are in your cycle even if you have your period as long as you are comfortable.
- During the consultation, you and your doctor will also decide the best course of treatment, and whether further testing will need to be completed before beginning any fertility treatment.
- You will also be paired with one of our Financial Counselors and you will be able to schedule a time to discuss the costs associated with your particular treatment plan. If you have insurance coverage for infertility your Financial Counselor will discuss your particular plan and what the benefits provide.
- You will receive a call from your clinical case manager (RN or MA) within 24 – 48 hours of your consultation to discuss either further testing and/or your IUI or IVF cycle plan.
SAN RAMON OFFICE
100 Park Pl., Suite 200, San Ramon, CA 94583
Tel: 925-867-1800 / Fax: 925-279-0933
Office Hours: Monday through Friday 7:00 AM - 5:00 PM
Saturday, Sunday and Holidays 7:30 AM - 11:00 AM

South 680: Exit Crow Canyon Rd. and turn right. Proceed about a quarter mile. Turn left at Park Pl. and the office will be on the right.

North 680: Exit Crow Canyon Rd. and turn left. Proceed about a quarter mile. Turn left at Park Pl. and the office will be on the right.

ORINDA OFFICE
89 Davis Road, Suite 280, Orinda, CA 94563
Tel: 925-867-1800 / Fax: 925-279-7810
Office Hours: Monday through Friday 8:30 AM - 5:00 PM

From Walnut Creek: Take Hwy 24 West to Orinda off ramp. Follow the signs towards Orinda which will take you to the second exit ramp under the freeway. Make a right onto Caroline Pable. At the stop sign turn left onto Brookwood. At the stop sign turn left onto Moraga Way and follow around to the right - Bryant Way. Turn right onto Davis Road (just after gas station and before freeway entrance). The office is located on the second floor of the Orinda Towers.

From Berkeley: Take Hwy 24 East to the Orinda exit. Go straight onto Brookwood. At the stop sign turn left onto Moraga Way and follow around to the right - Bryant Way. Turn right onto Davis Road (just after gas station and before freeway entrance). The office is located on the second floor of the Orinda Towers.

SAN JOSE OFFICE
1101 S. Winchester Blvd., Suite O-282
Tel: 408-385-8781 / Fax: 408-655-9974
Office Hours: Monday through Friday 8:00 AM - 5:00 PM

From 280-S: Take exit 6 for Winchester Blvd. Turn left at Moorpark Ave. Turn right at S Winchester Blvd. RSC will be on your right.

From 280-N: Take 880 N exit toward Oakland. Follow signs for Stevens Creek Blvd and merge onto Stevens Creek Blvd. Turn left at S Winchester. RSC will be on your right.

From 680-S/700-S: Take Stevens Creek Blvd exit toward W. San Carlos St. Turn right at Stevens Creek Blvd. Turn left at S Winchester. RSC will be on your right.

From 880-N/700-N: Take exit 25 toward Hamilton. Turn left at Creekside Way. Turn left at Hamilton. Turn right at S. Winchester. Make a U-turn at Williams. RSC will be on your right.

FOSTER CITY OFFICE
1088 Foster City Blvd., Suite 210, Foster City, CA 94404
Tel: 650-437-7122 / Fax: 650-312-2055
Office Hours: Monday through Friday 8:00 AM - 5:00 PM

From South Bay: Take US 101 N. to E. Hillsdale Blvd. San Mateo. Turn right on E. Hillsdale Blvd. Turn right on Foster City Blvd. Clinic will be on the right in the Martin Cove Shopping Center.

From North Bay: Take US 101 S. to 92 E. towards Hayward. Take the Foster City Blvd/E. Hillsdale exit. Turn left onto Metro Center Blvd. Turn right to Foster City Blvd. Clinic will be on the right in the Martin Cove Shopping Center.

From East Bay: From 880, take San Mateo Bridge/Jackson St. exit. Take Foster City Blvd/E. Hillsdale exit. Merge onto Chabot Dr. Turn right onto Foster City Blvd. Clinic will be on the right in the Martin Cove Shopping Center.
PATIENT CONSENT FOR RELEASE OF MEDICAL INFORMATION

Date: ______________

I hereby authorize _________________________________________________________________
to release to the Reproductive Science Center of the Bay Area our medical records including history
and physical, physician notes, laboratory reports, x-rays and any other material regarding
consultations and treatment(s) which we have received. This information is requested for the purpose
of medical treatment and/or continuity of care.

If the information to be disclosed contains any of the types of records or information listed below,
additional laws relating to the use and disclosure of the information may apply. I understand and
agree that this information will be used or disclosed if I place my (and my partner’s, if applicable)
initials in the space next to the type of information:

Drug/Alcohol diagnosis, treatment referral information ______ / ______
HIV/AIDS information ______ / ______
Mental health information, including provider notes ______ / ______
Genetic testing information ______ / ______

Please release the requested information to:

The Reproductive Science Center of the Bay Area
Mail: 100 Park Pl, Suite 200, San Ramon, CA 94583
eFax: (925) 973-5064 Email: liz.gamez@integramed.com
Alternative fax (in case you have difficulty with the eFax line): (925) 901-1481

Appointment Date:_________________________ Physician: ________________________________

Name(Print): _______________________________ Spouse/Partner: _____________________________
Signature: _________________________________ Signature: _________________________________
Date of Birth: _____________________________ Date of Birth: _____________________________

Revocation: This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of
information by the disclosing party. My written revocation will be effective upon receipt, but will not be effective to the extent that the
requester or others have acted in reliance upon this authorization.

Redisclosure: I understand that the requester may not lawfully further use or disclose the health information obtained from another
health care provider unless another authorization is obtained from me or unless such use or disclosure is specifically required or
permitted by law. If this information is disclosed it may not be complete.

Duration: Please process this request within 15 days as provided by law. This authorization shall remain valid for 90 days from the
signature below. A copy of this authorization form shall be deemed as valid as an original.
In order to be more efficient and to better serve you, please take the time to complete this form in full. PRINT and do not use abbreviations, except N/A. We appreciate your time.

**PATIENT (Female) INFORMATION**

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<th>FIRST NAME</th>
<th>MIDDLE NAME</th>
<th>LAST NAME</th>
<th>STREET ADDRESS</th>
<th>CITY</th>
<th>STATE</th>
<th>ZIP</th>
<th>E-MAIL ADDRESS</th>
<th>HOME PHONE</th>
<th>WORK PHONE</th>
<th>TEL. # FOR CALL BACKS</th>
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<th>BIRTHDATE</th>
<th>AGE</th>
<th>EMPLOYER NAME</th>
<th>OCCUPATION</th>
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<th>MARITAL STATUS</th>
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**PARTNER INFORMATION**

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**EMERGENCY CONTACT** (If other than listed above)

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**ALLERGIES TO MEDICATIONS**

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**INDIVIDUAL RESPONSIBLE FOR PAYMENT** (If other than self or partner, please fill out)

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**INSURANCE INFORMATION** (Please present insurance cards to receptionist for copying)

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**FOR OFFICE USE ONLY - DO NOT WRITE BELOW THIS LINE**

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<th>DATE REGISTERED</th>
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Date Checked In | Initials | Date Registered | Initials | Date Updated | Initials | Date Updated | Initials
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction
This Notice of Privacy Practices is being provided to you on behalf of Reproductive Science Center (RSC) with respect to reproductive medical services provided at RSC’s facilities (collectively referred to herein as “We” or “Our). We understand that your medical information is private and confidential. Further, we are required by law to maintain the privacy of “protected health information.” Protected health information includes any individually identifiable information that we obtain from you or others that relates to your past, present or future physical or mental health, the health care you have received, or payment for your health care.

Your Rights
Although your health record is the physical property of RSC you have the right to:

- request a restriction on certain uses and disclosures of your information as provided by applicable law
- obtain a paper copy of this Notice of Privacy Practices upon request
- inspect and copy your health record as provided for by applicable law
- request an electronic copy of your electronic health record
- request to amend your health record as provided by applicable law
- obtain an accounting of disclosures of your health information as provided by applicable law.
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken
- request a restriction of disclosure of your healthy information to your health insurer for services for which you pay “out of pocket” in full
- transmit copies of your health information to third parties when request by you, in writing

Our Responsibilities:
We are required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations
- where required by law, notify you in the event that there has been a breach of your unsecured health information

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post the revised Notice of Privacy
Practices on our website at http://rscbayarea.com as well as at our offices and provide you with a hard copy upon request.

We will not use or disclose your health information without your authorization, except as described in this notice. We will not sell your health information (unless permitted by law) or use or disclose such information for paid marketing (for which we receive payment from a third party) without your authorization. If we obtain your authorization, you may revoke it at any time, and this revocation will take effect except where we have already relied upon your authorization.

Permitted Uses and Disclosures

We will and disclose use your health information for treatment. For example: information obtained by a nurse, physician or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him/her in treating you once you're discharged from this practice.

We will use your health information for payment. For example: A bill may be sent to you or a third party payer, such as an insurance company or health plan, for the purposes of receiving payment for treatment and services that you receive. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment. If you indicate your interest in participating in the Attain IVF Program, we will provide relevant information concerning your medical condition to IntegraMed America’s Attain Fertility Division for determination of your qualifications for this financing program.

We will use and disclose your health information for our health care operations. For example: Members of the clinical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and the reproductive medicine service we provide.

Other Uses or Disclosures of Protected Health Information

Business Associates: There are some services provided at RSC through contacts with business associates. For example: the management services of IntegraMed America, Inc. and certain laboratory tests. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we have asked them to do, and bill you or your third party payer for services rendered. So that your health information is protected, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with Spouse/Family: Health professionals, using their best judgment, may disclose to your spouse, family member, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. We will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object.
Research: We may disclose information to researchers when their 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.

Marketing: Where permitted by law, we may contact you to tell you about or recommend possible treatment alternatives or other medical technology and services that may be of interest to you. We may also seek your authorization to contact you with other marketing communications.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post marketing surveillance information to enable product recalls, repairs or replacement.

Public Health: As required by law, your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, disability or for other health oversight activities.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law, or in response to a valid subpoena. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Note:HIV-related information, genetic information, mental health records and other specially protected health information may be subject to certain special confidentiality protections under applicable State and Federal law. Any disclosures of these types of records will be subject to these special protections.

For More Information or to Report a Problem/Complaint

If you believe your privacy rights have been violated, you should immediately contact:

Karen Volpe, Director of Operations at 925 867 1800

We will not take action against you for filing a complaint. You may also file a complaint with the Secretary of Health and Human Services.

If you have any questions or would like further information about this notice, please contact Karen Volpe at the above address. This notice is also available on our website at http://rscbayarea.com

This notice is effective as of 5.1.2013
Privacy and Message Requirements

- I acknowledge that we have received a copy of Reproductive Science Center of the San Francisco Bay Area's Joint Notice of Privacy Practices and understand how my protected health information will be used for treatment, payment and healthcare operations.

- We authorize the Reproductive Science Center of the San Francisco Bay Area (RSC) to release information on medical care, treatment, and diagnostic results to each other because we are partners in care, and this information affects both of us.

- We also authorize the Reproductive Science Center of the San Francisco Bay Area to release information on our medical care, treatment, and diagnostic results to:  Name________________________  Date of birth____________

*This number will be entered into our computer system and always used to contact you. If you do not answer, a detailed message or cycle instructions will be left in voice mail. We do not recommend using a work number unless you can easily access it from home on the weekends. Please make sure the message identifies you by name.*

Patient’s Preferred Phone Number (   )Cell                (   )Home                        (   )Work
Private Phone Number with identified voicemail

Partner’s Preferred Phone Number (   )Cell                (   )Home                        (   )Work
Private Phone Number with identified voicemail

In signing this notice, you are giving us permission to leave detailed messages/instructions at this number. We look forward to providing you the highest quality care throughout your entire cycle with RSC.

Patient’s Printed Name                                          Signature                                                         Date
Partner’s Printed Name                                          Signature                                                         Date

Some patients prefer email be used in place of, or in addition to phone messages. RSC uses a secure email system for communication with patients. If you still wish us to use email please sign below that you are giving us permission to send detailed instructions / messages via the internet to the email address noted.

Patient’s Email Address

Partner’s Email Address

Patient’s Printed Name                                          Signature                                                         Date
Partner’s Printed Name                                          Signature                                                         Date
CONDITIONS OF TREATMENT / ASSIGNMENT OF BENEFITS

- I hereby voluntarily consent to outpatient care at the Reproductive Science Center of the SF Bay Area, encompassing routine diagnostic procedures, examination and medical treatment including, but not limited to routine laboratory work (such as blood, urine and other studies), ultrasound exams and administration of treatments and medications prescribed by the physician.

- I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the medical staff and their assistants, including nurse practitioners, registered nurses, medical assistants, or their designees as is necessary in the medical staff’s judgment.

- I understand that I am ultimately financially responsible for any and all charges incurred regardless of my insurance coverage. I understand that the Reproductive Science Center will bill my insurance as required by insurance contract provisions for those insurance plans that the Reproductive Science Center are currently contracted with. I further understand that I will remain responsible for any and all balances after the claim has been adjudicated, such as deductibles, co-pays, co-insurance, non-covered medical services, and supplies, etc.

- I further agree in the event of non-payment, my account is subject to collection action, in which I will be responsible for all costs of collection/legal fees, etc., should they be required.

- I hereby authorize the Reproductive Science Center to release all or part of my medical records and information necessary to process upon written request by my insurance company(s).

- I authorize payment of my medical benefits be made directly to the Reproductive Science Center.

- I further agree that a photocopy of this agreement shall be as valid as the original. I have fully read and I understand and agree to all of the above.

Note: Although the staff tries to stay abreast of all insurance information, it is the patient’s responsibility to review their benefits handbook and to know if they need a second opinion or pre-certification.

In acceptance of all these conditions above, signed:

Patient Name: ____________________________________________________________
Signature: _______________________________________________________________ Date: ______________

Partner Name: __________________________________________________________
Signature: _______________________________________________________________ Date: ______________
PATIENT HISTORY

Name: ____________________________________________  Age: _____________
Occupation: ____________________________________________

How did you hear about Reproductive Science Center? ________________________________________

How long have you been trying to become pregnant? ________________________________________

First day of your last period: _________________  Age when you had your first 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? _________________________________
If no, have you been told that you have polycystic ovary syndrome? _________________________
If no, do you have hot flashes? _______________________________________________________

When you bleed, how many days do you usually bleed for? _________________________________

Do home urine ovulation kits turn positive? □ Yes, on cycle day ______________________   □ No

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, lubricant type _____________________________   □ No

How much pain do you have with periods? □ Mild  □ Moderate  □ Severe
What medication(s) do you take for the pain? ____________________________________________
Do you notice any discharge from your breasts? ____________________________________________
Do you have any excess hair on your chin, chest, stomach, or thighs? __________________________

Have you ever had an abnormal pap smear? ____________________________________________

Have you ever had a biopsy, freezing procedure, or surgery on your cervix? __________________

Do you have fibroids, polyps, or any problems with your uterus? ____________________________

What forms of birth control have you used in the past?
□ Pills/Patch/Ring  □ IUD  □ Depo-Provera  □ Withdrawal  □ Condoms  □ Rhythm

Have you ever had an infection in your uterus or tubes requiring antibiotics? __________________

Have you had an HSG (x-ray test of the tubes)? □ Yes, results _____________________________   □ No

Have you ever had a laparoscopy surgery? □ Yes, results _____________________________   □ No

Have you been diagnosed with endometriosis? □ Yes, details _____________________________   □ No

Have you had your FSH level checked? □ Yes, results _____________________________   □ No

Have you had any other fertility testing? □ Yes, results _____________________________   □ No
If you have had any infertility treatment(s) in the past, please list below:

Clomid or Femara: _______________________________________________________________
Intrauterine insemination (IUI): _________________________________________________
Fertility Injections & IUI: _______________________________________________________
IVF: _________________________________________________________________________

How many times have you been pregnant? ___________  If you’ve been pregnant, please list below:

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<tbody>
<tr>
<td>1st Pregnancy</td>
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<tr>
<td>2nd Pregnancy</td>
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<tr>
<td>3rd Pregnancy</td>
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<tr>
<td>4th Pregnancy</td>
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</tbody>
</table>

Height: __________  Weight: ___________

Please list any medical conditions that you have been treated for in the past (including in childhood) or are currently being treated for by a doctor?
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

Current medications including prescription, over-the-counter, vitamins, supplements, and herbs:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Frequency</th>
<th>Route</th>
<th>Reason</th>
<th>Date Started</th>
</tr>
</thead>
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</tbody>
</table>

Do you have any allergies? ☐ Yes ☐ No  If Yes, what to? _______________________
Explain the reaction _________________________________________________________

Have you had any overnight stays in the hospital? _____________________________
Have you ever had a blood transfusion? ______________________________________

If you have had any surgeries in your lifetime, please give details below:

<table>
<thead>
<tr>
<th>Type of Surgery</th>
<th>Year</th>
<th>Reason</th>
<th>Findings or Results</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Please list any immediate family members with a history of diabetes, high blood pressure, cancer, early menopause, endometriosis, or any genetic diseases:
________________________________________________________________________________
________________________________________________________________________________

Are you a current smoker or have you ever been a regular smoker? _______________________
How many alcoholic beverages do you usually drink per week? ___________________________
How many caffeinated beverages do you drink per day (include coffee, tea, and soda)? __________
Have you ever had chicken pox or been vaccinated for varicella? If so, when? __________________________
MALE PARTNER HISTORY

Name: ___________________________________________         Age: _____________

Occupation: _______________________________________________

Height: _______     Weight: _________

Please list any medical conditions that you have been treated for in the past (including in childhood) or are currently being treated for by a doctor?
__________________________________________________________________________________________________
__________________________________________________________________________________________________

Current prescription medications, vitamins, supplements, herbs that you take regularly:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Times per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Have you had any allergic reactions to any medications in the past?  

- Yes, _______________  
- No

Have you had a semen analysis in the past?  

- Yes, results _______________________________  
- No

Have you ever produced a child with another partner?  

- Yes, _________________________  
- No

Have you had any other fertility testing?  

- Yes, results ____________________________  
- No

Have you had any infertility treatment in the past?  

- Yes, details _______________________  
- No

Do you have trouble getting an erection?  

- Yes  
- No

Do you have trouble maintaining an erection?  

- Yes  
- No

Do you have trouble ejaculating?  

- Yes  
- No

Have you noticed a change in your sexual drive?  

- Yes  
- No

Have you had any surgeries in your lifetime?
______________________________________________________________________________________
_____________________________________________________________________________________________

Do you have any medical history that would relate to a sperm or fertility issue such as:

- Frequent hot tubs, saunas?  
  - Yes, _________________________  
  - No

- Undescended testicle?  
  - Yes, _________________________  
  - No

- Groin injury or surgery?  
  - Yes, _________________________  
  - No

- Varicocele?  
  - Yes, _________________________  
  - No

- Vasectomy?  
  - Yes, _________________________  
  - No

Are you a current smoker or have you ever been a regular smoker?  
______________________________________________________________________________________

How many alcohol beverages do you usually drink per week?  
______________________________________________________________________________________

Do you use any recreational drugs?  
______________________________________________________________________________________

Please list any immediate family members with a history of diabetes, high blood pressure, cancer, or any genetic diseases:
______________________________________________________________________________________
GENETIC SCREENING CONSENT

The physicians at the Reproductive Science Center of the San Francisco Bay Area support your desire to conceive and have a healthy baby. There have been many advances in the area of genetics and, therefore, recommendations for screening have changed greatly in recent years. The American College of Obstetricians and Gynecologists (ACOG) and other professional societies now recommend that ALL women and men consider genetic screening before conceiving.

There are many diseases that are recessive, meaning a child can only get the disease if a mutation is inherited from both parents. If both partners carry a mutation for the same disease, they have a 25% chance of having a baby with the disease. When a person carries a recessive gene mutation, she/he does not have any symptoms and, therefore, most people do not know that they are carriers. The only way to find out if you are a carrier is to undergo genetic screening through a blood or saliva test. Many recessive diseases are serious, resulting in significant symptoms and a shorter life span. Two of the recommended standard genetic carrier screening tests are Cystic Fibrosis (“CF”) and Spinal Muscular Atrophy (“SMA”).

Your RSC physician recommends that you undergo genetic screening before you conceive. It may take 2-3 weeks to receive the genetic carrier screening test results. You can decide if you wish to proceed with this testing or decline this testing. Your treatment, however, cannot proceed until you have made a decision regarding genetic screening and signed the informed consent form attached. The decision to proceed with or decline screening will not impact any other aspect of your medical care at RSC.

If you and your partner are both found to be carriers, you may then choose certain fertility procedures such as in vitro fertilization (IVF) with preimplantation genetic diagnosis (PGD) or you may decide to conceive and have early testing in pregnancy to determine if the baby has the disease. Not all diseases can be tested for at the present time. Even if you test negative with the current technology available today, there is still a small chance that you could carry a gene mutation and, thus, have an affected child.

Once you undergo genetic screening, you will have the chance to review your results in detail with a genetic counselor. The physicians at RSC are not genetic counselors. If you have any questions about your decision to proceed with genetic screening, we can refer you to a genetic counselor. The cost of this appointment may not be covered by your insurance.

I/We acknowledge:
- My/Our RSC physician has recommended that I proceed with genetic screening before conceiving. I understand that it is my choice whether or not I proceed with this testing and that if I decline testing, I understand that a pregnancy could result in a child with a genetic disorder.
- Fertility treatment cannot proceed until I/we have made a decision regarding genetic carrier screening and, if I proceed with genetic carrier screening, I cannot start treatment until my results are reviewed and it is determined that screening for my partner is not indicated.
- The cost of the recommended testing may not be covered by my insurance plan and I will be responsible for the costs associated with the genetic carrier testing.
- It may be possible that even with a negative result I still could be a genetic carrier or predisposed to the genetic condition being tested due to the limitations of the testing.
Current Federal & State laws prohibit discrimination by insurance carriers based on results of genetic carrier screening tests.

I/We have had the opportunity to ask questions and have all my/our questions answered to my/our satisfaction. I/we understand that I/we have the option of meeting with a genetic counselor to discuss any aspect of genetic screening in further detail.

I/We have made the following decision regarding genetic carrier screening, free from coercion:

PLEASE INITIAL YOUR CHOICES. DO NOT USE CHECK MARKS

1. I/We **consent to** genetic screening and elect:
   - _____ _____ Counsyl Universal Panel (includes Cystic Fibrosis, Spinal Muscular Atrophy, and over 100 other autosomal recessive diseases)
   - _____ _____ Counsyl 2.0 Gene Sequencing (tests for the same diseases as the Universal panel but is a more detailed test and therefore is more expensive. It is often done if one partner screens positive as a carrier).
   - _____ _____ I/We understand that it can take 2-3 weeks for results to be received by RSC and that treatment cannot be started until that time. If we choose to test one partner to start and that partner tests positive as a carrier, we will need to wait to start treatment until the second partner’s test results are completed.

2. _____ I/We have already had genetic screening at RSC and **decline** further testing, understanding that our prior testing may not have been complete/comprehensive.

3. I/We **decline** genetic screening and understand this is against the advice of RSC physicians.
   - _____ _____ I/We agree to hold RSC, its physicians, agents and staff harmless from any and all liability should any consequences occur secondary to my declination of genetic carrier screening.

__________________________________________________________
________________________
Patient Name

________________________
Date of Birth

__________________________________________________________
________________________
Patient Signature

________________________
Date

**Picture Identification**

**Patient:**

Type: ____________________________ Exp. Date: ____________________________

**Picture Identification and Signature Confirmed/Witnessed By:**

________________________
Witness - Print Name and Title

________________________
Witness – Signature
Partner Name (If applicable)                          Date of Birth

Partner Signature                          Date

**Picture Identification**

**Partner:**
Type: _________________________________  Exp. Date: __________________

**Picture Identification and Signature Confirmed/Witnessed By:**

Witness - Print Name and Title          Witness – Signature