Kutteh Ke Fertility Associates of Memphis, PLLC
80 Humphreys Center, Suite 307
Memphis, TN 38120-2363
(901) 747-BABY (901) 747-2229 Fax (901) 747-4440
www.fertilitymemphis.com

Registration Form

PATIENT INFORMATION

NAME (Last, First, Middle Initial)			Date of Birth / /	Social Security Number - -
Address	City	State/Zip		Home Phone ( )
Employer	Occupation/Department			Cell Phone ( )
Employment Address	City	State/Zip		Work Phone ( )
Referring Physician	Address	City		State/Zip
Your email to notify you of announcements about our practice				
How did you hear about our practice?				

SPOUSE INFORMATION

NAME (Last, First, Middle Initial)			Date of Birth / /	Social Security Number - -
Address	City	State/Zip		Spouse Phone ( )
Spouse Employer	Occupation/Department			Work Phone ( )
Employer Address	City	State/Zip		

INSURANCE INFORMATION

Provider Name			Expiration Date	Relationship ____ Self ____ Spouse ____ Child ____ Other
Insurance Company	Address	City	State/Zip	
Insured Name	Group No., Policy No., I.D. No., Effective Date			
Secondary Insurance Co.				Relationship ____ Self ____ Spouse ____ Child ____ Other
Address		City	State/Zip	
Insured Name	Group No., Policy No., I.D. No., Effective Date			

PLEASE PRESENT INSURANCE CARD(S) TO RECEPTIONIST FOR PHOTOCOPYING

PATIENT'S RESPONSIBILITIES: I understand that as the patient, parent, or guardian, I am legally responsible for payment of all charges relating to my care. Patient and/or guarantor(s) agree to pay reasonable attorney's fees and cost of same.

PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment is correct. I authorize any holder of medical or other information about me to release to the insurance company or its representatives, any information needed for this or other insurance claim. In consideration of services rendered, I transfer and assign to Kutteh Ke Fertility Associates of Memphis, PLLC, any payment which may become due to me for medical and/or surgical services under policies applicable to me or my dependent.

Patient Signature _____ Date _____

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Initial Female Evaluation

Today's Date: _____

Name: _____ What is your age? _____ Date of birth: _____

Occupation? _____ Partners Name: _____

Who referred you to our care? _____ Who is your OB/Gyn? _____FAX_____

WHAT IS THE MAIN PURPOSE OF TODAY'S VISIT *(Circle as many as apply)*

1. Infertility (_____ years)
2. Blocked or damaged tube(s)/Tubes tied
3. Amenorrhea (*no periods*)
4. Polycystic Ovaries (PCOS)
5. Irregular menstrual cycles *(irregular periods)*
6. Hirsutism *(excess facial/body hair*)
7. Endometriosis
8. Leiomyomata (fibroids)
9. Male infertility/ low sperm count
10. Pelvic pain/Pelvic adhesions *(scar tissue)*
11. In vitro Fertilization (IVF)
12. Recurrent pregnancy loss (*miscarriages*)
13. Pregnancy compliation/Stillbirth
14. Menorrhagia *(heavy periods*)
15. Premature menopause
16. Other (Specify) _____

Have you been treated with these medications? *(Please circle)*

Provera (medroxyprogesterone acetate)	Progesterone (Prometrium, Crinone)
Clomiphene (Serophene, Clomid)	hCG (Profasi, Pregnyl, Ovidrel,Novaryl)
Letrazole (Femara)	Bromocriptine, cabergoline (Dostinex)
Gonal F, Follistim,	Lupron, Cetrotide, or Antagon
Bravelle, Repronex, Menopur	Synthroid/Levothyroxine
Glucophage , Metformin, or Avandamet	Heparin, Lovenox, Aspirin 81mg, IVIG

Other _____

Have you ever had any of these treatments? *(Please circle and indicate number of treatments)*

Intrauterine insemination (IUI)_____	Tubal/uterine surgery_____
In vitro fertilization (IVF)_____	Donor sperm insemination_____
Embryo adoption_____	Donor egg IVF _____
Frozen embryo transfer (FET)_____	Other_____

YOUR PREGNANCY HISTORY *(Please list ALL pregnancies)* Blood Type?_____

	Year of delivery	How many months to get pregnant	How long did the Pregnancy Last?	Who is the Father?	Any Complications?
1.					
2.					
3.					
4.					
5.					
6.					

PHYSICIAN USE ONLY

Total number of pregnancies _____
Full term (>37 weeks) _____
Pre term(20 to 37 wks)_____
Miscarriage (<20 wks)_____
Termination _____
Ectopic (tubal) _____
Living children _____

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ANATOMIC-UTEROTUBAL ASSESSMENT

Have you had a hysterosalpingogram (x-ray dye test of the tubes)? **Yes** **No**

When? _____ Where? _____

Results: _____

Have you had a sonogram (ultrasound of the uterus/ovaries)? **Yes** **No**

When? _____ Where? _____

Results: _____

Have you had surgery in your abdomen or pelvis? **Yes** **No**

When? _____ Where? _____

Procedure: _____

Procedure: _____

Have you had surgery (biopsy or conization) on your cervix? **Yes** **No**

Date of your last pap smear: _____ Was it normal? **Yes** **No**

Have you ever had: *(Circle as many as apply)*

Ovarian cysts or tumors	Endometriosis	Ectopic (tubal) pregnancies
Scar tissue in your pelvis	Uterine septum	Scar tissue inside your uterus
Uterine fibroids	Uterine polyps	Uterine birth defects
Chlamydia	Gonorrhea	Pelvic inflammatory disease

Any other sexually transmitted infection (e.g. herpes, genital warts, HPV, others)

ENDOCRINOLOGIC-OVULATION ASSESSMENT

Do you have regular, predictable, spontaneous menstrual periods? **Yes** **No**

Age of your first period: _____ How many days does your period last? _____

How many days from the first day of one period to the first day of the next? _____

If you do not have periods, when did they stop? _____

Do you have pre –menstrual symptoms: **Yes** (___Cramps ___breast pain, __bloating, ___mood change) **No**

Do you have pain or cramps with your periods? **Yes** (___mild, ___moderate, ___ severe) **No**

Do you have pelvic pain between your periods? **Yes** (when? _____) **No**

What medicine or action helps decrease the pain? _____

What have you used for birth control?_____ When did you stop? _____

Has you ever taken medicine to start your periods? **Yes** (when _____ what_____) **No**

Do you have or have you ever had: *(Please circle)*

Blood test for: Progesterone FSH TSH (thyroid) Glucose insulin hemoglogin A1C

nipple discharge hot flashes night sweats hair loss acne, diabetes thyroid disease

Unwanted hair on ____chin,____ sideburns, ____mustache,_____chest ____abdomen

What is your weekly exercise? _____

What is your weight? Currently_____ Ideally_____ One year ago_____ Five years ago_____

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PAST MEDICAL HISTORY/SYSTEMS REVIEW *[Circle any conditions that you have or have had]*

High blood pressure	Heart disease	Stroke	Mitral valve prolapse
Lung disease/Asthma	Cystic fibrosis	Hepatitis	Gallbladder disease
Bowel disease	Liver disease	Blood in stool	Skin disease
Psychiatric disease	Headaches	Depression	Neurological disease/seizures
Urinary tract infections	Kidney disease	Blood in urine	Cancer
Bleeding Disorder	HIV infection	Breast disease	Vision/hearing defects
Sickle cell anemia/trait	Other blood disease	Diabetes	Thyroid Disease

Other _____

Surgery or hospitalizations *(Give dates)*: _____

_____

_____

Date of your last mammogram? _____ Was it normal? **No** (explain_____) **Yes**

Current Medications *(include dosage, frequency, and any over-the counter or herbal drugs)*

_____

_____

_____

Medication Allergies _____

_____

Habits: Do you use tobacco? **Yes** **(**_____cig/day: _____total # of years) **No**

Are you a former smoker? **Yes** **(When did you quit? _____)** **No**

Do you drink alcohol? **Yes** **(**drinks/week: _____) **No**

Caffeine drinks per day: _____ Illicit drug use? **Yes** **No**

FAMILY HISTORY

	Age	Age at Death	Medical or Pregnancy Related Problems	
Mother:	_____	_____	_____	
Is she menopausal? **Yes** (what age _____ Reason for menopause _____)				**No**
Father:	_____	_____	_____	**None**
Brother/Sister:	_____	_____	_____	**None**
Brother/Sister:	_____	_____	_____	**None**
Brother/sister:	_____	_____	_____	**None**

Any cancer in the family? **Yes** (_____breast, ____ovarian, ____other _____ **No**

Any blood clots in the family? **Yes** (describe_____) **No**

Any autoimmune disease in the family? **Yes** (describe_____) **No**

Any medical diseases in your family? **Yes (**describe _____**)** **No**

Anyone in your family have? **Yes** (___genetic/inherited disease, ____birth defects, ___mental retardation) **No**

What is your ethnic background?_____

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MALE PARTNER EVALUATION P NP NA

Name: _____ Date of Birth:_____

Occupation: `_____ Name of urologist (if applicable): _____

Any previous pregnancies? **Yes** (Year and Outcome _____) **No**

Has your sperm been tested? **Yes** (When? _____ Result? _____) **No**

Have you had a varicocele of the scrotum? **Yes** (describe _____) **No**

Have you seen a urologist for any reason **Yes (describe _____)** **No**

Have you had? _____genital surgery, _____trauma, _____ genital infections, _____hernias? **No**

What health problems do you have?_____ **None**

What medications do you take?_____ **None**

Do you : smoke or use tobacco? **Yes** (cig/day: _____ Number of Years _____) **No**

use alcohol? **Yes** (drinks/week: _____) **No**

use illicit drugs? **Yes** (_____) **No**

Do you have allergies to any medications? **Yes** (_____) **No**

Does infertility run in your family? **Yes** (Whom? _____) **No**

What diseases run in your family? _____ **None**

SEXUAL HISTORY

How often do you and your partner have sexual intercourse? _____

Do you try to time intercourse to your ovulation? **Yes** (how? _____) **No**

Do you use any lubricants during intercourse? **Yes** (what kind? _____) **No**

Do you have any pain with intercourse? **Yes** (where? _____) **No**

Do you have any other sexual difficulties as a couple? **Yes** (explain _____) **No**

RECURRENT PREGNANCY LOSS: Yes___*(please answer below)* No __*(skip to next page)*

Genetic Factors:

Have you had a karyotype (chromosome) test? **Yes (**When_____Result:_____ **No**

Has your partner had a karyotype test? **Yes** (When_____Result_____ **No**

Have you had karyotype test on a miscarriage? **Yes (**When_____Result_____ **No**

Have you/your partner had any other genetic tests? **Yes** (When_____Result_____ **No**

Immunologic Factors: Do you have an autoimmune disease (e.g. lupus, rheumatoid arthritis, etc) **Yes** **No**

Personal history of autoimmune disease or abnormal immune tests? (Circle below**)** **Yes** **No**

Positive syphilis test	Lupus anticoagulant	Anticardiolipin antibodies
Antithyroid antibody	PTT dRVVT	Antiphospholipid antibodies
Rheumatoid factor	Immunologic therapy	Antinuclear antibodies

Other immune tests: Describe_____

Thrombophilic Factors:

Do you have a history of blood clots? **Yes** (When ____ What type_____**)** **No**

Circle any of these tests you have had: Factor V Leiden Factor II (prothrombin) MTHFR

Protein S Antithrombin Protein C

Have you ever been on a blood thinner? **Yes** (___Heparin, ___Lovenox,____Coumadin ____Baby Aspirin) **No**

Explain:_____

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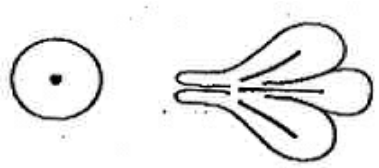
PHYSICIAN USE ONLY: PHYSICAL EXAMINATION

Ht: _____ Weight: _____ BMI: _____ kg/m^2 BP: _____ RR: _____ Temp: _____

HEENT incl. thyroid	N	AbN
Skin incl. hirsutism	N	AbN
Neurological	N	AbN
Heart/CV	N	AbN
Respiratory	N	AbN
Ext. Genitalia/Vagina/Cervix	N	AbN
Adnexae	N	AbN



Uterus Size: _____ Position: _____

FEMALE DIAGNOSIS and CPT

1) CPT _____ CPT _____
2) CPT _____ CPT _____
3) CPT _____ CPT _____
4) CPT _____ CPT _____
5) CPT _____ CPT _____
6) CPT _____ CPT _____

MALE DIAGNOSIS and CPT

1)_____ CPT _____
2)_____ CPT _____
3)_____ CPT _____
4)_____ CPT _____

LMP: _____ Today is cycle day: _____ Urine hCG Result:_____

MICRO: Chlamydia Mycoplasma Aero/Anaerob Culture Urine Analysis Urine C&S

GENERAL: PNS CBC CMP Platelet Iron Profile Sickle cell Screen

REI: CD3 FSH/LH/E2 Random FSH/LH CD _____ P4 AMH Quant hCG

ENDO: TSH PRL HgBA1C Fasting Insulin Free T Total T Lipid Profile
8am Cortisol 17-OHP SHBG DHEAS

GENETIC: Karyotype-wife FMR1 PCR CF mutation analysis

ANATOMIC: HSG GYN USG DAY 3 USG Sonohysterogram Trial Transfer

IMMUNE: LAC APA anti-β2GP1 Anti-adrenal Anti-thyroid ANA anti-DS-DNA

THROMB : Factor V Leiden Factor II MTHFR Prot C Act Prot S Act Antithrombin

MALE: Semen analysis Sperm culture Retrograde analysis ASAb Refer to Urology

MALE ENDO: FSH LH PRL TSH Total T Free T

MALE STD: HIV I/II RPR Hepatitis BsAg Hepatitis C Ab

MALE GENETIC: Karyotype Y-chromosome microdeletion CF mutation analysis CryoBank

Need HSG films/Records from: _____ Book OR: _____ F/U Appt: _____

INFO/ADVICE

Clomid/Femara
DOR
PCOS
FSH IUI
RPL
LS/HS
APA/Heparin
Lovenox
Fibroids
IVF ICSI PGS
Stop Smoking
Weight Loss
MALE
Clomid Resistance
Donor oocytes
Donor Sperm

Date _____ Nurse/Resident_____ MD _____ Dictated _____

Authorization for the Release of Medical Information

(Copying Charges:$20 for 1st 5 pages & $.50 each addional page for personal use, physician, insurance and attorneys)

I hereby authorize and request records to be released for:

Patient's Name:_____Other names seen under:_____

Patient's Address:_____

Phone #:_____Social Security #:_____Date of Birth:_____

Chart #:_____ Records Requested for date(s) of _____to _____

Records To Be Received From:	**Records To Be Sent To:**
_____	_____
Health Care Facility or Physician Name	Health Care Facility or Physician Name
_____	_____
Address	Address
_____	_____
City, State & Zip Code	City, State & Zip Code

Authorization applies to the following information: (Check all applicable)

☐ Office Notes ☐ Lab Reports ☐ HSG Reports ☐ Ultrasounds ☐ OP Reports
☐ H & P's ☐ D/C Summary ☐ Semen Analysis ☐ Misc. Correspondence

Purpose of Release: (Check Applicable Reason)

☐ Consult (2nd Opinion) ☐ Seeking New Physician ☐ Relocation ☐ Referral
☐ Dissatisfied with Service ☐ Attorney Request ☐ Insurance Request ☐ Personal Reasons

Expiration Notice: I understand that this authorization shall expire, without express revocation, when processing is completed and/or 90 days.

Records from other facilities/redisclosure: It is a policy of Fertility Associates of Memphis, PLLC to release only medical information documented, or dictated by Fertility Associates of Memphis, PLLC health care providers. If you have been treated by other health care providers, please contact them and make arrangements to release any information you may need. Federal Regulations prohibit us from making any further disclosure of disclosed information without specific written consent of the person to whom it pertains.

Fertility Associates of Memphis ___will _____will not receive payment or other remuneration from a third party other than my insurance in exchange for using or disclosing this Personally Identifiable Health Information. I do not have to sign this authorization in order to receive treatment and may, in fact, refuse to sign.

_____

Signature of Person Authorized (Parent or Legal Guardian) **Date**

Completed by: Date Mailed: Date of Pick Up/Fax: Paid (if applicable): $

FERTILITY ASSOCIATES of MEMPHIS

William H. Kutteh, MD, Ph.D Raymond W. Ke, MD

I hereby grant Catalyst HCM, Inc. and Kutteh Ke Fertility Associates of Memphis, PLLC the use of videotape, photo and/or audio tape recordings of my likeness/voice/performance in connection with the production, presentation and distribution of the videotape presentation named below.

I agree that my name, likeness, voice and biographical material about me may be used in connection with publicity about the production named below. I release you and your assigns from any further claims or demands arising from the uses of materials you may record in which I appear or am heard.

Kutteh Ke Fertility Associates of Memphis, PLLC Website or Fertility Story _____initials

Kutteh Ke Fertility Associates of Memphis, PLLC Television , Print Advertisements_____initials

Participant's signature_____

Participant's name printed_____Date signed_____

Participant's address_____

City_____ State_____ Zip_____ Phone _____

Email address:_____

If the participant is a minor(s), please complete section below:

I represent that I am a parent or guardian of the minor(s) named above. I hereby agree that we shall both be bound thereby.

Minor(s) name _____

Parent or guardian signature_____

Parent or guardian name printed_____Date signed_____

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