



**THE MIDWEST CENTER FOR
REPRODUCTIVE HEALTH, P.A.**

Arbor Lakes Medical Building, Suite 350
12000 Elm Creek Blvd North
Maple Grove, MN 55369

Phone 763.494.7700

Toll Free 800.508.9763

Fax 763.494.7706

Web Site www.mcrh.com

Patient Guide

The Midwest Center for Reproductive Health, P.A.

Thank you for choosing The Midwest Center for Reproductive Health, P.A. (MCRH). Please accept our warmest welcome to you from the staff at MCRH, as well as our thanks for your interest in the services we provide. We understand the struggles that you face and truly strive to provide the finest care possible in a compassionate and professional environment. It is our hope that we will lay the foundation for success with our individualized treatment based on the unique needs of each patient. We ask that you use this information as a guide in order to familiarize you with MCRH and prepare yourself for what to expect before, during, and beyond your first appointment.

Before Your Appointment:

To ensure your new patient appointment is most beneficial to you, we begin by asking that the following forms be thoughtfully completed and received in our office one week before your appointment. Please feel free to return your completed forms by mail, using the enclosed addressed envelope, or by fax at (763) 494-7706. If you choose to fax your completed forms, please bring the original copy to your scheduled appointment. If you have a copy of your medical records, you may include a copy with the following forms:

_____ **Patient Registration Form and Consent for Treatment** – Carefully read and complete both pages of this form. Since this serves as a consent for services, completion of this form is required before your appointment. Be sure to have both patient and spouse or partner (if applicable) initial, sign, and date and mail or fax back to MCRH.

_____ **History Forms** (both female and spouse/partner) – Each of you should individually complete the appropriate form to the best of your knowledge. Please indicate “not applicable” when this is the case. Completion of these forms allows the staff at MCRH to better understand your individual situation and provide a more individualized discussion during your consultation. Please complete both of these forms and mail or fax back with your **Patient Registration Form and Consent for Treatment**.

If you do not have a copy of your medical records, we ask that you authorize the release of pertinent medical information from your doctor to MCRH. Obtaining a copy of your medical records, in addition to your male and female history forms, will provide the MCRH staff with more knowledge about your fertility treatments (if any) thus far. To obtain a copy of your medical records, please see instructions below:

_____ **Medical Records** – It is most beneficial if medical records from current and/or previous infertility treatment are received in our office as soon as possible before your consultation. In order to expedite the transfer of your previous medical records, enclosed is an “**Authorization for Release of Medical Information**” form for you to return directly to your physician. If you and/or your partner have more than one physician that you have been working with, please feel free to duplicate or to ask MCRH for additional copies of this form. Any medical records released from other facilities will have pertinent information extracted and will be returned to you at the time of your new patient consultation. If your new patient consultation is done via phone, the records will be mailed back to you. This will also enable you to have your own copy to reference in the future.

You should also expect a telephone call from one of the MCRH nursing staff before your appointment. The nurse will confirm your appointment, the receipt of your new patient paperwork and your medical records, and will ask any questions regarding your medical history. This phone conversation will help further to clarify your individual situation and any specific topics you wish to discuss during your initial consultation.

What to Expect at Your New Patient Appointment:

Your initial appointment is scheduled as a consultation with your physician. In order to give you both the opportunity to meet your physician and other members of the MCRH team, we strongly recommend both you and your spouse or partner attend the new patient consultation. During this appointment you will have the opportunity to have a dialogue between you and your physician, outline any previous treatments, and discuss options for further treatment. Generally, this appointment is approximately 30 minutes in length however, please keep in mind that your appointment may be longer or shorter depending on your unique requirements. **It is with sensitivity to all patients and with regards to the particular nature of our practice, we ask that children do not accompany you to your appointment.**

If you decide that you would like to proceed with a treatment program, you may have the opportunity to meet with the specific program coordinators if you desire. Specialists from the billing office will also be available to outline your financial options and to answer any billing and/or insurance questions you may have.

Office Location:

Our office is located in Maple Grove, MN. Please see the enclosed map for specific location. There are also many additional satellite locations in other areas as well. Please see the Practice Locations sheet also included in this folder for alternate locations. If you have any questions regarding directions, please call the front desk at: (763) 494-7700 or (800) 508-9763 and select option 1.

Cancellation Policy:

A fee will apply for appointments not cancelled at least 72 hours in advance. While we regret the need to do this, this policy allows us to better serve all of our patients who may be waiting for an appointment time.

Billing and Insurance Policies and Questions:

Understanding your medical insurance coverage and your benefits for infertility treatment can be confusing and time consuming. Our Business Office staff is available to answer questions as they arise. However, because plans vary greatly, it is probably best to start by contacting your insurance company directly. Please see the "Insurance and Financial Information" packet included in this new patient folder for more information. A representative from the Business Office will also meet with you after your initial consultation to discuss your individual treatment costs and payment options.

The fee for a new patient consultation is generally \$355, although this can vary depending on the amount of time spent, the complexity of your medical history, and your options for treatment. This appointment may or may not be covered by insurance and includes chart preparation, extraction of your previous medical records, medical records review with a member of the nursing staff before your appointment, and your physician consultation.

If you have questions or concerns regarding fees or insurance coverage, please contact the Business Office by calling (763) 494-7736. Many times all it takes is a phone call to ease your insurance concerns and answer your questions.

We look forward to meeting you at your new patient consultation. Please do not hesitate to call with further questions. We also encourage you to visit our website at www.mcrh.com for more information.

Additional Helpful Information

Office Hours:

- Monday through Thursday, 7:00 a.m. - 4:00 p.m.
- Friday, 7:00 a.m. - 12:00 p.m.
- Weekend/holiday hours are available by appointment.

Appointment Scheduling:

Telephone hours are as follows:

- Monday through Thursday, 8:00 a.m. - 12:00 p.m., 1:00 p.m. - 4:00 p.m.
- Friday, 8:00 a.m. - 12:00 p.m.

Please feel free to call for appointments, medication refills, general questions, and other routine clinic communications during these times.

After clinic hours and weekends:

- **Non-emergency calls** should be made to the nurse line at (763) 494-7726. Messages may be left at any time and if necessary, a nurse will return your call by the following day.
- **In case of an emergency**, the answering service may be phoned at (763) 494-7700 or (800) 508-9763. A nurse will be paged to return your call and medical direction will be given.

Please note that in order to serve all of our patients, we ask that you only page the on-call nurse in an emergency. Non-emergent pages will be billed accordingly.

Laboratory Services:

- Monitoring services and procedures that can be performed at MCRH include: ultrasounds, specific blood testing, intrauterine insemination, post coital testing and sonohysterograms.
- Laboratory services are coordinated between our office and the North Memorial Laboratory. A lab requisition form is needed for any necessary blood work and can be obtained through our office.
- Patients may also choose to coordinate specified laboratory procedures through the services affiliated with their satellite physician.

Andrology Services:

- Andrology services include: semen analysis, semen analysis with strict criteria, antisperm antibody testing, intrauterine insemination preparation, and cryopreservation of back up semen specimen.
- Andrology services are available and conducted through our Reproductive Biology Laboratory by appointment. Testing will be done from 7:00 a.m. - 1:00 p.m. Monday through Thursday and 7:00 am - 9:00 am on Friday. Our office will provide lab order forms for these appointments. Inseminations will be coordinated between the lab and the clinical staff of MCRH.

Support Services/Social Worker:

- Sally Sibbitt, MSW, LICSW, is a clinical social worker specializing in working with infertility and reproductive loss, as well as with other issues. She is a valuable member of our team and we encourage you to utilize her services. She may be contacted directly by calling (952) 925-3533.

Medical Records Policy:

- If you would like to receive a copy of your medical records after becoming a patient of ours, please call (763) 494-7700 or (800) 508-9763 and select option 1. An MCRH Authorization for Release of Medical Information and/or a current Patient Registration Form is required and must be signed by both patient and spouse/partner if applicable. As per MCRH policy, appropriate fees will apply.

Please visit our web site at:

www.mcrh.com

for more information about our clinic.



**THE MIDWEST CENTER FOR REPRODUCTIVE HEALTH, P.A.
AND THE SUBSIDIARY GREAT PLANES REPRODUCTIVE CENTERS, P.A.**

Full completion of this form is mandatory prior to MCRH providing any medical services.

PATIENT REGISTRATION RECORD/CONSENT FOR TREATMENT

Date _____ Appt. Date _____ Physician Referred: Yes____ No____ If yes, Name _____

FEMALE PATIENT INFORMATION (Print legal name as it appears on driver's license, social security card, etc.)

Patient _____

Last First MI Nickname

Address _____ City _____

State _____ Zip _____ Phone (_____) _____ - _____ *Choose one:* Home Cell Voicemail Y / N

Birth Date _____ - _____ - _____ Age _____ Social Security Number _____ - _____ - _____

Current Marital Status _____ Married _____ Divorced _____ Single _____ Widowed

*Marital Status is required to provide necessary consenting and patient chart preparation.

Employer _____ Phone (_____) _____ - _____ *Choose one:* Work Cell OK to Call Y / N

Employer's Address _____ City _____ State _____ Zip _____

INSURANCE INFORMATION

Patient's Primary Insurance Company/Plan Name _____

Group # _____ Contract/ID# _____ Policy Holder Name _____

Eff Date _____ Insurance Company Address _____

SPOUSE/PARTNER INFORMATION Spouse Partner (please check appropriate box)

(Print legal name as it appears on driver's license, social security card, etc.)

Spouse/Partner Name _____

Last First MI Nickname

Birth Date _____ - _____ - _____ Age _____ Social Security Number _____ - _____ - _____

Employer _____ Phone (_____) _____ - _____ *Choose one:* Work Cell OK to Call Y / N

Employer's Address _____ City _____ State _____ Zip _____

SPOUSE/PARTNER INSURANCE INFORMATION

Insurance Company/Plan Name _____

Group # _____ Contract/ID# _____ Policy Holder Name _____

Eff Date _____ Insurance Company Address _____

*Please refer to the business office information in your new patient packet for specifics regarding insurance.

EMERGENCY CONTACT

Name of Person to Contact (not living with you) _____ Relationship _____

Address _____ Phone (_____) _____ - _____

CONSENT FOR SERVICES

The following information must be **initialed and signed** by **both** patient and spouse/partner below. Please indicate if spouse/partner is not applicable. **Full completion of this form is mandatory prior to The Midwest Center for Reproductive Health, P.A (MCRH) providing any medical services.**

Patient Initial _____
Spouse/ Partner Initial

CONSENT FOR TREATMENT. I hereby consent to and authorize the physician(s) and their designees to perform whatever routine diagnostic procedures, treatment, laboratory tests, and to administer such medications in his/her opinion are necessary or advisable.

Patient Initial _____
Spouse/ Partner Initial

TESTING. I understand that while receiving care accidental exposure to my blood or other body fluid may occur. If this rare event occurs, I understand that my blood will be tested for the presence of Bloodborne Pathogens (Hepatitis B, Hepatitis C, and Human Immunodeficiency Virus). These tests are necessary to help protect and counsel the exposed individual. I understand that results of the tests will be a part of my medical record and will not be released except with my prior consent or as required or permitted by law.

Patient Initial _____
Spouse/ Partner Initial

RELEASE OF MEDICAL RECORDS. I hereby authorize MCRH to release to myself, spouse/partner, my referring physician, insurance company, physicians referred by MCRH, or legal guardian, any information, including diagnosis and records of treatment, concerning my past and present medical care. I understand that my medical records will be maintained jointly with my spouse/partner's throughout my care at MCRH. Additionally, I authorize access to MCRH Reference Laboratory results if previously tested. I accept the risks associated with releasing medical records via fax and/or mail.

Patient Initial _____
Spouse/ Partner Initial

NOTICE OF PRIVACY PRACTICES. I acknowledge the receipt the Notice of Privacy Practices Effective April 14, 2003.

Patient Initial _____
Spouse/ Partner Initial

RELEASE OF PERSONAL PROPERTY RESPONSIBILITY. I understand that MCRH is not responsible for the loss of valuables and assumes no responsibility for any losses.

Patient Initial _____
Spouse/ Partner Initial

PAYMENT/INSURANCE CONSENT. I acknowledge responsibility for payment for services rendered to me at MCRH. If my account becomes delinquent, I agree to pay all costs the center may incur in collecting its fees including collection agency & attorney fees. If charges on my account are not fully paid within 120 days of the date of service, I also agree to pay interest from that date at a rate of 1.5% per month. Unless full payment is made on the date of service, I authorize my insurer to pay my medical benefits directly to MCRH.

Patient Initial _____
Spouse/ Partner Initial

HEALTHPARTNERS INSURANCE (HealthPartners Patients Only). I understand that MCRH is a participating provider with HealthPartners insurance and it is my responsibility to obtain a referral from my primary care physician for all care received at MCRH. I acknowledge and accept responsibility for all charges denied or identified as non-covered by HealthPartners.

Patient Initial _____
Spouse/ Partner Initial

BCBS INSURANCE (BCBS Patients Only). MCRH is an "in-network" provider for consultations and services at Duluth, Fargo, and Bismarck. However, coverage for services provided at MCRH in Maple Grove will be considered "out-of-network".

In addition, a photograph will be taken and used as additional means of identification throughout your care at MCRH.

Patient Legal Name Printed _____

Patient Signature _____ Date _____

Spouse/Partner Legal Name Printed _____

Spouse/Partner Signature _____ Date _____

THE MIDWEST CENTER FOR REPRODUCTIVE HEALTH, P.A.

Female History Form

Each of you should individually complete the appropriate form to the best of your knowledge.

I. IDENTIFYING INFORMATION

Date _____

Name _____ Partner's Name _____

Date of Birth _____ Duration of Relationship _____ Duration of attempting pregnancy _____

Nature of present employment (title, brief description) _____

II. MEDICAL HISTORY

Height _____

Weight _____

Do you have or have you ever been diagnosed with or treated for (check all that apply):

- | | | |
|---|--|--|
| <input type="checkbox"/> Chronic Headaches | <input type="checkbox"/> Anemia | <input type="checkbox"/> Breast Discharge |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Cancer Specify: _____ | <input type="checkbox"/> Chlamydia |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hirsutism (excessive hair growth) | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Thyroid Disease/Surgery | <input type="checkbox"/> Gonorrhea |
| <input type="checkbox"/> Neurological Problem | | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Poor Sense of Smell | <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Ovarian-Cysts |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Colitis | <input type="checkbox"/> Pelvic Infection |
| <input type="checkbox"/> Visual Disturbance | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Syphilis |
| | <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gall Bladder Disease/Surgery | <input type="checkbox"/> Kidney Infection |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Lupus Erythematosus |

Cardiovascular History

- | | | |
|--|-----|----|
| Bleeding Disorder | Yes | No |
| Blood Clots | Yes | No |
| High Blood Pressure | Yes | No |
| History of Heart Disease | Yes | No |
| Heart Murmur | Yes | No |
| Antibiotics needed for dental/surgical procedure | Yes | No |

Allergies

- | | | | |
|-------------------|-----|----|---------------------|
| General Allergies | Yes | No | If yes, list: _____ |
| Drug Allergies | Yes | No | If yes, list: _____ |
| Latex Allergy | Yes | No | |
| Iodine Allergy | Yes | No | |
| Egg Allergy | Yes | No | |

Prescribed Medications:

- | | | | |
|-----------|-----|----|---------------------|
| Past Year | Yes | No | If yes, list: _____ |
| Current | Yes | No | If yes, list: _____ |

Over-the-Counter Medications:

- | | | | |
|--------------------|-----|----|---------------------|
| Current | Yes | No | If yes, list: _____ |
| Homeopathic/Herbal | Yes | No | If yes, list: _____ |

Current Use of the Following:

- | | | | |
|--------------------|-----|----|--|
| Alcohol | Yes | No | If yes, type: _____ amount per week: _____ |
| Smoking | Yes | No | If yes, number of packs per day _____ |
| Recreational Drugs | Yes | No | If yes, type: _____ frequency: _____ |

III. CONTRACEPTIVE/SEXUAL HISTORY

Have you used in the past (check all that apply):

____ Birth Control Pills Name: _____

____ IUD Name: _____

____ Depo-Provera

If you've ever been on oral contraceptives (pills), were your periods regular after stopping the pills? Yes No

Do you use lubricants for intercourse? Yes No If yes, type: _____

Is intercourse painful or difficult for you? Yes No

How many times per week do you and your partner have intercourse? _____

How many times do you have intercourse at the time of ovulation? _____

Indicate your sexual orientation by circling one of the following: Heterosexual Homosexual Bisexual

IV. MENSTRUAL AND PREGNANCY HISTORY

Age at first period? _____

Are your periods regular? Yes No

If yes, what is the usual length (from onset of period to the onset of your next period) ? _____

If no, how many times per year do you menstruate? _____

Progesterone or Provera needed to initiate bleeding? Yes No

What is the usual duration of your period? _____

Are cramps: ____mild ____moderate ____severe

Do you bleed or spot between periods? Yes No

How many pregnancies (including elective abortions) have you had? _____

Pregnancy	Year conceived	How long to conceive?	Infertility therapy required to conceive?	(choose one)		Date baby born	Vaginal delivery or C-section?	Complications?	Male or female	Is current partner the father?	
				Elective Abortion?	Miscarriage?					Yes	No
1st					____ wks					Yes	No
2nd					____ wks					Yes	No
3rd					____ wks					Yes	No
4th					____ wks					Yes	No
5 th					____ wks					Yes	No

V. FAMILY HISTORY

Is there a family history of cancer/malignancy

____ Ovarian Yes No whom: _____

____ Breast Yes No whom: _____

____ Other Yes No whom: _____

Is there a history of hormonal disorders in your family? Yes No

If yes, who and what type _____

Is there a family history of

Cystic Fibrosis? Yes No If yes, whom: _____

Tay Sachs Disease Yes No If yes, whom: _____

Sickle Cell Anemia Yes No If yes, whom: _____

With which of the following racial/ethnic group do you identify? Check the appropriate racial/ethnic group?

- American Indian/Alaska Native Asian Black/African American
 Hispanic/Latino Native Hawaiian or Other Pacific Islander White/Caucasian
 Unknown/Not Stated

VI. INFERTILITY HISTORY/TREATMENT

Have you been treated for infertility before? Yes No

If yes, who was your physician? _____
Infertility diagnosis? _____

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

- | | | |
|--|-------------|----------------|
| <input type="checkbox"/> BBT (Basal Body Temperature) | When? _____ | Results: _____ |
| <input type="checkbox"/> Postcoital Test | When? _____ | Results: _____ |
| <input type="checkbox"/> Hormonal Testing (FSH, LH, prolactin, estrogen, DHEA-S, testosterone, progesterone) | When? _____ | Results: _____ |
| <input type="checkbox"/> Endometrial Biopsy | When? _____ | Results: _____ |
| <input type="checkbox"/> Hysterosalpingogram (HSG) | When? _____ | Results: _____ |
| <input type="checkbox"/> Mycoplasma/Chlamydia cultures | When? _____ | Results: _____ |
| <input type="checkbox"/> Thyroid tests | When? _____ | Results: _____ |
| <input type="checkbox"/> Pap Smear (most current) | When? _____ | Results: _____ |
| <input type="checkbox"/> Other - Specify _____ | When? _____ | Results: _____ |

Immunology/Recurrent Pregnancy Loss Testing (if applicable)

- | | | | | |
|--------------------------|-----|----|-------------|----------------|
| Anticardiolipin Antibody | Yes | No | When? _____ | Results: _____ |
| Lupus Anticoagulant | Yes | No | When? _____ | Results: _____ |
| Anti-Chlamydial Antibody | Yes | No | When? _____ | Results: _____ |

Have you ever had any of the following procedures/surgeries:

- | | | | |
|--------------------------------|-----|----|-------------|
| Appendectomy | Yes | No | Date: _____ |
| Cervical Conization or Cautery | Yes | No | Date: _____ |
| C-Section | Yes | No | Date: _____ |
| D & C | Yes | No | Date: _____ |
| Hysteroscopy | Yes | No | Date: _____ |
| Laparoscopy | Yes | No | Date: _____ |
| Laparotomy | Yes | No | Date: _____ |
| Tubal Ligation | Yes | No | Date: _____ |
| Tubal Reversal | Yes | No | Date: _____ |
| Other _____ | Yes | No | Date: _____ |

Indicate the following treatment types you have undergone or are currently undergoing:

- | | |
|--|-------------------------|
| <input type="checkbox"/> Clomid | Number of Cycles: _____ |
| <input type="checkbox"/> Superovulation | Number of Cycles: _____ |
| <input type="checkbox"/> Intrauterine Insemination (IUI) | |
| <input type="checkbox"/> Husband's Sperm | Number of Cycles: _____ |
| <input type="checkbox"/> Donor Sperm | Number of Cycles: _____ |

In Vitro Fertilization Yes No
Number of Fresh Cycles: _____ Number of Frozen Cycles: _____

Facility/location where treatment occurred _____

THE MIDWEST CENTER FOR REPRODUCTIVE HEALTH, P.A.

Male History Form

Each of you should individually complete the appropriate form to the best of your knowledge.

I. IDENTIFYING INFORMATION

Date _____

Name _____ Partner's Name _____

Date of Birth _____ Nature of present employment (title, brief description) _____

II. MEDICAL HISTORY

Height _____ Weight _____

Do you have or have you ever been diagnosed with or treated for (check all that apply):

- | | | |
|--|---|---|
| <input type="checkbox"/> Neurological Problem | <input type="checkbox"/> Asthma | <input type="checkbox"/> Breast Discharge |
| <input type="checkbox"/> Poor Sense of Smell | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Chlamydia |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> Gonorrhea |
| <input type="checkbox"/> Visual Disturbance | | <input type="checkbox"/> Herpes |
| | | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Colitis | <input type="checkbox"/> Mumps/Testes Involvement |
| <input type="checkbox"/> Cancer Specify: _____ | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Prostatitis |
| | <input type="checkbox"/> Gall Bladder Disease/Surgery | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Testes Infection |
| <input type="checkbox"/> Thyroid Disease/Surgery | | <input type="checkbox"/> Testes Injury |
| | | <input type="checkbox"/> Testes Tumor |
| | | <input type="checkbox"/> Undescended Testes |

Allergies

General Allergies Yes No If yes, list: _____
Drug Allergies Yes No If yes, list: _____

Prescribed Medications:

Past Year Yes No If yes, list: _____
Current Yes No If yes, list: _____

Over-the-Counter Medications:

Current Yes No If yes, list: _____
Homeopathic/Herbal Yes No If yes, list: _____

Current Use of the Following:

Alcohol Yes No If yes, type: _____ amount per week: _____
Smoking Yes No If yes, number of packs per day _____
Recreational Drugs Yes No If yes, type: _____ frequency: _____

Do you frequently use saunas, steam baths, or whirlpools? Yes No

Have you had a high fever (over 102° F) during the past three to four months? Yes No

III. SEXUAL HISTORY

- Have you ever tried to produce a child with another partner? Yes No
- Have you produced a child with another partner? Yes No
If yes, how long did it take to produce the child? _____
When? _____
- Do you have trouble getting an erection? Yes No
- Do you have trouble maintaining an erection? Yes No
- Do you have trouble with ejaculations? Yes No
If yes, ___ premature ejaculations ___ retrograde ejaculations
- Do you feel that your ejaculate is deposited into the vagina? Yes No
- Do you have any abnormal discharge from your penis? Yes No
- How many times per week do you and your partner have intercourse? _____
- How many times do you have intercourse around ovulation? _____
- Have you recently noticed a change in your sexual drive? Yes No
- Have you had an injury or an abnormality of penis, testicles or prostate? Yes No
If yes, when? _____ Outcome/result _____
- Indicate your sexual orientation by circling one of the following: Heterosexual Homosexual Bisexual
- Has your partner ever conceived a child with someone other than yourself? Yes No

IV. FAMILY HISTORY

Is there a history of hormonal disorders in your family? Yes No
If yes, who and what type _____

Is there a family history of

Cystic Fibrosis?	Yes	No	If yes, whom: _____
Tay Sachs Disease	Yes	No	If yes, whom: _____
Sickle Cell Anemia	Yes	No	If yes, whom: _____

With which of the following racial/ethnic group do you identify? Check the appropriate racial/ethnic group:

- ___ American Indian/Alaska Native ___ Asian ___ Black/African American
- ___ Hispanic/Latino ___ Native Hawaiian ___ White/Caucasian
or Other Pacific Islander
- ___ Unknown/Not Stated



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Web Site www.mcrh.com

AUTHORIZATION FOR RELEASE OF PATIENT MEDICAL INFORMATION

Patient Name (print) _____ Birth Date _____

Former Name (if any) _____ Telephone _____

Spouse/Partner Name (print) _____

RELEASE INFORMATION FROM (Medical Facility):

Facility: _____

Address: _____

City, State, Zip _____

Phone: _____

Fax: _____

RELEASE INFORMATION TO:

MCRH c/o Trinity Medical Group

Attn: Candace Langseth

400 Burdick Expressway East

Minot, ND 58701

Phone: (701) 857-7385 Fax: (701) 857-7879

I hereby authorize the above party to release the following medical information from (date) _____ to _____.
Date last seen in your office _____.

This information should be including but not limited to the following records:

FEMALE

- | | | |
|---|---|------------------------------|
| • Operative Reports | • Biopsy Reports | • Current Pap |
| • HSG Reports and Films | • Post Coital Results | • Antisperm Antibody Results |
| • Flow sheet from ovulation induction and superovulation cycles | • Hormonal Studies (LH, FSH, TSH, Prolactin, and DHEAS) | • Rubella |

MALE

- | | | |
|--------------------------|------------------------------|-------------------------------|
| • Semen Analysis Results | • Antisperm Antibody Results | • Urology - Operative Reports |
|--------------------------|------------------------------|-------------------------------|

OTHER

- Any other records pertaining to the specific problem you are coming in to see the physician for.

* If applicable: If there is documentation pertaining to alcoholism/drug abuse, mental health/rehabilitation, HIV/AIDS, do you wish for this information to be released? Yes____ No____

I (we) understand that I (we) may revoke this consent at any time with written notification, but that the revocation will not have any affect on the information released prior to notification of cancellation. Further, I (we) realize that the above mentioned facility cannot prevent the re-disclosure of records released as a result of this request; therefore, released from any and all liability resulting from re-disclosure.

PATIENT SIGNATURE

DATE

SPOUSE / PARTNER / GUARDIAN SIGNATURE
(circle appropriate relationship)

DATE