NEW YORK MEN'S HEALTH

Peter N. Schlegel, M.D.

MEDICAL INFORMATION RELEASE

I, _____ a patient of Peter N. Schlegel, M.D. at New York Men's Health Medical, PLLC, hereby authorize the release of my medical information and test results to my spouse/partner _____ and our physicians.

Signature: _____

Date: _____

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I understand that medically indicated services for evaluation and treatment of infertility provided by Dr. Peter N. Schlegel, M.D. (initial consultation and subsequent treatment including surgery) may or may not be covered by my insurance company.

I understand that payment by my insurance company for covered services will not be paid if the insurance company deems these services not covered or not medically necessary.

If a procedure is determined by your insurance company to be not covered or not medically necessary, you are responsible for the payment. Some insurance companies plans specifically exclude reimbursement for infertility services. Others consider that infertility is not a disease so they consider that treatment is not medically necessary even though the treatment is medically dedicated and appropriate.

I accept full financial responsibility for any services not paid by my insurance company and agree to pay the amount due to Dr. Schlegel within 30 days of treatment.

_____

Patient's Name (please print)

_____

Patient's Signature

_____

Date

Male Fertility Evaluation Questionnaire

Please complete this questionnaire as completely & honestly as possible. Please bring this form with you to your initial consultation with Dr. Schlegel. If any semen analyses, blood tests, or other evaluations have been previously performed, please bring these reports and/or have any other doctors fax the reports to us at (646) 767-7425. If a testis biopsy has been performed, please bring the glass slides of the biopsy (obtained from The Department of Pathology where the biopsy was done).

_____

Background Information:

Name:_____

Address: _____

Birthdate: _____ Age: _____

Telephone: (Home) _____ (Mobile) _____

(Work) _____

Partner's Name: _____

Marital Status: Single Married Divorced Widowed

Who referred you: _____

Relationship to you:_____

Fertility History:

How many months have you been trying to achieve pregnancy with your current partner? _____

Have you ever achieved a pregnancy with your partner in the past? Yes No

If yes, please give date & outcome of pregnancies:_____

_____

_____

How many months have you lived with your partner? _____

Did you use birth control before attempting to conceive? Yes No

What methods did you use? _____

_____

Have you ever contributed to a pregnancy with another partner? Yes No

Please present the outcome of these pregnancies:_____

_____

_____

Has your current partner ever had any pregnancies with another man? Yes No

Please describe the outcome of these pregnancies:

_____

_____

_____

How old is your partner? _____

Has she had any tests for evaluation of her fertility? Yes No

Does she ovulate every month? Yes No

Past Medical History:

Allergy to Medications	Yes	No	Age at Diagnosis _____
Arthritis	Yes	No	Age at Diagnosis _____
Bowel Disorders	Yes	No	Age at Diagnosis _____
Cancer	Yes	No	Age at Diagnosis _____
Change in Body appearance	Yes	No	Age at Diagnosis _____
Color Blindness	Yes	No	Age at Diagnosis _____
Deafness	Yes	No	Age at Diagnosis _____
Diabetes	Yes	No	Age at Diagnosis _____
Disk Problems	Yes	No	Age at Diagnosis _____
Heart Problems	Yes	No	Age at Diagnosis _____

Hepatitis	Yes	No	Age at Diagnosis _____
High Blood Pressure	Yes	No	Age at Diagnosis _____
Indigestion or frequent Abdominal pain	Yes	No	Age at Diagnosis _____
Other Liver Problems	Yes	No	Age at Diagnosis _____
Lung or Breathing Problems	Yes	No	Age at Diagnosis _____
Thyroid Disease	Yes	No	Age at Diagnosis _____
Nervous System Diseases	Yes	No	Age at Diagnosis _____
Sickle Cell Disease	Yes	No	Age at Diagnosis _____
Sinus Problems	Yes	No	Age at Diagnosis _____
Skin Diseases	Yes	No	Age at Diagnosis _____
Spinal Cord Problems	Yes	No	Age at Diagnosis _____
Tuberculosis	Yes	No	Age at Diagnosis _____
Ulcers	Yes	No	Age at Diagnosis _____

Any medication taken on a regular basis (& dose):

Have you been given any antibiotics in the past 3 months?

Have you ever taken any of the following medications:

Allopurinol	Yes	No
Antidepressant drugs	Yes	No
Antihypertensive drugs	Yes	No
Antiparasitic drugs	Yes	No
Antipsychotic medications	Yes	No
Barbiturates	Yes	No
Chemotherapy for cancer	Yes	No
Cholesterol-lowering drugs	Yes	No
Clomid	Yes	No
Dilantin	Yes	No
hCG Injections	Yes	No
Hormones	Yes	No
Immunosuppressant drugs	Yes	No
Insulin	Yes	No
Tagamet (cimetidine)	Yes	No
Tranquilizers	Yes	No
Zantac (ranitidine)	Yes	No
Zovirax (acyclovir)	Yes	No

Urological History:

Have you ever had an infection involving:

Prostate (or prostatitis)	Yes	No
Epididymis (epididymitis)	Yes	No
Testes	Yes	No
Venereal (sexually transmitted) infection	Yes	No
Urethritis (or NSU)	Yes	No
Gonorrhea	Yes	No
Herpes	Yes	No
Syphilis	Yes	No
Urinary Tract(urinary/bladder)infection	Yes	No

Have you :

Had blood in your semen?	Yes	No
Had pain after ejaculation?	Yes	No

Had prolonged pain or swelling of testes? Yes No
Developed mumps after puberty? Yes No

Urological History(continued):

Did it cause pain in your testes? Yes No
Had a fever(>101 F) for more than 1 day in the past 3 months? Yes No

Surgical History:

Have you had any operations on the urinary tract, including the bladder or prostate? Yes No
Have you ever had a vasectomy? Yes No
Vasectomy reversal? Yes No
Other microsurgery for infertility? Yes No

Any of the following procedures:

Hernia Yes No
Varicocelectomy(for enlarged veins in the scrotum) Yes No
Hydrocele repair Yes No
Testis biopsy Yes No
Other operations on the testis Yes No
Operations on the penis Yes No
Other Operations (describe):

Have you been told that your testes did not descend? Yes No
Had to surgically be moved? Yes No

Hormonal Development & Changes:

Have you been able to smell? Yes No
Do you have frequent headaches? Yes No
Has your vision changed recently? Yes No
Have you had a recent change in your energy level? Yes No
Did your armpit and pubic hair develop at the same time as other boys your age? Yes No
If not, when did you go through puberty? _____
Do you have more or less chest hair than other men in your family? _____

Social/ Drug Exposures:

Do you take long hot baths, saunas or jaccuzzis? Yes No
Do you smoke? Yes No
If so, how many packs/day? _____
Have you smoked marijuana heavily in the past? Yes No
How many drinks do you have in an average week? _____
Do you ever drink more than 2-3 drinks in a 24 hour period? Yes No
How many cups of coffee or caffeine-containing drinks do you have a day? _____
Do you currently use, or have you extensively used any of the following substances:
Cocaine Yes No
LSD Yes No
Amphetamines Yes No
Heroin Yes No
What type of work do you do? _____
Have you ever been heavily exposed to toxins, poisons, pesticides, radiation or solvents? Yes No

Sexual History:

Please rate your interest in sex: None Minimal Moderate Intense

How many times do you ejaculate (per week)? _____

How often do you masturbate (per week)? _____

Do you ejaculate during intercourse? Yes No

Do you ejaculate into your partner's vagina? Yes No

Have you ever been unable to achieve an erection adequate for intercourse? Yes No

Sexual History (continued):

Have you ever ejaculated through a soft (flaccid) penis? Yes No

Do you ever ejaculate prior to vaginal penetration? Yes No

Is intercourse ever painful for your partner? Yes No

Is her vagina ever so tight that you cannot penetrate? Yes No

Do you use any lubricant for intercourse? Yes No

If so, what lubricant: _____

Do you frequently ejaculate into your partner's rectum? Yes No

Does your partner usually lie down for at least 30 minutes after intercourse? Yes No

Does your partner douche after intercourse? Yes No

Do you have intercourse daily or every other day when you partner is ovulating? _____

Family History:

How many brothers do you have? _____

Do any have fertility problems? _____

How many sisters do your have? _____

Do you have fertility problems? _____

Are any of these problems present in your family, if so please identify the affected family member :

Birth Defects Yes No _____

Cystic Fibrosis Yes No _____

Diabetes Yes No _____

Hormone Problems Yes No _____

Kidney Problems Yes No _____

Prostate Cancer Yes No _____

Tuberculosis Yes No _____

Fertility Problems Yes No _____

No Significant History Yes No _____

Other:

Please describe any other health problems you may have that Dr. Schlegel should know about:

_____

_____

_____

_____

_____

_____

_____

Reviewed by: Peter N. Schlegel, M.D.