the Fertility Center of New Mexico

JIM THOMPSON, M.D.
201 Cedar Street SE, Suite 51-20 • Albuquerque, NM 87106
PH: 505-248-0000 • Fax: 505-842-0000
Infertility • Reproductive Endocrinology
NMFertility.com

Dear Patient:

Welcome to our office. We want to thank you for choosing The Fertility Center of New Mexico for your healthcare needs. We have a dedicated team of professionals who are available and committed to serving you. Our goal is to provide you with the highest quality services in a timely manner.

Included in this packet are forms that need to be printed and filled out by you and your partner (if applicable). Please bring the *completed* paperwork to your appointment along with picture ID and your insurance card(s).

A Medical Records Release form is enclosed to assist you in obtaining any relevant records from other providers for your appointment. Complete and forward to providers as needed.

Please plan to arrive 15 minutes prior to your scheduled appointment time.

A representative from our office will call you prior to the appointment to discuss your benefits as they relate to care in this office.

A $125.00 deposit was collected at the time you scheduled your appointment. This will be applied to your charges. We require a 48-hour notice to cancel or reschedule this appointment or the deposit will be forfeited.

We look forward to meeting you.

If you need any additional assistance, please do not hesitate to call.

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NEW PATIENT HISTORY QUESTIONNAIRE - MALE

A. IDENTIFYING DATA Date this form completed _____ Appointment Date _____

Name _____ Age _____ Birth Date _____ SS# _____
Height _____ Weight _____
Home Address _____City/State _____ Zip _____

Best daytime contact #_____ (home/cell/other) OK for detailed message? O Yes O No

Other contact # _____ (home/cell/other) OK for detailed message? O Yes O No

OK to discuss lab results or plan of care with your partner? O Yes O No E-Mail Address _____

Type of relationship: Married or Significant Other Duration of Relationship _____ Duration of Infertility _____
Are you and your partner sexually intimate? O Yes O No

Biological sex: Female Male (please circle)

Preferred Gender: Cis-Female Cis-Male Trans-Female Trans-Male Other (please circle)

Self-reported ethnicity:
O Refused
O White
O Asian
O Not asked
O Unknown
O Hispanic or Latino
O American Indian or Alaska Native
O American Indian or Alaska Native
O American Indian or Alaska Native
O Black or African American

Partner's name _____ Age ___ Birth Date _____ SS# _____

Partner Identity Known: Yes No (anonymous sperm donor) Biological sex: Female Male (please circle)

Preferred Gender: Cis-Female Cis-Male Trans-Female Trans-Male Other (please circle)

Self-reported ethnicity:
O Refused
O White
O Asian
O Not asked
O Unknown
O Hispanic or Latino
O American Indian or Alaska Native
O American Indian or Alaska Native
O American Indian or Alaska Native
O Black or African American

Sperm source: Yes No (please circle) Intended Parent: Yes No (please circle)

Male's Employer _____ Work Phone _____

Partner's Employer _____ Work Phone _____

Emergency Contact _____ **Phone** _____

New Patient History Questionnaire – Male

Insurance Carrier – Primary: _____ Group # _____
Identification # _____ Plan # _____

Secondary: _____ Group # _____
Identification # _____ Plan # _____

Reason for your visit today? _____
_____

Primary Care Physician _____
Referred by _____

By signing below, I confirm that the information above is, to the best of my knowledge, true and accurate. I am aware that TFCNM is a specialty clinic, and the short-term, focused nature of the care I receive at the clinic does not afford for long-term follow-up. I understand that I need to have a primary-care provider (PCP), and that routine care, such as physicals need to be performed and followed by my PCP.

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO PHYSICIAN

_____ _____
Signature (Insured or authorized person) Date

List all serious or chronic illnesses or injuries _____

Medications _____

Years of formal education _____
Cigarettes – packs smoked per day _____
Alcohol – type and number of drinks per week _____
Radiation exposure _____
Hot tub or sauna use _____
Other drugs – type and amount _____

Marijuana – amount _____
Caffeine drinks per day _____
Ever used intravenous drugs? _____
Toxic exposure _____

Any problems with erection or ejaculation? O Yes O No _____

Has semen analysis ever been abnormal? O Yes O No _____

Have you (male) seen a doctor for infertility evaluation? O Yes O No _____

Doctor _____ Diagnosis _____

Treatment _____

Have you (male) ever fathered a pregnancy with another woman? O Yes O No

Any inherited diseases in your (male's) family? O Yes O No _____

New Patient History Questionnaire – Male

Do you (male) have or have had:

Chlamydia	O Yes O No	Vasectomy	O Yes O No
Antichlamydial antibodies	O Yes O No	Vasectomy reversal	O Yes O No
Gonorrhea	O Yes O No	Varicocele	O Yes O No
Syphilis	O Yes O No	Varicocele surgery	O Yes O No
Genital herpes	O Yes O No	Biopsy of testicles	O Yes O No
Mycoplasm	O Yes O No	Hernia surgery	O Yes O No
Ureaplasma	O Yes O No	Abdominal surgery	O Yes O No
Urethritis/epididymitis	O Yes O No	Cancer	O Yes O No
Prostatitis	O Yes O No	High blood pressure	O Yes O No
Penile discharge or pain	O Yes O No	Diabetes	O Yes O No
Undescended testicle	O Yes O No	Colitis	O Yes O No
Injury to the testicle(s)	O Yes O No	Seizures	O Yes O No
Mumps with injury to testicles	O Yes O No	Psychiatric treatment	O Yes O No
Physical abnormality	O Yes O No	Excessive stress	O Yes O No
DES exposure in womb	O Yes O No	Strenuous exercise	O Yes O No
Tight underwear	O Yes O No		

Please use the bottom of this page to explain any additional information you feel your doctor may need.