Center for Reproductive Care
MARY WOOD MOLO, MD

Date: _____

Single Female Fertility Questionnaire

Identifying Information

Name: _____ Date of Birth: _____ Age: ___
Address: _____ Phone (Home): _____
_____ Phone (Mobile): _____
Race: _____ Ethnic Background: _____
Employer: _____
Occupation: _____ Hours Worked: _____
Extensive Travel: --
Referring Physician _____ Established OB/GYN _____

Chief Medical Problem

Describe the reason for your visit: _____
_____

Are you interested in a Fertility Assessment: --
Are you interested in Fertility Preservation: --
Are you interested in Single Motherhood: --

Medical History

Weight: _____ Height: _____ Blood Group and RH: _____
Do you follow a particular diet or have any special dietary habit: --
If yes, explain: _____
Do you exercise on a regular basis? --
If yes, detail frequency and form of exercise: _____

Nicotine Usage: -- If no, have you smoked previously? _____
If yes, for how long/Cigarettes per day: _____
Caffeine Usage: -- If yes, Cups per Day: _____
Alcohol Usage: -- Average Weekly Consumption: _____
Recreational Drug Usage: -- If yes, specify: _____

Allergies (Please List): _____
Current Prescription Medication: _____
_____
Current Over-The-Counter Medication: _____
_____
Current Herbal Supplements/Medication: _____

Do you have or have you ever had: (Check all that apply)

- ☐ Anemia
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Prolonged Fever
- ☐ Congenital disease
- ☐ Kidney Disease
- ☐ Thyroid Disease
- ☐ Liver Disease
- ☐ Diabetes
- ☐ Breast Lump
- ☐ Psychiatric Disorder
- ☐ Syphilis
- ☐ Gonorrhea
- ☐ Chlamydia
- ☐ Inguinal Hernia
- ☐ Tubal Infection
- ☐ Cystitis
- ☐ Tumor
- ☐ Epilepsy

If yes to any, or to add something that was not listed, please explain: _____

_____

_____

Surgical History

What previous surgeries or biopsies have you had performed?

- ☐ Laparoscopy
- ☐ Hysteroscopy
- ☐ Abdominal Surgery
- ☐ Myomectomy
- ☐ Pelvic Surgery

If you checked yes to any of the procedures, or if you have had other procedures or biopsies performed that are not listed, please elaborate: _____

_____

_____

Menstrual and Pregnancy History

Age at first menstruation: _____ Comments: _____

Age first noted breast development: _____ Comments: _____

Age first noted pubic hair: _____ Comments: _____

Age first noted axillary hair: _____ Comments: _____

Present Menstrual Cycles:

Length (in days from start to start): _____ Duration: _____ Cramps: _____

Amount of Flow: _____ Spotting/Bleeding between periods: _____

Pains or Cramps with periods? _____ Age at which pains or cramps began: _____

Are the pains worse now than previously: _____ Pain between menstrual cycles? _____

Do you experience premenstrual symptoms? If yes, what: _____

Anything else about your cycles you wish to share? _____

Last Pap smear: _____ Result: _____

Last Mammogram: _____ Result: _____

Last Menstrual Period: _____

Pregnancy History:

Have you ever been pregnant: -- (If yes, see below)

	Year	Abortion?	Miscarriage?	Ectopic?	Treatment Required?	How long to Conceive?	Live Birth?	Current Partner Father?
1st Pregnancy								
2nd Pregnancy								
3rd Pregnancy								

Were there any complications during or after your pregnancies? --

If yes, explain: _____

Contraceptive History

What form of contraception do you use, or have you used in the past?

- ☐ Oral Contraceptive, Name: _____
- ☐ IUD, Name: _____
- ☐ Diaphragm
- ☐ Depo-Provera
- ☐ Withdrawal
- ☐ Condoms
- ☐ Tubal Ligation

For each contraceptive method, please specify duration of use:

_____

_____

If you've ever been on oral contraceptive (pills), were your periods regular after stopping the pill? --

Endocrine History

Have you noticed any of the following symptoms?

- ☐ Increased hair growth
- ☐ Breast secretion
- ☐ Skin stretch marks
- ☐ Weight gain
- ☐ Weight loss
- ☐ Headaches
- ☐ Anxiety
- ☐ Fatigue
- ☐ Hair loss
- ☐ Dry skin
- ☐ Oily skin
- ☐ Acne
- ☐ Increase in size of feet
- ☐ Increase in size of hands

If yes, please explain in more detail: _____

_____

_____

_____

Family History

Have there been any of the following diseases in your family?

- ☐ Diabetes
- ☐ Hypertension
- ☐ Heart disease
- ☐ Kidney disease
- ☐ Tuberculosis
- ☐ Cancer
- ☐ Breast/Ovarian Cancer
- ☐ Cystic Fibrosis
- ☐ Sickle Cell Disease
- ☐ Early deaths
- ☐ Abnormal genitalia
- ☐ Recurrent miscarriage

- ☐ Children born with malformations
- ☐ Other congenital abnormalities
- ☐ Schizophrenia or depressive psychosis
- ☐ Developmental delays
- ☐ Bleeding disorders
- ☐ Deep Vein Thrombosis
- ☐ Pulmonary Embolism
- ☐ Thyroid disorders
- ☐ Spina bifida
- ☐ Muscular dystrophy
- ☐ Cleft lip or palate
- ☐ Limb deformities
- ☐ Blindness
- ☐ Deafness
- ☐ Menstrual problems
- ☐ Infertility
- ☐ Fragile X

If the answer to any of the above is yes, please elaborate: _____

_____

_____

Fertility Treatment History

Have you had any previous fertility treatment? --

If yes, who was your physician? _____

Was a specific diagnosis identified? _____

What medications, if any, have you taken for treatment? Check all that apply:

- ☐ Clomiphene citrate (Clomid)
- ☐ Letrozole
- ☐ FSH (Follistim, Gonal F)
- ☐ HCG (Pregnyl, Novarel, Ovidrel)
- ☐ Progesterone
- ☐ Antibiotics
- ☐ Ganirelix/Cetrotide
- ☐ hMG (Menopur)
- ☐ Prednisone
- ☐ Estrogen
- ☐ Lupron
- ☐ Metformin
- ☐ Other: specify _____

Which of the following tests have you had performed? Check all that apply:

- ☐ Postcoital test — When: _____ Results: _____
- ☐ Hormone tests — When: _____ Results: _____
- ☐ Endometrial Biopsy — When: _____ Results: _____
- ☐ Hysterosalpingogram (HSG) — When: _____ Results: _____
- ☐ Ultrasound/Sonogram — When: _____ Results: _____
- ☐ Intrauterine Insemination (IUI) — When: _____ Results: _____
- ☐ In Vitro Fertilization (IVF) — When: _____ Results: _____

Anything else you wish to share that we have not yet asked: _____

_____

Center for Reproductive Care
MARY WOOD MOLO, MD

Questions to Ask your Insurance Regarding Fertility/Infertility Coverage

Insurance benefits vary widely dependent upon insurance company, insurance plan, where your company is headquartered, or if your plan is self-insured.

Please complete this insurance verification form prior to your initial consultation with the doctor. Use this form as a questionnaire when calling the member services phone number on your insurance card.

It is *your responsibility* to call your insurance company to review your fertility benefit. Once you have this information, it is your responsibility to inform office staff of benefit information and/or change of insurance.

Patient Name: _____ Patient DOB _____

Provider: _____

ID Number: _____ Group: _____

Questions to ask:

General:

- Am I in-network with Dr. Wood Molo and the Center for Reproductive Care?
  _____
- What is my deductible/coverage once deductible met:
  _____
- What is my specialist office visit copay?
  _____

Fertility Testing: (Diagnosis Code: Z31.41)

- Are there any restrictions or exclusions to be eligible for fertility benefit?
  _____
- Do I have fertility testing coverage? (CPT: 76856, 76857, 74740, 76830, 76831, 58340)
  _____
- Do I need to register with the insurance as a fertility patient?
  _____

Fertility Treatment: (Diagnosis Code(s): N97.9, Z31.83)

- Do I qualify for infertility benefits?
  _____

- Do I have fertility treatment coverage?

  _____

- Do I have Intrauterine Insemination (IUI) Coverage? (CPT Code: 58322)

  _____

- Do I have In Vitro Fertilization (IVF) Coverage? (CPT: 58970, 58974)

  _____

- Do I have any lifetime or yearly limits for fertility treatments?

  _____

- Does my insurance require a prior authorization before treatment begins?
  - If yes, what is the contact information for the prior-authorization department?

  _____

- Do I have infertility medication coverage?
  - If yes, what is my specialty pharmacy?

  _____

- Do my medications count towards my lifetime or yearly fertility allowance?

  _____

Fertility Preservation (Diagnosis Code(s): Z31.62, Z31.84)

- Does my plan cover fertility preservation counseling?

  _____

- Does my plan have any exclusions for Egg Retrieval CPT 58970?

  _____

Donor Egg: (Diagnosis Code: Z51.810)

- If I am using an egg donor, will her medical services and/or medications be covered?

  _____

Date: _____

Representative: _____

Reference #: _____