MAIN LINE FERTILITY

Transgender Medical History Form

(Please complete any questions that apply. If not applicable to you, please write "N/A".)

Preferred Name: _____ D.O.B.: _____ Age: _____ **Today's Date: _____**

Legal Name (If different from preferred name): _____

Gender Identity: _____ Sex Assigned at Birth : _____ Height: _____ Weight: _____

Occupation: _____ Highest Education: _____ Ethnicity: _____

Partner's Name (if applicable): _____ D.O.B.: _____

Is the primary reason for your visit: ☐ Infertility ☐ Recurrent Pregnancy Loss ☐ Endocrine Disorder ☐ Fertility Preservation ☐ Hormonal Supplementation ☐ Other (please explain): _____

Patient Medical History:

Do you have a personal history of:	YES / No	Dates/Comments:
Malignant hyperthermia or complication with anesthesia	☐ Yes ☐ No	
Any condition requiring antibiotics before a procedure	☐ Yes ☐ No	
Rubella (German Measles), chicken pox, measles, mumps	☐ Yes ☐ No	
Rheumatic fever	☐ Yes ☐ No	
Elevated blood pressure	☐ Yes ☐ No	
Blood clots (deep vein thrombosis, pulmonary embolism)	☐ Yes ☐ No	
Heart murmur, heart disease, MVP	☐ Yes ☐ No	
Strokes, seizures	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No	
Lung disease, asthma	☐ Yes ☐ No	
Liver or gall bladder disease, jaundice, hepatitis _____	☐ Yes ☐ No	
Irritable bowel syndrome	☐ Yes ☐ No	
Kidney infections, kidney stones	☐ Yes ☐ No	
Muscle or joint problems, arthritis	☐ Yes ☐ No	
Breast problems	☐ Yes ☐ No	
Gout	☐ Yes ☐ No	
Urinary tract abnormalities	☐ Yes ☐ No	
Thyroid disease	☐ Yes ☐ No	
Excessive body or facial hair	☐ Yes ☐ No	
Auto immune diseases (lupus, rheumatoid arthritis, etc.)	☐ Yes ☐ No	
Anxiety, depression, bipolar disorders	☐ Yes ☐ No	
Bleeding or Blood Disorder	☐ Yes ☐ No	
Erectile or ejaculation disfunction	☐ Yes ☐ No	
Other serious or chronic diseases (Please note disease)	☐ Yes ☐ No	

Have you ever been involved in psychotherapy or counseling? ☐ Yes ☐ No If yes, please indicate why, with whom, and any other pertinent information: _____

Patient Surgical History:

Have you ever had any gender confirmation surgeries? ☐ Yes ☐ No If yes, please specify: _____

Have you ever had tubal ligation? ☐ Yes ☐ No If yes, when: _____

Have you ever had a vasectomy? ☐ Yes ☐ No If yes, what and when: _____

Please list any other surgeries you have had (type of surgery and year):

_____

Allergies:

Do you have any allergies (medications, food, latex, iodine, contrast dye, etc.)? ☐ Yes ☐ No If yes, please indicate allergies and reactions experienced: _____

Medications:

Please list any prescription and over the counter medications you are taking now or have taken in the past:

Currently taking:	Previously taken:

Do you have any history of therapeutic x-ray treatment or anti-cancer drugs? ☐ Yes ☐ No If yes, what and when: _____

_____

Have you taken hormone replacement therapy to support gender reassignment? ☐ Yes ☐ No If yes, what and when: _____

_____

Have you ever taken anabolic steroids and/or growth hormone for body building purposes? ☐ Yes ☐ No

Sexual History:

Frequency of sexual intercourse (if applicable) : _____ times per week Is intercourse painful to you? ☐ Yes ☐ No

Do you use lubricants? ☐ Yes ☐ No Type:_____

If applicable, does your partner ejaculate in vagina during intercourse? ☐ Yes ☐ No ☐ Not applicable

Please mark any previous contraception used: ☐ diaphragm ☐ condom ☐ foam ☐ rhythm ☐ female sterilization ☐ male sterilization ☐ none

Do you have a history of genital herpes? ☐ Yes ☐ No

Have you ever been treated for:

Syphilis	☐ Yes, date: _____	☐ No
Gonorrhea	☐ Yes, date: _____	☐ No
Chlamydia (non-specific urethritis)	☐ Yes, date: _____	☐ No
Genital warts	☐ Yes, date: _____	☐ No
Prostatitis (infection of the prostate)	☐ Yes, date: _____	☐ No ☐ Not applicable
Infection of the testicles	☐ Yes, date: _____	☐ No ☐ Not applicable
Infection of the seminal vesicles	☐ Yes, date: _____	☐ No ☐ Not applicable

Please let the doctor know if you: ☐ currently are not sexually active ☐ never had sexual intercourse ☐ have been sexually abused

Occupational/Leisure History:

	Yes / No	Dates/Comments:
Have you ever been employed in an occupation with sustained high temperature?	☐ Yes ☐ No	
Do you drive long distances as part of your employment?	☐ Yes ☐ No	
Do you use hot tubs, saunas, etc.?	☐ Yes ☐ No	
Are you exposed to chemical or x-rays in work or hobby?	☐ Yes ☐ No	
Do you consume/use:	**Yes / No**	**Amount per day/week:**
Caffeine	☐ Yes ☐ No	
Smoking	☐ Yes ☐ No	
Alcohol	☐ Yes ☐ No	
Marijuana	☐ Yes ☐ No	
Nutritional Supplements, Herbs, etc.	☐ Yes ☐ No	
Drugs	☐ Yes ☐ No	

Please describe any recreational/sport activities (frequency, length of time, etc.): _____

Please fill in a review of any current or recent symptoms:

	Yes / No		Yes / No		Yes / No
Chronic headaches	☐ Yes ☐ No	Increased thirst	☐ Yes ☐ No	Excessive Fatigue	☐ Yes ☐ No
History of head injury	☐ Yes ☐ No	Increased Sweating	☐ Yes ☐ No	Tremors	☐ Yes ☐ No
Convulsion history	☐ Yes ☐ No	Intolerance to heat	☐ Yes ☐ No	Desire for extra salt	☐ Yes ☐ No
Visual Problems	☐ Yes ☐ No	Intolerance to cold	☐ Yes ☐ No	Excess loss of scalp hair	☐ Yes ☐ No
Dizziness	☐ Yes ☐ No	Difficulty swallowing	☐ Yes ☐ No	Change in size of clitoris	☐ Yes ☐ No
Rapid Weight Change	☐ Yes ☐ No	Change in voice or hoarseness	☐ Yes ☐ No	Discharge from nipples	☐ Yes ☐ No
Acne	☐ Yes ☐ No	Difficulty Sleeping	☐ Yes ☐ No	Growth of hair on face or body in new places	☐ Yes ☐ No
Change of appetite	☐ Yes ☐ No	Change in appetite	☐ Yes ☐ No		

Family History:

Father's age, if alive: _____ If deceased, cause of death: _____
Medical problems: _____
Mother's age, if alive: _____ If deceased, cause of death: _____
Medical problems: _____Age at Menopause: _____
Did your mother take DES or any other medications while pregnant with you? ☐ Yes, medication _____
☐ No ☐ Unknown

Sister(s) age: _____ Medical problems: _____
Brother(s) age: _____ Medical problems: _____

Is there a family history of:	Yes / No	Comments:
Birth defects or genetic diseases	☐ Yes ☐ No	
Infertility	☐ Yes ☐ No	
Hormone problems	☐ Yes ☐ No	
Miscarriage/stillbirths	☐ Yes ☐ No	
Pregnancy problems	☐ Yes ☐ No	
Cancer	☐ Yes ☐ No	
Stroke	☐ Yes ☐ No	
Heart Disease	☐ Yes ☐ No	
Lung Disease	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No	
Early Menopause	☐ Yes ☐ No	
Thyroid/endocrine problems	☐ Yes ☐ No	
High blood pressure	☐ Yes ☐ No	
Blood clots (deep vein thrombosis, pulmonary embolism)	☐ Yes ☐ No	
Any women who have never menstruated	☐ Yes ☐ No	
Any men who have never had to shave	☐ Yes ☐ No	

Additional comments regarding family health history that you feel may be pertinent and have not already been addressed:
_____

Gynecological History (if applicable):

Age of first period: _____ Start dates of last 3 periods: _____, _____, _____
How often do you get a period? ☐ Never ☐ Regular, every _____ to _____ days ☐ Irregular, every _____ to _____ days
Usual duration of bleeding: _____ days
Amount of flow: ☐ Light ☐ Moderate ☐ Heavy
Is cramping: ☐ Minimal ☐ Moderate ☐ Severe ☐ No cramping
Do you experience bleeding between periods? ☐ Yes ☐ No
Do you have symptoms at the time of ovulation (i.e., pain)? ☐ Yes ☐ No
Do you have a history of pelvic pain? ☐ Yes ☐ No
Do you have a history of endometriosis? ☐ Yes ☐ No
Dates of last PAP _____ Breast Exam _____ Mammogram _____
Have you taken birth control pills? ☐ Yes ☐ No
If yes, how many years did you take birth control pills? _____ Date birth control was last taken: _____
Were menses regular before birth control pills? ☐ Yes ☐ No
Were menses regular after stopping birth control pills? ☐ Yes ☐ No
How long after stopping birth control pills did menses start? _____
Any previous use of IUD (intrauterine device)? ☐ Yes ☐ No
If yes, # of years taken: _____ Date of removal: _____ Reason: _____

Obstetrical History (if applicable):

Have you been pregnant before? ☐ Yes ☐ No If yes, please record all pregnancies:

Pregnancy #	Year	How long did it take to conceive?	Full Term	Pre-Term (Include # of weeks)	Miscarriage	Termination	Complications	Fertility Treatment Required? Y/N	With Current or Previous Partner
								☐ Yes ☐ No	
								☐ Yes ☐ No	
								☐ Yes ☐ No	
								☐ Yes ☐ No	

Urological History (if applicable):

Have you ever fathered a baby? ☐ Yes ☐ No If yes, when (year of birth): _____

Have you ever been told you are infertile? ☐ Yes ☐ No If yes, when and by whom:_____

Length of time attempting pregnancy _____ Years _____ Months

Length of time not using contraceptives _____

Has there been any change in your libido or sexual drive? ☐ Yes ☐ No

Is intercourse painful to you? ☐ Yes ☐ No

Is there any difficulty in maintaining an erection? ☐ Yes ☐ No ☐ Not applicable

Do you ejaculate into vagina without difficulty? ☐ Yes ☐ No ☐ Not applicable

Do you have any pain or burning with urination or ejaculation? ☐ Yes ☐ No ☐ Not applicable

Have you ever had any discharge from the penis? ☐ Yes ☐ No ☐ Not applicable

Have you ever had a urological exam? ☐ Yes ☐ No If yes, results: _____

Have you ever had a semen analysis? ☐ Yes ☐ No If yes, please note results:

Date of SA	Count (million/cc)	Motility (% moving)	Morphology (% normal shape)

Have you had any specialized sperm testing (acrosome reaction, sperm penetrating assay, antibody testing)? ☐ Yes ☐ No

If yes, results: _____

Have you had specific treatment for **male** infertility? ☐ Yes ☐ No

If yes, details: _____

Please complete the following to the best of your ability and bring a copy of any test results to share with your physician.

Pre-Conceptual Health Screening:

Have you ever been tested for:	Yes / No	If yes, give dates/results:
Hepatitis B	☐ Yes ☐ No	
Hepatitis C	☐ Yes ☐ No	
HIV(AIDS)	☐ Yes ☐ No	
RPR	☐ Yes ☐ No	
CMV	☐ Yes ☐ No	
Rubella	☐ Yes ☐ No	
Varicella	☐ Yes ☐ No	
TB (Tuberculosis)	☐ Yes ☐ No	
Blood Type	☐ Yes ☐ No	
Tay-Sachs	☐ Yes ☐ No	
Ashkenazi Jewish Panel	☐ Yes ☐ No	
Cystic Fibrosis	☐ Yes ☐ No	
Sickle Cell	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No	
Anemia or Thalassemia	☐ Yes ☐ No	
Fragile X Syndrome	☐ Yes ☐ No	

Previous Infertility Testing:

Length of time currently attempting pregnancy: _____ Years _____ Months

Length of time not using contraceptives: _____ Years _____ Months

Have you previously had a reproductive endocrinology and infertility evaluation? ☐ Yes ☐ No

Do you have an infertility diagnosis (tubal, ovulation, polycystic ovarian syndrome, premature ovarian failure, endometriosis, history of multiple miscarriages, problem with sperm, uterine abnormality, need for PGD/PGS, etc.)? ☐ Yes ☐ No If yes, please note diagnosis: _____

Please complete:

Was test previously completed?	**Yes / No**	**Year completed**	**Normal**	**Abnormal**	**Comments:**
Temperature Charts	☐ Yes ☐ No				
Hysterosalpingogram (x-ray of tubes and uterus)	☐ Yes ☐ No				
Hysteroscopy (looking inside uterus)	☐ Yes ☐ No				
Endometrial Biopsy (taking tissue from inside uterus)	☐ Yes ☐ No				
Post Coital test (to test sperm in cervical mucus)	☐ Yes ☐ No				
Semen Analysis	☐ Yes ☐ No				
Laparoscopy (looking inside abdomen)	☐ Yes ☐ No				
Hormone Tests: Day 3 FSH Day 3 Estradiol Clomid Challenge Test AMH	☐ Yes ☐ No				
Thyroid Tests	☐ Yes ☐ No				
Chromosome Tests	☐ Yes ☐ No				

Previous Infertility Treatment (Continued):

Have you ever had treatment with Clomiphene (Clomid, Serophene)? ☐ Yes ☐ No

If yes:

Cycles **without** Intrauterine Insemination (IUI)? ☐ Yes, #Cycles & Dates _____ ☐ No

Cycles **with** Intrauterine Insemination (IUI)? ☐ Yes, #Cycles & Dates _____ ☐ No

Did the clomid cycle(s) result in pregnancy? ☐ Yes, #Cycles & Dates _____ ☐ No

Have you ever had treatment with Gonadotropins (Follistim, Gonal-F, and Menopur)? ☐ Yes ☐ No

If yes:

Cycles **without** Intrauterine Insemination (IUI)? ☐ Yes, #Cycles & Dates _____ ☐ No

Cycles **with** Intrauterine Insemination (IUI)? ☐ Yes, #Cycles & Dates _____ ☐ No

Did the gonadotropin cycle(s) result in pregnancy? ☐ Yes, #Cycles & Dates _____ ☐ No

Have you ever had treatment with IVF or other Reproductive Technologies (GIFT, ZIFT)? ☐ Yes ☐ No

If yes, please complete the following:

Cycle #	Protocol (If known)	Dose of FSH or LH	Estrogen Level at Retrieval	# of Eggs Retrieved	# of Embryos Transferred	Pregnant?	Delivery?
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No

Other comments on infertility treatments:

_____

_____

Please include any other information which you believe may be pertinent to your fertility:

_____

_____

MAIN LINE FERTILITY

Patient Responsibilities/Consents

Patient Name: _____

Patient D.O.B.: _____

Financial Responsibility:

Patients are required to pay any non-covered services on the day of service in full. Cash, check, Visa, MasterCard, and American Express are all acceptable forms of payment.

PATIENTS WITH INSURANCE COVERAGE

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. We must, however, emphasize that as medical care providers, our relationship is with you, not your insurance company. It is your responsibility to be aware of your insurance coverage. While Main Line Fertility is responsible for timely filing of your insurance claims, all charges are your responsibility from the date services are rendered and **YOU ARE RESPONSIBLE FOR RESOLVING ANY PROBLEMS WITH YOUR INSURANCE COMPANY.**

Portions of the bill that may not be paid by the insurance company are to be paid by the patient, i.e. **COINSURANCE, DEDUCTIBLES OR BALANCES FOR NON-COVERED SERVICES**. If your insurance company has not paid your claim, you will be required to pay services rendered and any insurance benefit later received will be credited and you will be refunded.

Furthermore, it is the patient's responsibility to obtain any referrals or authorizations required by your insurance plan(s) prior to the appointment from either the Primary Care Physician or the referral/authorization hotline determined by your insurance policy. If the appropriate referral or authorization is not obtained, you will be responsible for payment of services in full if the insurance company refuses payment on any submitted claim.

PAYMENT OF BALANCE

If your insurance company sends you a check for services rendered by Main Line Fertility and Reproductive Medicine, LTD or Main Line Fertility Center, Inc., you agree to endorse and forward that check to the address below. You also agree to be financially responsible and to promptly pay any balance for professional services not covered or paid in full by your insurance company.

MEDICARE AND MEDICAID

If you have Medicare or Medicaid as a primary or secondary insurance, please be aware that we are a non-par opt-out provider. Therefore, if you choose to be seen by our physicians, you will have to pay the full amount of charges for your care on the date of service.

OUT OF NETWORK COVERAGE

If our facility or physicians are out of network with your insurance plan and you choose to be seen for medical testing/treatment, you are accepting full responsibility of any patient balance which may accumulate as a result and understand that this is not appealable thru your insurance carrier. Furthermore, if you are referred by our physicians or staff to an outside facility for lab work or other testing/treatment, it is your responsibility to verify if the facility participates with your insurance carrier and any and all fees that result from said testing are the patient responsibility and are not appealable thru your insurance carrier.

ADDITIONAL TERMS

Checks returned by your bank are subject to a $50 processing charge. Accounts greater than 60 days past due will be subject to a finance charge at the rate of 1.5% per month. If your account is referred for collection, you will be responsible for the outstanding balance, collection costs (up to 50%), court costs, and attorney's fees. Furthermore, you will not be permitted to schedule further appointments until all collection costs are paid in full.

AUTHORIZATION TO RELEASE INFORMATION

You also authorize the release of any information pertinent to your case to any insurance company, adjuster or attorney involved in your case.

I have read and understand the financial policy of the office and understand that a photocopy of this assignment shall be considered as effective and valid as the original.

Signature: _____ (Seal)

Authorization to leave voicemail regarding protected health information:

By initialing below, I authorize the practice to leave my protected health information (including but not limited to results, prescriptions and appointments) on my answering machine or voicemail at phone # _____.

Patient Initials: _____

HIPAA - Notice of Privacy Practices:

I have reviewed and/or received the HIPAA Notice of Privacy Practices. *(Copy is available in office or www.mainlinefertility.com.)*

Patient Initials: _____

THIS AUTHORIZATION DOES NOT EXPIRE UNLESS OTHERWISE NOTED

Authorization to disclose protected health information:

I hereby authorize the disclosure of my protected health information (including HIV/AIDS related information, if any) to the person(s) designated below.

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

□ If box is checked, *I do not authorize my protected health information to be released to persons other than myself.*

Patient Initials: _____

Use of E-Mail:

Risk of Using Email: Transmitting patient information by E-mail has a number of risks that patients should consider before using E-mail. These include, but are not limited to, the following risks:

a. It is possible that the confidentiality of such communications may be breached by a third party.
b. E-mail can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
c. E-mail senders can easily misaddress an E-mail.
d. E-mail is easier to falsify than handwritten or signed documents.
e. Backup copies of E-mail may exist even after the sender or the recipient has deleted his or her copy.
f. Employers and on-line services have a right to inspect E-mail transmitted through their systems.
g. E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
h. E-mail can be used to introduce viruses into computer systems.
i. The server could go down and E-mail would not be received until the server is back on-line.
j. Email can be used as evidence in court.

Conditions for the Use of E-mail: Main Line Fertility cannot guarantee but will use reasonable means to maintain security and confidentiality of E-mail information sent and received. Main Line Fertility and its employees, owners, or agents must acknowledge and consent to the following conditions:

a. E-mail is not appropriate for urgent or emergency situations. Main Line Fertility cannot guarantee that any particular E-mail will be read and responded to within any particular period of time.
b. Emails to or from the patient concerning treatment may be printed in full and made part of patient's medical record or placed in any electronic file. Because they are part of the medical record, authorized individuals will have access to the medical record/email.
c. Main Line Fertility will not forward patient identifiable E-mails outside of Main Line Fertility without the patient's prior written consent, except as authorized or required by law.
d. The patient should not use E-mail for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, or substance abuse. Main Line Fertility is not responsible for breaches of confidentiality caused by the patient or any third party.
e. It is the patient's responsibility to follow up and/or schedule an appointment if warranted.
f. This consent will remain in effect until terminated in writing by either the patient or Main Line Fertility.
g. In the event that the patient does not comply with the conditions herein, Main Line Fertility may terminate patient's privilege to communicate by E-mail with Main Line Fertility.

Instructions: To communicate by E-mail, the patient shall:

a. Avoid use of his/her employer's computer.
b. Put the patient's name in the body of the E-mail.
c. Key in the topic (e.g., medical questions, billing question) in the subject line.
d. Inform Main Line Fertility of changes in his/her E-mail address.
e. Acknowledge any E-mail received from Main Line Fertility.
f. Take precautions to preserve the confidentiality of E-mail.
g. Protect his/her password or other means to E-mail.

Patient Acknowledgement and Agreement: I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of E-mail and consents to the condition and instructions outlined, as well as any other instructions that Main Line Fertility may impose to communicate with patient by E-mail. If I have any questions, I may inquire with Main Line Fertility.

I, for myself, my heirs, executors, administrators and assigns, fully and forever release and discharge Main Line Fertility and its affiliates, shareholders, officers, directors, physicians, agents and employees, from and against any and all losses, claims, and liabilities arising out of or connected with the use of such E-mail.

Patient Initials: _____

Fertility Medication Consent:

I hereby consent to treatment with fertility medication as part of my treatment protocol by Main Line Fertility. The probability of pregnancy, given the specific characteristics of my case, have been explained to me. I understand there are other possible treatment options, including no treatment. I understand that if pregnancy is established, there is a risk of fetal malformation which is thought to be similar to spontaneously conceived pregnancies and am aware of the availability of tests to detect some, but not all fetal malformations during pregnancy. I am aware that multiple pregnancies and tubal/ectopic pregnancies and ovarian hyperstimulation syndrome can result from fertility medications. If conception occurs, there is a risk of pregnancy complications including, but not limited to: gestational diabetes, pre-eclampsia, bleeding, blood clot/stroke, even death. The risk of pregnancy complications is believed to be slightly higher in women requiring fertility treatment as compared to women who do not require any assistance to conceive.

I acknowledge that I have been given this information and have the opportunity to discuss with my physician and/or clinical staff all other questions and concerns.

Patient Initials: _____

Purchasing of Medication through Office:

Main Line Fertility is able to provide limited medications to be purchased in office at discounted price if they are not covered by your insurance. Once purchased, these medications are NOT returnable.

I understand that if I purchase any medication through Main Line Fertility the medication cannot be returned to the office and there are NO REFUNDS once purchased.

Patient Initials: _____

Zika Virus:

The Zika Virus is spread mostly by the bite of an infected *Aedes* species mosquito (*Ae. aegypti* and *Ae. albopictus*). These mosquitoes bite during the day and night. Many people infected with Zika virus won't have symptoms or will only have mild symptoms. The most common symptoms of Zika are: Fever, rash, joint pain, red eyes, muscle pain and/or headache. Symptoms can last for several days to a week. People usually don't get sick enough to go to the hospital, and they very rarely die of Zika.

- Zika can be passed from a pregnant woman to her fetus. Infection during pregnancy can cause certain birth defects.
- There is no vaccine or medicine for Zika.
- Local mosquito-borne Zika virus transmission has been reported in the continental United States

Per the Center for Disease Control (CDC) women with possible Zika virus exposure are recommended to wait to get pregnant until at least 8 weeks after symptom onset (if symptomatic) or last possible Zika virus exposure or travel to possible Zika infested area (if asymptomatic).

The CDC now recommends that all men with possible Zika virus exposure who are considering attempting pregnancy with their partner wait to get pregnant until at least 6 months after symptom onset (if symptomatic) or last possible Zika virus exposure (if asymptomatic).

The CDC recommends that if you are attempting pregnancy you check the CDC website for areas with Zika risk, talk to your doctor or other healthcare provider before traveling to areas with Zika risk, taking steps to plan for travel, and consider avoiding nonessential travel to areas with a CDC Zika travel notice.

There are still many unknowns about the Zika virus and its transmission. As updates become available Main Line Fertility will pass along such information and recommendations.

I have read this information, have had the opportunity to ask questions, have decided to accept the above risks known and unknown, and wish to proceed with fertility treatment to attempt pregnancy.

Patient Initials: _____

I am signing this form voluntarily and confirm that I have read and understand all consents included in this document. I understand that I have the right to a signed copy of this form if I request one.

Patient Signature: _____ Date: _____

Patient Name (Printed): _____ D.O.B.: _____