

THE NEW HOPE CENTER *for* REPRODUCTIVE MEDICINE

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NEW HOPE CARES* PROGRAM APPLICATION

(*Cost Assistance for Reproductive Endocrinology Services)

Please Read All Questions Carefully And Answer As Thoroughly As Possible.

Our Medical Team Will Review Your Application To Determine What Treatment And Cost Assistance Options May Be Best For You.

Date: _____

Patient Name: _____ Partner's Name: _____

Address: _____

Home Phone: () _____

1. Your Age: _____ Date Of Birth: _____

2. Are You A Smoker?

- No, I've Never Smoked
- Yes, But I Quit _____ Days/Months/Years Ago
- Yes, Currently. I Smoke _____ Per Day

3. Do You Drink Alcohol?

- No, I've Never Drank An Alcoholic Beverage
- No, Not Now. I Used To Drink, But I Quit Completely _____ Months/Years Ago
- Yes, I Drink Occasionally—(Less Than 5 Alcoholic Beverages Per **Month**)
- Yes, I Drink In Moderation—(5 Or Less Alcoholic Beverages Per **Week**)
- Yes, I Drink _____ (Number of) Alcoholic Beverages Per **Day** (If You Drink More Than 5 Alcoholic Beverages Per Week)
List Type Of Drink: _____

4. Do You Use—Or Have You Ever Used—Any Recreational Substances/Drugs?

- No, I've Never Used Any Recreational Substances/Drugs
- No, Not Now. I Used To Use, Or Have Used, Recreational Substances/Drugs, But Not Since: _____
- Yes, I Use _____ (Type of Drug) Occasionally List Frequency: _____
- Yes, I Use _____ (Type of Drug) In Moderation List Frequency: _____
- Yes, I Use _____ (Type of Drug) Regularly List Amount Per Day: _____

5. Have You Had Any Previous Infertility Testing? No/ Yes—If Yes, Please List All Tests You Have Had:

- | | | | |
|---------------------|-------------|------------------------------|-------------------------------|
| CD #3 Labs | Date: _____ | <input type="radio"/> Normal | <input type="radio"/> Abormal |
| PCT | Date: _____ | <input type="radio"/> Normal | <input type="radio"/> Abormal |
| Endometrial Biopsy | Date: _____ | <input type="radio"/> Normal | <input type="radio"/> Abormal |
| HSG or Sono-HSG | Date: _____ | <input type="radio"/> Normal | <input type="radio"/> Abormal |
| AMA Labs | Date: _____ | <input type="radio"/> Normal | <input type="radio"/> Abormal |
| Pelvic Anatomy Scan | Date: _____ | <input type="radio"/> Normal | <input type="radio"/> Abormal |
| Androgen Panel | Date: _____ | <input type="radio"/> Normal | <input type="radio"/> Abormal |
| Other: _____ | Date: _____ | <input type="radio"/> Normal | <input type="radio"/> Abormal |
| Other: _____ | Date: _____ | <input type="radio"/> Normal | <input type="radio"/> Abormal |
| Other: _____ | Date: _____ | <input type="radio"/> Normal | <input type="radio"/> Abormal |

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PATIENT NAME _____ PHONE NUMBER _____

6. Have You Had Any Previous Infertility Treatment? No / Yes

If Yes, Please List Any/All Treatments You Have Had: (NHC Will Need Copies Of All Medical Records For Any Previous Treatments/Surgeries.)

IUI(s)	Date: _____	Where: _____	Outcome: _____
	Date: _____	Where: _____	Outcome: _____
Natural Cycle(s)	Date: _____	Where: _____	Outcome: _____
	Date: _____	Where: _____	Outcome: _____
Clomid Cycle(s)	Date: _____	Where: _____	Outcome: _____
	Date: _____	Where: _____	Outcome: _____
	Date: _____	Where: _____	Outcome: _____
	Date: _____	Where: _____	Outcome: _____
Ovulation Induction	Date: _____	Where: _____	Outcome: _____
	Date: _____	Where: _____	Outcome: _____
	Date: _____	Where: _____	Outcome: _____
	Date: _____	Where: _____	Outcome: _____
IVF Cycle(s)	Date: _____	Where: _____	Outcome: _____
	Date: _____	Where: _____	Outcome: _____
	Date: _____	Where: _____	Outcome: _____
	Date: _____	Where: _____	Outcome: _____
Cryo Cycle(s)	Date: _____	Where: _____	Outcome: _____
	Date: _____	Where: _____	Outcome: _____
	Date: _____	Where: _____	Outcome: _____
Donor Egg IVF	Date: _____	Where: _____	Outcome: _____
	Date: _____	Where: _____	Outcome: _____

7. Have You Had Any Prior GYN or Infertility Surgeries?

No / Yes—*If Yes, Please List Any/All Surgical Procedures You Have Had:*

Procedure: _____	Date: _____	Diagnosis: _____
Procedure: _____	Date: _____	Diagnosis: _____
Procedure: _____	Date: _____	Diagnosis: _____
Procedure: _____	Date: _____	Diagnosis: _____

8. Check If You Have Been Diagnosed As Having Any Of The Following. (If Yes, When, And Did You Have Treatment?)

<input type="radio"/> Endometriosis	When: _____	Treatment? <input type="radio"/> Yes / <input type="radio"/> No
<input type="radio"/> Pelvic Adhesive Disease	When: _____	Treatment? <input type="radio"/> Yes / <input type="radio"/> No
<input type="radio"/> Uterine Fibroids	When: _____	Treatment? <input type="radio"/> Yes / <input type="radio"/> No
<input type="radio"/> Polycystic Ovaries	When: _____	Treatment? <input type="radio"/> Yes / <input type="radio"/> No
<input type="radio"/> Tubal Disease	When: _____	Treatment? <input type="radio"/> Yes / <input type="radio"/> No
<input type="radio"/> Abnormal Uterus	When: _____	Treatment? <input type="radio"/> Yes / <input type="radio"/> No
<input type="radio"/> Ovarian Cyst	When: _____	Treatment? <input type="radio"/> Yes / <input type="radio"/> No
<input type="radio"/> Ruptured Appendix	When: _____	Treatment? <input type="radio"/> Yes / <input type="radio"/> No
<input type="radio"/> Chlamydia / Gonorrhea	When: _____	Treatment? <input type="radio"/> Yes / <input type="radio"/> No
<input type="radio"/> Other STDs (please list): _____	When: _____	Treatment? <input type="radio"/> Yes / <input type="radio"/> No
_____	When: _____	Treatment? <input type="radio"/> Yes / <input type="radio"/> No
<input type="radio"/> Other: _____	When: _____	Treatment? <input type="radio"/> Yes / <input type="radio"/> No

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PATIENT NAME _____ PHONE NUMBER _____

9. *What Is Your Height?* _____ Feet _____ Inches *What Is Your Weight?* _____ Pounds

(To Be Completed By Physician)

Patient BMI: _____

10. *Have You Had Any Recent Weight Loss Or Weight Gain?* No / Yes—*If Yes, Please Indicate Amount:*

Loss: _____ Pounds *Time To Lose?* _____

Gain: _____ Pounds *Time To Gain?* _____

11. *Have You Ever Been Pregnant?*

No / Yes—*If Yes, Please List All Completed Pregnancies, Miscarriages And/Or Pregnancy Interruptions:*

#1) _____ *Result:* Live Birth (*Gender:* Male / Female) Miscarriage Selective Abortion

#2) _____ *Result:* Live Birth (*Gender:* Male / Female) Miscarriage Selective Abortion

#3) _____ *Result:* Live Birth (*Gender:* Male / Female) Miscarriage Selective Abortion

#4) _____ *Result:* Live Birth (*Gender:* Male / Female) Miscarriage Selective Abortion

#5) _____ *Result:* Live Birth (*Gender:* Male / Female) Miscarriage Selective Abortion

12. **MALE PARTNER**— *Have You Ever Had, Or Were You Ever Scheduled To Have Any Of The Following:*

Semen Analysis *When?* _____ *Result:* Normal / Abnormal

Testicular Biopsy *When?* _____ *Why?* _____

Hernia Repairs *When?* _____ *Treatment?* _____

Surgery For Undescended Testicles *When?* _____ *Treatment?* _____

Other: _____ *When?* _____ *Treatment?* _____

13. **OTHER**— *Please Note Any Other Information You Feel Pertinent To Your Infertility Treatment:*

Patient Signature: _____

(For Clinic Use Only)

Information Reviewed By: _____, MD/PA *Date:* _____

Information Reviewed By: _____, MD/PA *Date:* _____

Information Reviewed By: _____, MD/PA *Date:* _____