Marc Goldstein, MD, DSc (hon), FACS
Matthew P. Hardy Distinguished Professor of Reproductive Medicine and Urology
Surgeon-in-Chief, Male Reproductive Medicine, and Surgery

Cornell Institute for Reproductive Medicine
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www.maleinfertility.org

Dear Patient:

Your appointment with Marc Goldstein, M.D., is on _____, 20____ at _____. Our office is located at New York Presbyterian – Weill Cornell Medical Center, **520 East 70th Street (between York Ave and the FDR Drive)** ninth floor of the Starr Pavilion (Room-Starr 900), Department of Urology. You are encouraged to bring your wife or partner with you although her presence is not mandatory.

Please be sure to complete the enclosed 4-page forms and the referring physician form, before arriving for your appointment. You must obtain a copy of all your test results including semen analyses, blood hormone levels, operative report (if applicable), glass testicular biopsy slides (if applicable). **PLEASE DO NOT MAIL ANY OF THE FORMS OR RESULTS TO THE OFFICE.**

The initial consultation fee varies from $690 - $828, depending on the length and complexity of your visit with the doctor. It includes an initial interview, and complete physical examination followed by a discussion of your treatment plan. Allow 2 to 2 ½ hours for your appointment. Payment is expected at the time of the visit. Dr. Goldstein is not a participating provider with any insurance company. We issue a physician's statement, which can be attached to your own insurance form for reimbursement.

*** PLEASE NOTE:** Patients will be billed for those appointments not cancelled within 48 hours. We have a 24-hour answering service available. **♦YOU MUST CALL TO CONFIRM AT LEAST 2 DAYS BEFORE YOUR SCHEDULED APPOINTMENT. IF YOU DO NOT CONFIRM, YOUR APPOINTMENT WILL BE AUTOMATICALLY CANCELLED.♦**

Thank you for your cooperation.

Center for Male Reproductive Medicine

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Center for Male Reproductive Medicine and Microsurgery

History and Examination Questionnaire

1. Name:
2. Address:
3. Date of birth: 4. Age:
5. Primary phone:
6. Alternate phone:
7. Referred by:
8. Partner's name:
9. Partner's age:
10. Marital status:

A. Fertility History

1. For how many months have you been trying to achieve pregnancy with your current partner?
2. Have you achieved pregnancy with your current partner in the past? Y N
3. If yes, give the date and outcome of pregnancies (i.e. spontaneous abortion, induced abortion, caesarean section, still birth, ectopic pregnancy, premature birth, normal delivery)

	Date	Outcome
Pregnancy #1		
Pregnancy #2		
Pregnancy #3		
Pregnancy #4		

4. For how many months have you used the following contraception methods and when did you discontinue use?
   - Condom:
   - Diaphragm:
   - Foam:
   - IUD:
   - Pills:
   - Rhythm:
5. Have you ever undergone sterilization? Y N
6. Has your partner ever undergone sterilization? Y N
7. Have you been examined for infertility problems elsewhere? Y N
8. Have you received treatment for infertility problems elsewhere? Y N
9. Has your partner been examined for fertility problems? Y N
10. Have you made any previous partner pregnant? Y N
11. If yes, give the date and outcome of pregnancies (i.e. spontaneous abortion, induced abortion, caesarean section, still birth, ectopic pregnancy, premature birth, normal delivery)

	Date	Outcome
Pregnancy #1		
Pregnancy #2		
Pregnancy #3		
Pregnancy #4		

12. Has your current partner had any pregnancies previously with someone other than you? Y N
13. If yes, give the date and outcome of pregnancies (i.e. spontaneous abortion, induced abortion, caesarean section, still birth, ectopic pregnancy, premature birth, normal delivery)

	Date	Outcome
Pregnancy #1		
Pregnancy #2		
Pregnancy #3		
Pregnancy #4		

B. Sexual History

1. Rate your level of sexual desire
   a. Strong
   b. Moderate
   c. Slight
   d. None
2. How many times each week do you have sexual intercourse?
3. Do you experience ejaculation during sexual intercourse? Y N
4. Do you ejaculate into your partner's vagina? Y N
5. Does semen leak out of your partner's vagina after intercourse? Y N
6. How many times per week do you ejaculate?
7. How many times per week do you masturbate?
8. Are you often unable to maintain an erection? Y N
9. Do you obtain erections easily? Y N
10. Do you often have erections in the morning? Y N
11. Are you aware of erections in the night? Y N
12. Do you often ejaculated through a flaccid (soft) penis? Y N
13. Do you usually ejaculate prior to penetration for intercourse? Y N
14. About how long does intercourse last before you ejaculate? ____ Min.
15. Is intercourse ever painful for you? Y N
16. Is intercourse ever painful for your partner? Y N
17. Is her vagina ever so tight that you cannot penetrate? Y N
18. Does she usually reach orgasm? Y N
19. If yes, through intercourse? Y N
20. Through other sexual activity? Y N
21. Do you use any form of lubrication for intercourse? Y N
22. Do you ever ejaculate into your partner's rectum? Y N
23. Is your partner subject to vaginal infections? Y N
24. Does your partner douche immediately following intercourse? Y N
25. Rate your partner's sexual desire:
    a. Strong
    b. Moderate
    c. Slight
    d. None
26. Are your partner's menstrual periods regular? Y N
27. Has your partner had any of the following illnesses:
    a. Herpes Y N
    b. Pelvic inflammatory disease Y N
    c. Sexually transmitted infection Y N
    d. Gonorrhea Y N

e.	Chlamydia	Y	N
f.	Syphilis	Y	N
28.	Has your partner had surgery on her tubes or ovaries?	Y	N
29.	Do you have intercourse every day or every other day during the ovulation cycle?	Y	N
30.	Does your partner usually get out of bed immediately following intercourse?	Y	N
31.	Do you have a good marriage?	Y	N

C. General Medical History

Have you ever had any of the following illnesses or conditions?			Age at Diagnosis
1.	Arthritis	Y	N
2.	Bowel Disorder	Y	N
3.	Cancer	Y	N
4.	Change in body appearance	Y	N
5.	Change in facial appearance	Y	N
6.	Color blindness	Y	N
7.	Deafness	Y	N
8.	Diabetes	Y	N
9.	Heart problems	Y	N
If yes, please specify:			
10.	Hepatitis	Y	N
11.	Liver Disease	Y	N
12.	Lung or breathing problems	Y	N
13.	Thyroid disease	Y	N
14.	Generalized viral infections (i.e. mono)	Y	N
15.	Mumps with swelling of testicles?	Y	N
16.	Nervous system disease	Y	N
17.	Sickle cell disease	Y	N
18.	Smallpox	Y	N
19.	Influenza	Y	N
20.	Tuberculosis	Y	N
21.	Ulcers	Y	N
22.	Frequent episodes of indigestion or abdominal pain	Y	N
23.	Neck or back problems	Y	N
If yes, please specify:			
24.	Skin diseases	Y	N
25.	High blood pressure	Y	N

D. Urologic History

Have you ever had:			Age at Diagnosis
1.	Infection of the prostate	Y	N
2.	Infection of the epididymis	Y	N
3.	Infection of the testicles	Y	N
4.	Kidney or bladder stones	Y	N
5.	Sexually transmitted infection	Y	N
	A. Chlamydia	Y	N
	B. Gonorrhea	Y	N
	C. Syphilis	Y	N
	D. Herpes	Y	N
6.	Have you ever had a white, green or yellow discharge from the end of your penis?	Y	N
7.	Urinary tract infection	Y	N
8.	A fever in the past three months?	Y	N
9.	Blood in your semen?	Y	N
10.	Pain in your scrotum or testicles?	Y	N
11.	Were both of your testicles descended at birth?	Y	N
12.	Any injury to your testicles or penis?	Y	N

Have you ever had an operation for:				**Side**	**Year**
13.	Hernia	Y	N		
14.	Varicocele	Y	N		
15.	Hydrocele	Y	N		
16.	Undescended testis	Y	N		
17.	Any abdominal surgery	Y	N		
If yes, please specify					
18.	Operation on testicles	Y	N		
If yes, please specify					
19.	Vasectomy	Y	N		
20.	Circumcision or other surgery on penis	Y	N		
21.	Other surgery	Y	N		
If yes, please specify					

22. Endocrine History

Do you have, or have you ever had:			
1.	Difficulty smelling	Y	N
2.	Headaches	Y	N
3.	Visual problems	Y	N
4.	Enlarging hands and feet	Y	N
5.	Problems with perspiration/sweating	Y	N
6.	Changing skin color	Y	N
7.	Frequent episodes of lightheadedness or dizziness	Y	N
8.	Growth problems	Y	N
9.	Do you have a general sense of well-being?	Y	N
10.	Do you notice a recent change in your energy level?	Y	N
11.	Do you have wide mood swings?	Y	N
12.	At what age did you first note armpit hair?		
13.	At what age did you first note pubic hair?		
14.	At what age did you start to shave?		
15.	How often do you need to shave?		
	a. Twice a day		
	b. Every two days		
	c. Once a day		
	d. Twice a week or less		
	e. Any change?		
16.	How does your beard compare with men of your family?		
	a. Same		
	b. Sparser		
	c. Heavier		

23. Occupational History

1.	What is your present occupation?		
2.	Past occupations:		
3.	Is your occupation stressful?	Y	N
4.	Do you need to meet rigid deadlines or time schedules?	Y	N

5.	How many hours do you work per week?		
6.	Do you frequently travel?	Y	N
7.	Do you fall asleep easily?	Y	N
8.	Do you wake up early?	Y	N
9.	In your work or elsewhere, are you or have you ever been exposed to any of the following?		
a.	Prolonged heat	Y	N
b.	Radiation	Y	N
c.	Pesticides	Y	N
d.	Industrial solvents	Y	N
e.	Agent Orange	Y	N
f.	Dyes	Y	N
g.	Heavy metals	Y	N
h.	Plastics	Y	N

24. Medication and Drugs

Are you taking, or have you ever taken, any of the following medications:

1.	Allopurinol	Currently	Previously	Never
2.	Antidepressants	Currently	Previously	Never
If yes, please specify:				
3.	Antihistamines	Currently	Previously	Never
4.	Antihypertensive drugs	Currently	Previously	Never
5.	Antiparasite agents	Currently	Previously	Never
6.	Antipsychotic agents	Currently	Previously	Never
7.	Aspirin	Currently	Previously	Never
8.	Barbiturates	Currently	Previously	Never
9.	Chemotherapy	Currently	Previously	Never
10.	Cholestyramine	Currently	Previously	Never
11.	Clofibrate	Currently	Previously	Never
12.	Digitalis	Currently	Previously	Never
13.	Dilantin	Currently	Previously	Never
14.	Diuretics	Currently	Previously	Never
15.	Hormones	Currently	Previously	Never
If yes, please specify:				
16.	Immunosuppressants	Currently	Previously	Never
17.	Insulin	Currently	Previously	Never
18.	Nicotinic Acid	Currently	Previously	Never
19.	Norpace	Currently	Previously	Never
20.	Penicillin	Currently	Previously	Never
21.	Streptomycin	Currently	Previously	Never
22.	Sulfa drugs	Currently	Previously	Never
23.	Tagamet (Cimetadine)	Currently	Previously	Never
24.	Tetracycline	Currently	Previously	Never
25.	Tranquilizers	Currently	Previously	Never
26.	Propecia or Proscar	Currently	Previously	Never
27.	Alternative Medicines	Currently	Previously	Never
28.	Other:			

Please list any allergies you have here:

25. Social History

1.	Do you smoke?	Yes	No	For how long?
If yes, what and how much do you use?:				
	A. Cigarettes			/Day
	B. Cigars			/Day
	C. E-cig (nicotine-based)			/Day
2.	Do you use smokeless tobacco?	Yes	No	For how long?
3.	Do you use marijuana?	Yes	No	For how long?
If yes, how often do you use marijuana?				/Week
4.	Do you drink alcohol-containing drinks?	Yes	No	For how long?
If yes, how much do you drink?				/week
5.	Do you drink caffeine-containing drinks?	Yes	No	How much? /Day
6.	Do you use any of the following substances?			
a.	Cocaine	Yes	No	
b.	LSD	Yes	No	
c.	Amphetamines	Yes	No	
d.	Quaalude	Yes	No	
e.	Angel Dust	Yes	No	
f.	Heroin	Yes	No	
g.	Methadone	Yes	No	
7.	Do you take long baths, saunas, Jacuzzis or steam on a regular basis?	Yes	No	

26. Family History

1.	How many brothers do you have?			
2.	Give the number of children of each of your brothers: Brother 1:_____ Brother 2:_____ Brother 3:_____ Other :_____			
3.	How many sisters do you have?			
4.	Give the number of children of each of your sisters: Sister 1: _____ Sister 2:_____ Sister 3:_____ Other :_____			
5.	Are any of the following diseases or conditions present in your family?			Who?
a.	Birth defects	Yes	No	
b.	Cancer	Yes	No	
c.	Cystic fibrosis	Yes	No	
d.	Diabetes	Yes	No	
e.	Heart disease	Yes	No	
f.	High blood pressure	Yes	No	
g.	Hormone problems	Yes	No	
h.	Kidney disease	Yes	No	
i.	Lung disease	Yes	No	
j.	Poor sense of smell	Yes	No	
k.	Tuberculosis	Yes	No	
l.	Genetic abnormalities	Yes	No	
m.	Varicocele	Yes	No	

FOR PHYSICIAN'S USE – DO NOT COMPLETE:		
Date:		
Vitals:		
Temp:		Height:
Weight:		BP:
Pulse:		Resp:
Symphysis to crown in cm:		Symphysis to floor in cm:
General Appearance:		
Skin:	NL	Abnormal
Fundoscopy:	NL	Abnormal
Eyes close together:	NL	Abnormal
Head & Neck:	NL	Abnormal
Facies:	NL	Abnormal
Palate:	NL	Abnormal
Back & Spine:	NL	Abnormal
Thyroid:	NL	Abnormal
Heart:	NL	Abnormal
Lungs:	NL	Abnormal
Abdomen:	NL	Abnormal
Extremities:	NL	Abnormal
Short 4th metacarpal:	NL	Abnormal
Short 4th metatarsal:	NL	Abnormal
Do knees touch when ankles are together?	NL	Abnormal
Neurologic Exam:		
Hair dist:	NL	Abnormal
Temporal:		Fascial:
Pubic:		Auxillary:
Chest:		
Fat Distribution:	NL	Abnormal
Gynecomastia:	NL	Abnormal
Nipples widely spaced:	NL	Abnormal
Musculoskeletal:	NL	Abnormal
Escutcheon:	NL	Abnormal
Penis:	NL	Abnormal
Length:		Foreskin:
Scrotum:		
		Right Left
Testis volume:		
Testis consistency:		
Epididymis:		
Vas deferens:		
Varicocele:		
Prostate:		
Symmetry:		Consistency:
Tenderness:		Nodules:
Mass:		
Seminal Vesicles:	NL	Abnormal:
Other:		

Diagnosis:

Plan:

Inclusion in Protocol #:

History of Present Illness:

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PLEASE FILL IN THE **NAME** AND **ADDRESS** OF THE DOCTOR OR RABBI WHO REFERRED YOU TO DR. GOLDSTEIN.

NAME: _____

MEDICAL SPECIALTY: _____

ADDRESS: _____

_____

PHONE: _____

FAX: _____

Patient Name: _____ Date of Birth :_____

Pharmacy Information

With the installation of EPIC, the new electronic medical record system, at this practice, your doctor is now able to e-prescribe. This means that any prescription the doctor may give you today will be automatically routed to the pharmacy of your choice.

Preferred Pharmacy	**Alternate Pharmacy**
Name of Pharmacy:_____	Name of Pharmacy:_____
Address: _____	Address: _____
_____	_____
City: _____	City: _____
State:_____	State:_____
Zip Code: _____	Zip Code: _____
Phone Number: _____	Phone Number: _____
Fax Number: _____	Fax Number: _____

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PATIENT ALERT

DEAR PATIENT:

THE LABORATORY TESTS ESSENTIAL FOR A THOROUGH INFERTILITY EVALUATION ARE OFTEN QUITE COSTLY. YOU ARE RESPONSIBLE FOR KNOWING THE POLICIES AND PROCEDURES OF YOUR INSURANCE CARRIER REGARDING ALLOWABLE LABORATORIES AND COVERAGE FOR ALL SERVICES.

FAILURE TO USE THESE LABORATORIES WILL RESULT IN DENIAL OF COVERAGE FOR THESE SERVICES. PLEASE INFORM THE OFFICE PERSONNEL THAT YOU MUST USE THESE LABORATORIES AND YOU WILL BE GIVEN A PRESCRIPTION (AUTHORIZATION) TO BRING TO THE APPROPRIATE LABORATORY.

YOU MAY CALL THE TELEPHONE NUMBERS LISTED BELOW FOR A LABORATORY THAT IS CONVENIENT FOR YOU:

LABCORP (NEW YORK 1-800-788-9091) (NJ 1-800-631-5250 X2642)

QUEST 1-800-377-8448 OR 1-800-225-7483 OR 1-800-222-0446
www.questdiagnostics.com